Knowledge is Power: Understandings of Accessibility From Mental Health Service Providers in Ethnically Diverse Communities

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Abstract

Background and Aims: Ethnically diverse communities experience inequity across mainstream mental health services in the UK, which impacts their accessibility. Multiple explanations have been suggested as underpinning these inequities, including: stigma, lack of cultural humility, inaccessible service structures, and widespread racism. Research has largely focused on the experiences of ethnically diverse service users, reinforcing that the responsibility for accessing services lies with individuals. In order to shift this narrative, the current study aimed to explore understandings of mental health service accessibility for ethnically diverse communities from the perspective of third sector service providers. This enabled consideration of system-level barriers impacting service accessibility.

Method: Semi-structured interviews were facilitated with fifteen ethnically diverse participants, representing fourteen different third sector organisations. Interviews were analysed using reflexive thematic analysis.

Analysis: Five themes were developed from the analysis relating to participants' understanding of service accessibility. These were: 'knowledge is power,' 'navigating the pathway to inclusivity,' 'from cultural competence to cultural humility,' 'deepening connection,' and 'building on a weak foundation'.

Discussion: This study highlights the multifaceted understandings of service accessibility. Broadly, uniting perspectives was the necessity for mainstream mental health services to proactively take responsibility for disseminating knowledge regarding service access to ethnically diverse communities, recognising that the availability of services is not equally learned. Participants reflected how enabling belonging, through developing collaborative, shared understandings of mental health difficulties, and forming flexible services to meet the individualised needs of ethnically diverse individuals, aids accessibility. Participants highlighted the value of authentic connection, supported by a willingness from clinicians to self-reflect and challenge their internal biases and assumptions. Mainstream services were encouraged to dismantle the institutionally racist foundations on which they are formed. This requires integration of services to challenge established power structures and meaningfully promote those with diverse cultural experiences to service leadership positions to build holistic, accessible services.

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Chapter One: Introduction

I start this chapter with a brief summary of the project, before exploring definitions and language surrounding ethnicity. I then discuss disparities in mental health outcomes in relation to ethnicity and outline a range of proposed explanations for these. Following this, I reflect on ways inequity in mental health services has been recognised and addressed through policy and initiatives. I conclude this chapter by exploring good practice examples of enabling accessibility and where my research project fits within the literature, alongside the research aims.

Summary

Research widely indicates that individuals from ethnically diverse communities experience inequity within mental health services, contributing to the maintenance of discrimination, stigma, power imbalances, and poor health outcomes (Arday, 2018; Chouhan & Nazroo, 2020). This includes over-representation of ethnically diverse communities in secure aspects of the mental health system, yet, there is under-representation of these communities in specialist mental health services and in referrals for psychological intervention (Das-Munshi et al., 2018; Halvorsrud et al., 2018; NHS Digital, 2021; Wessley, 2018). The picture of mental health service accessibility, defined as the ability to have health and care needs met by existing care pathways and services, is therefore complex (Suresh & Bhui, 2006). Factors including mistrust, culturally insensitive environments, and racist service structures have all been proposed as underpinning and contributing to accessibility inequities (Nazroo et al., 2020; Razai, Osama, et al., 2021).

Previous literature has often categorised ethnically diverse communities as a ‘hard to reach’ group, reinforcing the narrative that the responsibility for accessing mental health services lies with individuals. This categorisation dismisses the impact of institutional and structural racism, in which the foundations of services prevent accessibility for ethnically diverse communities. As a result, previous research has largely focused on the experiences of individuals, potentially limiting the exploration of service-related factors. In order to enhance the accessibility of mental health services for ethnically diverse communities, research needs to explore wider understandings of what culturally appropriate, inclusive care looks like, alongside the barriers to implementing this. The current study aimed to address this by developing an understanding of accessibility of mental health services from the perspectives of employees and volunteers working at third sector organisations in ethnically diverse communities. Interviews were facilitated to explore understandings of accessible care, the ways this has been achieved, and how mainstream services, namely NHS-based mental health services, can increase accessibility.

Personal Reflections Regarding the Project Development

This study initially aimed to explore the accessibility of mental health services for ethnically diverse communities who self-harm. This was due to my personal experience of working within mental health services and observing the heightened impact of stigma for ethnically diverse individuals also experiencing self-harm. I began researching the interacting impact of experiencing self-harm within ethnically diverse communities to examine if there were specific accessibility considerations for this population. This seemed to be an under researched area which I decided to explore. As a result, information included in the appendices for this thesis refer to the initial focus of this study researching accessibility of services for self-harm in ethnically diverse populations.

However, upon starting recruitment I noticed an absence of third sector services supporting ethnically diverse communities specifically for self-harm. Therefore, the decision was made to broaden the inclusion criteria to services providing mental health support for a range of difficulties within ethnically diverse communities, whilst still asking specifically about self-harm. Following the two pilot interviews, it became clear the impact of self-harm did not appear to form a distinct part of the interviews. Alternatively, participants reported that the accessibility considerations they raised applied to many mental health difficulties they encountered in ethnically diverse communities. In the remaining interviews, participants continued to be asked about whether there were specific accessibility barriers for ethnically diverse communities who self-harm. Participants referred to self-harm being associated with greater stigma and concealment, due to its link to feelings of shame. However, some participants had limited experience working directly with individuals who self-harm and felt unable to comment on accessibility considerations for this specific population.

Accordingly, the decision was made that, to aid coherence and to communicate the most meaningful aspects of the data, the focus would involve exploring understandings of mental health service accessibility for mental health difficulties broadly. The remainder of this thesis therefore focuses on mental health service accessibility in relation to all mental health difficulties.

Defining Race, Racism and Ethnicity

Race is a social, political construction, not based on biological or scientific truth, but is a term created by people, to categorise, marginalise, discriminate against and exclude people on the basis of skin colour and physical characteristics (Schouler-Ocak et al., 2021; Sternberg et al., 2005). There is nothing distinct about race which requires differentiating people in this way, however, the consequences of these categorisations are vast and powerful. Race can have very real effects due to the historical, social and political meaning ascribed and how power is negotiated in relation to race, leading to ongoing discrimination (Emirbayer & Desmond, 2015; Hughey & Jackson, 2017).

Racism is a term used to define oppression, centred around one race being perceived as superior to another and forming the basis of ongoing power imbalances, prejudice and exclusion (Heinz et al., 2014; Omi & Winant, 2014). Golash-Boza (2016) states that racism acts to link a physical difference to a cultural and social difference, which forms a power hierarchy, enabling subordination of particular groups over others. Racism can take many forms, including: internalised, interpersonal, institutional, and structural (Schouler-Ocak et al., 2021). Internalised racism relates to incorporating racist attitudes, stereotypes and beliefs about racialised groups into one's worldview (Schouler-Ocak et al., 2021). Interpersonal racism involves expressions of racism which occur relationally, within interactions between members of different ethnic groups (Kornienko et al., 2022; Nazroo et al., 2020). Institutional racism refers to racism embedded within policies, processes, cultures and services which reinforce discrimination (Schouler-Ocak et al., 2021). Institutional racism is highlighted by unequal access to resources and opportunities for Black individuals (Schouler-Ocak et al., 2021). It also incorporates an individual's beliefs, prejudices, biases and stereotypes, which together make up organisations and social structures. Wider still, structural racism encompasses all societal, political and economic systems which interact to reinforce inequality (Schouler-Ocak et al., 2021). It refers to discrimination embedded within laws, public policies, media, and services which favour White individuals and heighten racial group inequity (Yearby & Mohapatra, 2020).

Crucially, these forms of racism do not operate independently. Each level of racism interacts and functions interdependently, supporting and reinforcing each other (Nazroo et al., 2020). For example, interpersonal racism exists within a range of environments and interactions, which provides a structural foundation in forming racist institutions and societies (Nazroo et al., 2020; Phillips, 2011).

Ethnicity is a multi-faceted social construction used to group individuals based on a shared race and culture, particularly considering factors including: intergenerational values, religious practices, language, skin colour, geographical origin, and cultural practices (Burlew, 2000). Ethnicity is often used interchangeably with race and despite being related terms, they are distinct. In contrast to race, ethnicity is a broader, dynamic construct, encompassing a spectrum of identities and can be chosen by an individual (The Law Society, 2020). According to the most recent census data collated in 2021, approximately 18% of individuals in England and Wales identify as an ethnic minority, which refers to all ethnic groups except White British (Office for National Statistics, 2020). More specifically, in England, 9.6% of the population identified as 'Asian or Asian British', 4.2% identified as 'Black, Black British, Caribbean or African', 3% identified as 'mixed or multiple ethnic groups' and 2.2% identified themselves in the 'other ethnic groups' category (Office for National Statistics, 2020). These figures illustrate ethnic diversity in the UK and situate the context of this research project.

There are current inconsistencies regarding the most helpful and appropriate terms, phrases and acronyms used to describe ethnicity, with an absence of universal agreement, as language continues to evolve and be evaluated. 'Black, Asian and Minority Ethnic' (BAME) is a frequently utilised term, referring to all ethnicities except White ethnic groups, however, this is not a universally recognised, or accepted term (Rugkåsa & Canvin, 2010). The term 'BAME' homogenises all non-White individuals, emphasising certain ethnicities, whilst excluding others, thereby masking specific inequalities in a clumsy acronym (Campbell-Stephens, 2020; Selvarajah et al., 2020; Sewell et al., 2021). Bunglawala (2019) reported that 'ethnic minorities' is a more appropriate term as it ensures White minority groups, including Gypsy and Traveller communities, are also acknowledged. However, it is important to be mindful that ethnic groups, which are minorities in the UK, make up the majority of the population globally. The term 'Global Majority' captures this and moves away from problematically situating White ethnicities as the norm to compare to (Campbell-Stephens, 2020). Global Majority also shifts the narrative from associating certain groups with disadvantage, to advantage and empowerment (Campbell-Stephens, 2020). Campbell-Stephens (2020) draws attention to how societal structures benefit the White minority, such that White individuals do not readily locate themselves as a minority group and are largely able to ignore race. The term 'racially minoritised' has a similar foundation, recognising individuals who may be part of a numerical majority, but have had their ethnic identity negatively impacted by cultural, political and social power (Selvarajah et al., 2020). Despite inconsistencies in terminology, one uniting position is that specific ethnicities should be used where known, aligning with the individual's language preferences, rather than inappropriately using generalising terms (Bradby, 2003; Campbell-Stephens, 2020).

As part of designing this research project, I had the opportunity to attend meetings with an existing network involving representatives from third sector organisations working directly with ethnically diverse individuals. The group itself was ethnically diverse and I gained their perspectives on the most appropriate term to use throughout this research project. 'Ethnically diverse communities' was recommended as it is empowering, inclusive and enables specific ethnicities to be named when known. I have therefore utilised 'ethnically diverse communities' when referring to individuals who do not identify as White British. It is important to acknowledge that since all individuals could be considered 'ethnically diverse,' this term may be suggested to continue to centre White identities, as specific reference is not made to racially minoritised communities. However, the term helpfully moves away from disempowering ethnically diverse communities, as it avoids associating certain communities with disadvantage. The term also captures all ethnically diverse identities, ensuring no specific ethnicities are emphasised over others. Notably, when describing previous research I have used the author's specified terminology. I have also capitalised ethnicities throughout to acknowledge their social construction and to illustrate that ethnicity is an aspect of an individual's identity and not part of a colour palette (Bunglawala, 2019).

In addition, language continues to evolve over time and since no language is perfect to all people, engaging in ongoing discussion supports highlighting the strengths and limitations of different terminology, which enables ongoing progression. I hope this discussion of language highlights the importance of continuing conversations to ensure the terminology we use is appropriate, sensitive, and prevents harm.

Evidence of Mental Health Inequity According to Ethnicity

Ethnic inequity is depicted as stretching across UK mental health services. Disparities in mental health outcomes amongst ethnically diverse communities have been widely reported and understanding these is essential for unpacking accessibility of mental health services (Nazroo et al., 2020). Broadly, ethnically diverse individuals are more likely to receive diagnoses of severe, enduring mental health difficulties and, more specifically, Black African and Black Caribbean are two to eight times more likely to be diagnosed with a severe mental health condition compared to White individuals (Bignall et al., 2022; Grey et al., 2013). However, Black service users are less likely than White service users to voluntarily access mental health services and are more likely to have adverse routes to intervention, consequently leading to a greater likelihood of compulsory treatment (Chouhan & Nazroo, 2020; Gazard et al., 2018; Nazroo, 2015).

Mental Health Diagnoses in Ethnically Diverse Communities

Every seven years, the Adult Psychiatric Morbidity Survey (APMS), commissioned by NHS digital, reports national mental health statistics for England, monitoring mental health difficulties in adults living in private households (McManus et al., 2016). The most recently published survey reported that, for men, there were no significant differences across ethnic groups in the experience of common mental health conditions, including: anxiety, depression, phobias, obsessive compulsive disorder and panic disorder. However, there were significant differences for women, depending on ethnicity. Namely, 29% of Black women and 24% of Asian women reported a common mental health condition, compared to 21% of White British women and 16% of other White women (McManus et al., 2016). More prominent disparities were evident in relation to specific diagnoses, in which Black adults were twice as likely to be screened as meeting criteria for a diagnosis of post-traumatic stress disorder and Black men particularly were approximately ten times more likely to experience difficulties associated with a diagnosis of psychosis than White men (McManus et al., 2016).

Previous analyses of APMS data, across three time periods, have demonstrated similar patterns. In particular, drawing attention to the differences in prevalence of psychosis diagnoses in Black ethnic groups which, per 1,000, was 14.2, compared to 4.4 for White ethnic groups (Qassem et al., 2015). Due to small sample sizes, the researchers combined all Black populations and were therefore unable to draw specific comparisons of ethnicities, possibly overlooking significant differences.

Interestingly, despite a consistent finding highlighting higher rates of psychosis diagnoses in Black populations compared to White populations, community studies differ to clinical studies, whereby the latter report even higher rates of disparity (Cooper et al., 2008; Fearon et al., 2006). These contrasting findings are likely to be reflective of methodological differences between approaches. Namely, survey methodologies are impacted by response rate difficulties, for example, individuals experiencing mental health difficulties may be less available or willing to participate (McManus et al., 2016; Qassem et al., 2015). In addition, those in care homes, temporary accommodation, prisons or psychiatric hospitals, are excluded from community studies which will impact their accuracy (McManus et al., 2016; Nazroo, 2015). Clinical incidence studies also have methodological considerations, including assuming that all incidents of psychosis will reach the attention of mental health services and the subjectivity of Western diagnostic criteria (Nazroo, 2015). Despite these methodological differences, all report that over the last 60 years, individuals from Black Caribbean and Black African backgrounds are consistently more likely to be diagnosed with a form of psychosis (Halvorsrud et al., 2019; Nazroo et al., 2020).

Access to Mental Health Services for Ethnically Diverse Communities

As described above, individuals from ethnically diverse communities appear to experience either comparable or greater mental health diagnoses than individuals from White backgrounds. Despite this, White individuals are twice as likely to be voluntarily receiving mental health support from services in the UK compared to Black individuals (McManus et al., 2016).

It is apparent that depending on what service is being investigated and the type of care it provides, ethnically diverse individuals are more or less represented. Concerningly, Black male service users are over-represented within restricted, compulsory parts of the mental health system, and are more likely to have contact with mental health services through the criminal justice system, secure forensic services and psychiatric intensive care units (Bhui et al., 2015; Keating et al., 2002; Suresh & Bhui, 2006). Additionally, Black African individuals are over three times more likely, and South Asian individuals one and a half times more likely, to experience compulsory admission to hospital under the Mental Health Act (Halvorsrud et al., 2018). Black individuals are also over-represented in assertive outreach services, designed to supervise those not engaging in community services and potentially minimising service users' autonomy and independence (Patel et al., 2011). A further review highlights that Black African and Caribbean individuals are eight times more likely to be subjected to community treatment orders and four times more likely to be detained than White individuals in the UK (Wessley, 2018). This finding has remained consistent, as demonstrated by statistics produced by NHS Digital (2021), which showed, in 2021, Black individuals were almost five times more likely to be detained under the mental health act compared to White individuals, with the highest rates amongst Black African individuals. The rise in these figures however, may have been impacted by improvements in data recording of detentions (NHS Digital, 2021).

Research exploring access to mental health services specifically for first episode psychosis reported that Black African and African Caribbean service users were more likely to have adverse pathways of care (Morgan et al., 2005b). This is demonstrated by significantly lower rates of referrals from general practitioners and higher rates of referrals from the criminal justice system, compared to White service users (Morgan et al., 2005b). These findings were maintained independent of living status, gender and involvement of family. Black African and African Caribbean service users were also more likely to be compulsorily admitted when first contacting mental health services compared to White service users (Morgan et al., 2005a). These studies obtained their sample from two locations in England and found comparable results across both sites.

In contrast to the above findings, ethnically diverse communities are under-represented in services where help is sought voluntarily (Myrie & Gannon, 2013). Black African and Black Caribbean individuals are approximately half as likely to visit a general practitioner before an admission than White individuals (Halvorsrud et al., 2018). The Leeds in Mind (2017), Mental Health Needs Assessment reported that individuals from Black and ethnic minority communities are one of the least likely groups to access support for mental health difficulties and are under-represented on primary care registers in Leeds.

This inequitable access to services extends to interventions offered, with Black individuals less likely to receive psychological support and antidepressants, whereas they are 50% more likely to be prescribed psychotropic drugs than White individuals (Das-Munshi et al., 2018). Specialist service provision for ethnically diverse individuals experiencing self-harm also appears to differ, with ethnic minority groups significantly less likely to receive specialist onward referrals or psychological counselling compared to White individuals (Cooper et al., 2010; Michelmore & Hindley, 2012). This aligns with outcome information collected by Improving Access to Psychological Therapies (IAPT) in English services, which highlighted that White individuals were more likely to complete interventions compared to all other ethnicities (Baker, 2020). White individuals were also more likely to move to recovery, observing greater improvements in their mental health difficulties compared to other ethnicities (Baker, 2020). These findings are particularly concerning as IAPT was launched with the focus of increasing accessibility to mental health services.

Sewell (2012) reported five key aspects of mental health service inequity for ethnically diverse communities that require consideration. Namely: greater exposure to experiences that are linked to poor mental health; higher access rates for services relating to severe mental health diagnoses; less access to community mental health services; poorer outcomes within services; and poorer experiences of working with mental health professionals. These areas begin to depict some of the explanations regarding differences in access to services and diagnoses received by ethnically diverse communities, which I will now explore in detail.

Explanations for Mental Health Inequities in Ethnically Diverse Communities

It is widely reported that ethnically diverse communities experience poorer mental health outcomes due to a complex interaction of factors (Memon et al., 2016; Schouler-Ocak et al., 2019). One line of argument suggests individual risk factors, including experiences of trauma and socioeconomic deprivation, drive health inequalities (Shim, 2021). Others ascribe to cultural determinism, suggesting that cultural factors between ethnic groups lead to differences in health outcomes (Shim, 2021). However, both these positions problematically dismiss the role of institutional and systemic racism in shaping mental health service provision (Fernando, 2004). I will now explore a range of explanations for mental health disparities, which are likely to interact and impact the accessibility of services.

Defining and Diagnosing Mental Health Difficulties

A potential explanation for inequity in mental health services relates to the models and diagnostic criteria used to define mental health difficulties in the UK, which operate within a Eurocentric paradigm (Fernando, 2012). As a result, variations in perceptions of mental ill-health across cultures are often overlooked (Fernando, 2004). Lazaridou and Heinz (2022) highlight the dominance of Western explanations of mental health difficulties, demonstrating that many ideas and theories have less relevance in the majority of the world. The Westernised mental health knowledge adopted in the UK is used with non-Western service users, due to beliefs it has universal value and applicability, thereby dismissing the impact of social norms (Bulhan, 2015; Fernando, 2004; Oppong, 2019; Vernon, 2011). Fernando (2012) recommends a critical, decolonising approach, through exploring transcultural theories of mental health, to illustrate how diagnostic misperceptions may lead to higher diagnoses in ethnically diverse communities.

There are many examples of alternative mental health diagnostic criteria, including the Azibo Nosology II, which is a classification scheme for the mental health of people of African heritage, with consideration of African culture and traditions (Lazaridou & Heinz, 2022). The Azibo Nosology II has been used in clinical research, demonstrating its efficacy and comprehensiveness of diagnosing mental health difficulties in people of African heritage (Dennard, 1998). Mental health diagnosis criteria used in the UK, including the DSM-5, rarely reflects on the impact of socio-political context of conditions, including experiences of racism, sexism, homophobia and ableism (Lazaridou & Heinz, 2022). Most crucially, in order to decolonise mental health diagnoses, the ideas and contributions of racialised minorities needs to be maximised, as White mental health clinicians lack the required lived experience to effectively achieve this (Lazaridou & Heinz, 2022).

Stigma and Cultural Narratives

Consistently, research indicates that individuals from ethnically diverse communities may not access mental health services due to cultural narratives and stigma associated with help seeking (Arday, 2018; Lamb et al., 2012). Gary (2005) describes the intersectionality of ethnically diverse individuals who also experience mental health difficulties and the combined, interacting stigma this can result in. Knifton et al. (2010) highlight that, within different communities, mental health difficulties attract varied forms of stigma. For example, in some Chinese communities, shame and guilt surrounding mental health difficulties leads to fear of criticism and disgrace associated with disclosure (Lee et al., 2005). Community led studies, utilising a focus group methodology, reported that uniting Pakistani, Indian, and Chinese communities was stigma surrounding mental health problems, resulting in shame, concealment, concerns regarding marriage prospects, and the effects on educational attainment (Glasgow Anti-Stigma Partnership, 2006). Expectations to be self-reliant and to independently manage problems to protect community status can also limit access to professional support in some ethnically diverse communities (Burr & Chapman, 2004; Nada-Raja et al., 2003).

In a qualitative study exploring barriers to accessing mental health services in England, for adults from minority ethnic populations, Memon et al. (2016) developed two overarching themes, using thematic analysis. The first related to personal and environmental factors with participants illustrating that they may not recognise or accept mental health difficulties, or wait until symptoms become debilitating before accessing services. This was particularly prevalent for participants who had grown up in their native countries and had varying levels of acceptance and knowledge of mental health difficulties. The researchers reported that participants experienced particular mental health difficulties as socially unacceptable and could stigmatise their whole family within a community (Memon et al., 2016). A separate subtheme collated ideas regarding how cultural background dictated acceptable responses to mental health difficulties, including narratives of displaying strength which prevented access to mental health services. An example of this was expressing mental health difficulties as physical symptoms to reduce stigma, whilst simultaneously heightening the risk of misdiagnoses (Memon et al., 2016).

The impact of stigma has also been identified in Black and minority ethnic University students, who expressed culturally defined responses and coping mechanisms to mental health difficulties (Arday, 2018). Arday (2018) reported the same overarching two themes as Memon et al. (2016) in their exploration of barriers to accessing mental health services. Replicating previous findings, participants expressed denying the existence of mental health difficulties due to fears of stigmatisation, such as damage to their reputation, and often delayed seeking support until experiencing crisis.

Specific mental health difficulties appear to be associated with a greater degree of stigma. In particular, self-harm, whereby stigmatising responses extend to the services providing support, with clinicians identified to be dismissive, judgemental, and expressing negative attitudes (Saunders et al., 2012). Linked to this is public stigma surrounding self-harm, which can become internalised and reduce help-seeking behaviours (Bathje & Pryor, 2011; Fortune et al., 2008). The impact of stigma related to self-harm is likely to be heightened in ethnically diverse communities that do not recognise self-harm, or believe self-harm behaviours should be managed within the family or community (Goldston et al., 2008). The role of religion and spirituality also results in lower reported rates of self-harm and an increased likelihood of concealing self-harm due to its associated stigma, which in turn reduces the likelihood of service access (Chu et al., 2010).

Narratives relating to mental health difficulties may be maintained by ethnically diverse community responses to long-standing discrimination, leading to the encouragement of community led self-care, rather than accessing services (Burr & Chapman, 2004; Edge & Rogers, 2005). Whilst acknowledging the shortcomings of generalisation, these findings tap into broad cultural and values-based differences between traditional Eastern and Western cultures. For example, some Eastern cultures prioritise relational mental health support within families and communities, contrasting to traditional Western cultures, which emphasise developing an individualised identity and therefore facilitate one to one interventions (Fernando, 2012). As a result, in Western mental health contexts, particular closeness with family members may be interpreted as a symptom of poor mental health. Additionally, Western mental health services largely attribute the cause of mental health difficulties as residing within the individual, which is not generalisable across all cultures (Fernando, 2012).

Myrie and Gannon (2013) reported that some Black men relate to discourses of having to ‘act tough’ and identified with the concept of ‘hypermasculinity,’ experiencing the need to be strong. The authors wondered whether needing to enact these stereotypes to defend against oppression actually led to further discrimination from services, suggesting if this need was omitted, perhaps Black men would feel more able to engage in mental health support (Myrie & Gannon, 2013). Comparably, knowing their greater likelihood of forced admission may lead to understandable resistance and anger towards services (Littlewood & Lipsedge, 1997). These discourses and cultural narratives also impact the perspectives of clinicians who are exposed to them. This includes psychiatrists being increasingly likely to label Black Caribbean service users who have been detained as more dangerous than their White counterparts (Rogers, 1990). These labels can be strengthened by stereotypes of perceiving Black individuals to be ‘big and dangerous’ (Keating, 2007).

Comparably, a proposed hypothesis for fewer specialist referrals for Black women relates to the frequently attributed ‘discourse of strength,’ which has been reinforced by historic depictions of Black women demonstrating perseverance through adversity (Edge, 2007; Nelson et al., 2016). An alternative explanation suggests mental health professionals may not prioritise referrals for ethnically diverse communities due to seemingly low-risk characteristics, such as being less likely to be single and increased availability of community support. This includes the role of ethnic density in which living amongst people of the same ethnicity can be a protective factor for mental wellbeing (Schofield et al., 2016).

Lack of Cultural Humility

A further explanation of disparities in access to mental health services for ethnically diverse communities relates to a lack of cultural humility within the practice of mental health clinicians. Cultural humility centres around the commitment to ongoing self-reflection, specifically recognising the impact of implicit racial biases, alongside maintaining an openness to learn about different cultures (Lekas et al., 2020). Poor cultural humility was alluded to by Memon et al. (2016) through participants’ frustration at having to repeatedly explain their experiences of racism in services, with some clinicians not managing these interactions well, demonstrating cultural naivety and insensitivity. Comparably, racialised service users have also reported feeling burdened by having to teach clinicians about their lived experiences of racism, with concerns about whether they will be listened to and believed (Alang, 2019).

Concerningly, research indicates that clinicians often avoid discussions about ethnicity and rarely consider the impact of discriminatory experiences within therapeutic intervention, consequently disrupting the therapeutic alliance (Arday, 2018; Beck, 2019). Mental health professionals have explained their reluctance to discuss ethnicity as underpinned by feeling anxious and uncomfortable, with fears of being labelled racist or offensive outweighing the perceived benefits of exploring cultural differences (Dogra et al., 2007; Mensah et al., 2021). Other professionals reportedly engage superficially and cautiously in these discussions (DiAngelo, 2018).

A review titled ‘Breaking the circles of fear’ by Keating et al. (2002), explored the relationship between Black African and Caribbean communities and mental health services, particularly considering service accessibility. Keating et al. (2002) outlined that mental health services are experienced as inhumane and characterised by a lack of respect. These communities also experienced a sense of secrecy surrounding discussions about racism within services, resulting in feeling unsafe addressing their cultural background (Keating et al., 2002). Due to the avoidance of clinicians there was a lack of opportunity for them to develop the confidence and competence to discuss cultural influences within mental health support (Keating et al., 2002). Accompanying this, a reported absence of staff training to navigate differing cultural experiences led to service users feeling unable to challenge clinicians’ views and eventually having to disengage from services. This lack of flexibility extended to staff not incorporating other world views, belief systems or models into their practice. Individuals noted that being unable to share their experiences of racism also led to shame responses (Keating et al., 2002). More recent research suggests Black and minority ethnic service users have experienced discomfort when sharing their experiences of racism, resulting in self-censoring to protect White healthcare professionals from becoming upset (Arday, 2022). Disturbingly, this suggests that despite the review by Keating et al. (2002) being facilitated over twenty years ago, its findings regarding service accessibility difficulties appear to remain relevant.

The absence of cultural humility is a unifying concept within the literature that implies mental health services often lack the provision to enable belonging and acceptance of difference, in order to increase accessibility. This relates to social identity theory, originally proposed by Tajfel (1981) which illustrates the importance of connection through describing the process of social categorisation. Social categorisation details how we form ingroups and outgroups, based on perceived similarities, to help make sense of our social environment. The theory acknowledges that humans have evolved to live in social groups as they provide us with enhanced social identity, wellbeing and self-esteem (Haslam et al., 2009). Social identity theory therefore suggests services can become discriminatory through overemphasising differences between ethnic groups, whereas inclusive services should enable all individuals to belong and feel understood. Belonging has also been shown to be protective against mental health difficulties, including low mood and anxiety (Procentese et al., 2020).

Research conducted by Dana (2002) describes how American mental health services frequently overemphasise the similarities between European Americans and discard the health needs of African Americans, consequently reducing the quality of assessments, and interventions delivered. Prioritising the needs of White individuals partly explains why cognitive behavioural therapy was developed for European Americans, yet is used with clients of all ethnicities, often with limited adaptations (Suinn, 1985). This lack of accommodation extends to mental health interventions, which are often piloted on middle-class, White students, thereby limiting their applicability and effectiveness for diverse populations (Kolivoski et al., 2014).

Inaccessible Service Structures

Mainstream mental health service structures have broadly been described as rigid, inflexible and lacking in accountability (Keating et al., 2002). It is therefore unsurprising that low rates of help-seeking behaviour reported in ethnically diverse communities may be due to poor experiences of support (Healthcare Commission, 2006; Raleigh et al., 2007).

Memon et al. (2016) reported many barriers to accessing mental health services located within service structures, including long wait times, leading to difficulties escalating before being responded to. Individuals who struggled to articulate their health problems, or had little understanding of English, experienced additional stress and in some cases inappropriate referrals and interventions. This has since been replicated, adding that language and communication barriers were especially prevalent for participants for whom English was a second language, with fears this could lead to miscommunications or having to repeatedly explain difficulties (Arday, 2018).

Inflexibility within services also impacts accessibility, with clinicians often demonstrating a generalised approach to care and expressing resistance to family members or friends joining appointments at the request of service users (Memon et al., 2016). This is concerning as previous literature has highlighted how family can help facilitate engagement with mental health services (Weich et al., 2012). In the review by Keating et al. (2002), family members felt ignored, dismissed and were not acknowledged by clinicians in a meaningful way. Families identified an imbalance of power between service users and mental health clinicians, which resulted in them continually fighting systems, and impacted their own mental wellbeing (Keating et al., 2002).

Service rigidity extended to mental health interventions, with reports that clinicians preferred to prescribe medication, rather than psychological therapy (Memon et al., 2016). Memon et al. (2016) discussed how participants were unaware of specialist services due to poor dissemination of information and consequently had no possibility of accessing them. This linked to their subtheme of power, in which mental health professionals' gatekeeping role to access interventions and referrals led to feelings of helplessness and a lack of control (Memon et al., 2016). Arday (2018) reported comparable fears about the power held by mental health professionals, for example, their ability to section individuals. A further area linked to lack of control is poor availability of consistent clinicians, leading to service users having to repeat personal and distressing information to different people (Keating et al., 2002).

Impact of Racism

Critical Race Theory (CRT) can be seen as central to explaining why individuals from ethnically diverse communities may not access mental health services and why inequities remain despite initiatives to address them. CRT highlights that racism is not only the product of biases at an individual level, but is embedded within institutions and systems, reinforcing that ethnically diverse communities are subordinate in regard to power and privilege (Trahan Jr & Lemberger, 2014). CRT is a socio-political movement, grounded in social justice, seeking to challenge systems which only reflect the experiences of White individuals, a process that has become normalised (Brown, 2003; Kolivoski et al., 2014). The movement encourages equity, rather than equality, acknowledging that not all ethnic groups have equal opportunities (Kolivoski et al., 2014).

CRT posits that all racism advances the experiences of White individuals and inclusive racial policies will be supported so long as they are still benefitted. It can be difficult to identify racism and confront its existence within services, policy and leadership due to claims of objectivity, for example, within mental health diagnoses (Brown, 2003). Alongside this, mental health difficulties are often categorised as being located within an individual, without recognition of socio-political and environmental influences (Brown, 2003). As a result, mainstream mental health services often choose not to integrate their care with third sector organisations as this may not benefit White individuals, but may limit accessibility for ethnically diverse populations (Kolivoski et al., 2014). Another principle of CRT is the ordinariness of racism, representing how racism exists unquestioned across time and settings (Bell, 2018). The normalisation of racist structures may partly explain why anti-racist recommendations, developed more than fifty years ago, are still not being actioned (Mensah et al., 2021). This is in spite of socio-political movements, including the Black Lives Matter movement, following the death of George Floyd in the USA, which have laid the foundation for change. CRT reflects that the lack of action to tackle power dynamics, which sustain mental health services, is due to the ongoing over-representation of White individuals in positions of power (Mensah et al., 2021).

A further consideration is how slavery, colonisation, and economic exploitations, have formed the foundations of mental health services (Kirmayer et al., 2021). Throughout history, exacerbating differences based on ethnicity has been used to justify these practices and impacted access to mental health services (Schouler-Ocak et al., 2021). Historical segregation of ethnically diverse communities has also resulted in poorer socioeconomic status, due to limited social and employment opportunities, and contributes to poorer mental health (Williams & Collins, 2001). Social identity theory, as referred to previously, explains how over-emphasising differences between ethnic groups can result in racism and discrimination, which reduces feelings of safety and threatens acceptance from others (Verkuyten et al., 2018). Racism can develop when members of a particular in-group emphasise difference of members of a contrasting out-group. This process can occur across settings, including service accessibility, conveying a message that links physical characteristics to belonging (Lazaridou & Heinz, 2022). Fernando (2012) suggests that categorising people as single identities, as opposed to recognising the capacity to hold several identities, can result in perceiving others as different, or even less human, and has previously been used to justify atrocities in health research. For example, the facilitation of the Tuskegee Syphilis Study, in which, without informed consent and through the use of deception, African American men were untreated for syphilis to investigate the long-term effects of the condition (Corbie-Smith et al., 1999; Shavers et al., 2002). The history of racism, and acts of discrimination within health research, understandably led to significant mistrust of medical professionals and researchers amongst ethnically diverse communities (Shavers et al., 2002).

A more recent illustration of structural racism is the Covid-19 pandemic, whereby ethnically diverse communities were disproportionately affected and over-represented in both hospitalisations and deaths caused by Covid-19 in the UK (Pareek et al., 2020; Phiri et al., 2021). Research highlights that central government did not prioritise promoting culturally adapted and translated public health messaging, failing to ensure ethnically diverse populations were protected from Covid-19 and able to access vaccinations (Mathur et al., 2020). This indicates the pandemic may not have produced health inequalities, but exacerbated existing inequalities that had previously been overlooked (Mathur et al., 2020; Public Health England, 2020). Similarly, the lower vaccine uptake in ethnically diverse communities represents the lack of trust in healthcare systems, resulting from negative healthcare experiences and culturally insensitive environments (Razai, Kankam, et al., 2021).

Due to both its pervasiveness and subtleties, it can be difficult to fully quantify the impact of racism (Nazroo et al., 2020). However, reported experiences of racism do not appear to have changed significantly over the last 20 years and experiences of prejudice have remained high (Kelley et al., 2017). Racism can understandably have significant negative impacts on mental health and is recognised as both a causal and mediating factor (Bailey et al., 2017).

Research has established that interpersonal experiences of racism results in poorer mental health, with an even stronger association between racism and mental health than the relationship between racism and general health (Bailey et al., 2021; Karlsen et al., 2005; Paradies et al., 2015). A critique of much of the research exploring the impact of racism on mental health is that it explores isolated incidents, captured in a particular time period, overlooking the cumulative and longitudinal impact of racist experiences (Nazroo et al., 2020). Wallace et al. (2016) therefore studied cumulative exposure to racism for ethnic minority individuals over time and how this affects mental health, using data from a longitudinal household panel survey. The study found a cumulative dose-response relationship between experiences of racism and the mental health of ethnic minority individuals. Those who experienced repeated incidents of racism over time had a significant reduction in mental health scores compared to those without these experiences (Wallace et al., 2016). Fear of racism, reported through feeling unsafe and avoiding places, also had a cumulative effect on mental health, indicating that perceived or anticipated racism is likely to impact service accessibility. More recent research findings also suggests that racism does not need to have been personally experienced to have a detrimental impact, as the threat of racism maintains disempowerment and fear (Nazroo et al., 2020) However, Wallace et al. (2016) acknowledge their study could not consider racism across the entire life course and this association could consequently be greater than the reported findings.

Despite research findings highlighting how racism negatively impacts mental health, Singh and Burns (2006) state that focusing on institutional racism precludes the real causes of differences between ethnicities and mental health difficulties being identified. They alternatively propose that accusations of racism within mental health services results in greater mistrust and creates a self-fulfilling prophecy of disengagement with services.

Furthermore, Weich et al. (2012) studied experiences of mental health care in an English city, particularly investigating whether participants felt their ethnicity impacted their care. Some participants reported ethnicity had an impact in relation to language barriers, however, broadly, ethnicity did not appear to impact on care received or preferences for interventions described. The exception to this was experiences of inpatient services, which were characterised as frightening, with poor communication (Weich et al., 2012). However, a limitation of this study was the poor representation of Black people in their sample, with 8 Black service users, in contrast to 16 White service users and 16 South Asian service users limiting the ability to generalise their conclusions.

Comparably, a recent government commissioned report aiming to present a new race agenda for the UK, dismissed the impact of racism within mental health services, concluding that racism and discrimination are not widely evidenced (Sewell et al., 2021). Alternatively, the report suggested there is a greater prevalence of mental health difficulties amongst ethnic minority groups, and less access to support, due to environmental and socioeconomic factors, such as poverty. This account seemingly fails to acknowledge how racist structures contribute to both mental health difficulties and socioeconomic disadvantage in ethnically diverse communities. It also appears to shift responsibility and accountability for inequity away from mental health services.

Attempts to Address Inequity through Policy

Despite a few exceptions, the literature generally points to ethnic inequity within service access, likely resulting from a combination of factors. Accordingly, many health and service policies have been developed over the past two decades to address inequity, however, with varying levels of success.

One of the first national policies aimed at improving the mental health care of service users from ethnic minority backgrounds in England, was titled ‘Inside Outside’ and published by the National Institute for Mental Health in England (2003). The policy addressed two distinct areas of reform: firstly, ‘inside,’ promoting changes within services, and secondly, ‘outside,’ referring to changes within communities (Sashidharan, 2003). The key objectives included eliminating ethnic inequalities through delivering effective multicultural support, and investing in the voluntary sector, involving Black and minority ethnic communities in these changes. The policy highlighted that the success of achieving change relied on the management of the implementation process (Sashidharan, 2003).

Following on from the Inside Outside report, ‘Delivering Race Equality in Mental Health Care’ built on this publication and formed an ambitious five year action plan developed by the Department of Health (2005). This national policy was developed following the death of a Black man, named David “Rocky” Bennett, who died after being forcibly restrained by nursing staff whilst in a mental health inpatient service (Department of Health, 2005). The subsequent inquiry highlighted how institutional racism within mental health services had contributed to Rocky’s death. The policy aimed to create responsive services, reduce fear, and address discrimination in mental health services for individuals from minority ethnic communities, particularly attending to the overrepresentation of Black individuals in psychiatric inpatient services. However, the following annual national census of inpatients across England and Wales suggests this policy had little success in reducing the number of ethnically diverse people in punitive and controlled parts of mental health services (Care Quality Commission, 2011).

Further guidance for mental health commissioners from the Joint Commissioning Panel for Mental Health (2014) was then developed, replicating many previous recommendations. This included increased co-production, alongside community development initiatives, to forge more trusting relationships between community and health organisations. The development of policies aiming to eradicate racial inequity and challenge NHS structures has since continued, a key example being the recent development of the NHS Long Term Plan (NHS, 2019). More specifically to psychological services, both the British Psychological Society guidelines and Health and Care Professions Council’s standards of proficiency for psychologists broadly illustrate that psychological services should be accessible and inclusive (British Psychological Society, 2017; Health and Care Professions Council, 2015).

Overall, these policies and initiatives collectively have led to limited long-term change. This may be due to an absence of specific detail relating to their implementation, resulting in a lack of effective action to restructure mental health services. Despite this, there are examples across health research and clinical practice evidencing ways of enhancing access to mental health services, which will now be explored.

What is Currently Increasing Accessibility of Mental Health Services?

As highlighted previously, many negative healthcare experiences reported by individuals from ethnically diverse communities are likely to be maintained by service structures which reinforce power imbalances between healthcare professionals and service users (Keating et al., 2002). The Power Threat Meaning Framework (PTMF) was developed to identify and summarise different forms of power in an individual's life, the threats that arise due to misuse of power, the understandable ways individuals respond to these threats in order to survive, and the personal meaning made of these experiences (Johnstone & Boyle, 2018). The framework can aid understanding of why services may be inaccessible to ethnically diverse communities, recognising racism and social factors as forms of power which contribute to mental health difficulties and instil fear around services (Johnstone & Boyle, 2018). The PTMF emphasises an individual's meaning making of their experiences, including how racism can increase feelings of powerlessness, leading to isolation and reduced access to mental health services (Johnstone & Boyle, 2018). It therefore presents an alternative to psychiatric diagnoses, offering a new perspective on why people experience distress, enabling ethnically diverse individuals to share their personal experiences. This moves away from locating difficulties and attributing blame within the individual (Johnstone & Boyle, 2018).

Additionally, the PTMF can be applied at a service level, whereby clinicians can collectively co-construct a shared understanding of an individual's presenting difficulties and their context, a process named team formulation (Johnstone, 2018). Team formulations are often facilitated by psychologists and can identify how institutional power operates within the lives of individuals from ethnically diverse communities, in relation to service accessibility (Health and Care Professions Council, 2015). This is particularly important in psychological professions which are dominated by White individuals, leading to a disproportionate level of White power in the profession (Johnstone & Boyle, 2018).

Furthermore, aligned with considering power within mental health services is acknowledging individual, deeply held, racial biases (Bell, 2018). Fernando (2004) suggests staff working with ethnically diverse service users should examine their own worldview to address their unconscious and implicit biases. This is an ongoing process, requiring courage from mental health clinicians to take responsibility for challenging ideas and being challenged, alongside humility to recognise defences, without becoming paralysed by shame (Patel & Keval, 2018). A part of this exploration may involve enabling individuals from diverse communities to provide their individualised narrative of how racism has impacted their life (Kolivoski et al., 2014). This can support White clinicians to understand the pervasive nature of racism and enables ethnically diverse individuals to share information that may have previously been ignored or undervalued (Kolivoski et al., 2014). Within therapeutic settings, when discussing the impact of racism, time should be spent building rapport with appropriate use of self-disclosure to understand the impact of institutional racism (Zhang & Burkard, 2008).

Gurpinar-Morgan et al. (2014) explored how the therapeutic relationship can enhance service accessibility for ethnic minority adolescents engaging in cognitive behavioural therapy with an ethnically dissimilar therapist. Participants found open conversations about their identity useful, particularly when incorporated in a non-tokenistic and sensitive way. Therapist self-disclosure about their ethnicity and culture also strengthened the therapeutic relationship and enhanced engagement (Gurpinar-Morgan et al., 2014). Previous literature suggests that therapists' willingness to understand an individual's beliefs, alongside conveying sensitivity and empathy, can be more important than matched ethnicity (Fountain & Hicks, 2010; Scheppers et al., 2006). In relation to this, matching on the basis of ethnicity can be problematic when wrongly assuming shared culture, simply on the basis of skin colour (Gurpinar-Morgan et al., 2014; Keating et al., 2002). Comparably, Klineberg et al. (2013) highlighted participants' preference to speak to a professional from a different culture, distant from their local community, to ensure limited disclosure to people they may have mutual connections with (Klineberg et al., 2013). Despite this, contrasting findings outline that, particularly when racial discrimination has been experienced within health care settings, ethnically diverse individuals prefer to see professionals who identify as the same ethnicity as they have a genuine understanding (Malat et al., 2010; Memon et al., 2016). Therefore, it is recommended that mental health services prioritise personal preferences, as an individualised approach can enable navigation of these contrasting viewpoints (Weich et al., 2012).

Within the literature, there are a number of case examples of increasing the accessibility of mental health services. Specifically, McEvoy et al. (2017) outlined a project called 'Eis Ledader' which aimed to increase mental health service accessibility in an Orthodox Jewish community in Greater Manchester. The project integrated NHS services and the Jewish community, forming collaborative partnerships with religious and community leaders, who often have a gatekeeping role to service access. Implementing accessible language and considering the translatability of psychological terms also facilitated service access (McEvoy et al., 2017). Language is particularly key as previous studies indicate that when service users and mental health professionals speak the same language, satisfaction with mental health services increases (Fountain & Hicks, 2010). The introduction of a self-referral process was also beneficial for individuals concerned about disclosing confidential information to their Jewish GP (McEvoy et al., 2017). As a result, the project outlined the potential conflict between acknowledging services can help with distress, whilst fearing the associated stigma or breaches of confidentiality. Previous literature supports these findings, demonstrating that prioritising interpersonal interaction, through developing a trusting, confidential space, facilitated positive experiences and improved service accessibility (Chew-Graham et al., 2002; Memon et al., 2016; Razai, Kankam, et al., 2021; Razai, Osama, et al., 2021).

Enhanced co-production of services has consistently improved engagement and intervention outcomes, as well as ensured services accommodate the values of ethnically diverse communities (Brach & Fraserirector, 2000; McEvoy et al., 2017). In a systematic review conducted by Acle et al. (2021), they recommended collaborative, curious approaches to integrate culture within interventions. This included utilising culturally flexible psychological models and assessments to incorporate the client's cultural worldview (Acle et al., 2021). In addition, religious beliefs, for example, prayer and support from religious leaders, may be important protective factors to discuss (Weich et al., 2012). A comparable recommendation by Kolivoski et al. (2014) suggests mental health services should increase their cultural understanding and co-production by integrating with ethnically diverse charities and religious organisations. Meaningful engagement can support building trust and developing knowledge of different populations, whilst potentially initiating mental health services offering care in non-conventional settings.

Keating et al. (2002) also identified ways service accessibility can be improved through working with families, communities, or religious organisations, which are rarely acknowledged in mental health services (Kilshaw et al., 2002). This would enable clinicians to understand aspects of an individual's life aside from their mental health difficulties, ensuring the 'whole person' is considered (Keating et al., 2002). Previous research has suggested involvement of family and friends increases the likelihood of referrals being made through a general practitioner and reduces the likelihood of involvement from a criminal justice agency (Morgan et al., 2005b).

Research findings have outlined that tackling stigma, through enhancing awareness of mental health difficulties and their prevalence, could support increasing accessibility of mental health services (Memon et al., 2016). This has been addressed by the National Institute for Health and Care Excellence (NICE) guidance, for specific mental health difficulties. In particular, it emphasises the importance of recognising the impact of stigma and discrimination for services who support individuals who self-harm (NICE, 2022). Knifton et al. (2010) explored the impact of community conversation workshops which designated space to discuss mental health and stigma, and were designed and delivered by community organisations for Pakistani, Indian and Chinese communities. The community workshops led to a reduction in stigma and participants expressed an increased willingness to talk to others about their mental health, potentially indicating less secrecy and shame. This suggests community workshops can promote acceptance and openness surrounding mental health, with the ability to construct shared understandings alongside community organisations being particularly valuable. It may be important to consider that this study explored broad mental health difficulties and previous research suggests stigma differs depending on the difficulty, which the researchers were unable to evaluate (Knifton et al., 2010).

Research Rationale

Broadly, existing literature has largely focused on service accessibility from the perspectives of ethnically diverse individuals and indicates that factors to consider include: cultural narratives; stigma; cultural humility; inflexibility of service structures; and the impact of racism.

Notably, many studies referenced used qualitative methodologies to explore service accessibility. Within these studies, participants were often interviewed by the authors, with a lack of self-reflexivity relating to how their identities, beliefs and epistemological position impacted their interpretations (Arday, 2018; Gurpinar-Morgan et al., 2014). As a result, it is challenging to ascertain the quality of their conclusions. This research would have benefited from detailing how the authors made sense of participants’ narratives, alongside how their experiences and values impacted the analysis (Shinebourne, 2011).

As highlighted previously, ethnically diverse communities are frequently categorised as ‘hard to reach’ groups. Despite existing policy acknowledging the blame this places on individuals rather than services, this narrative and terminology continues to remain prevalent (Healthcare Commission, 2006). As a result, many studies focus on individual experiences and there is limited research exploring service-related factors that shift the responsibility for change away from individuals or communities onto services. The current study aims to address this by utilising a methodology that enables third sector service providers to offer their understandings of accessible care, drawing on their experiences of barriers and facilitators. Working alongside third sector organisations has also been recommended due to their increased understanding of the needs and concerns of diverse populations (Alvarez et al., 2006; Kolivoski et al., 2014).

The study aimed to recruit an inclusive sample, representing a range of third sector services providing support for ethnically diverse communities. This contrasts to previous studies which have focused on the experiences of specific ethnicities or age ranges, for example, University students or Jewish individuals (Arday, 2018; McEvoy et al., 2017). Accessibility issues are likely to vary on an individual basis, however focusing on wider service perspectives will hopefully provide new insights in this research area and demonstrates a clear rationale for the current study.

Research Aims

The overall aim of this study is to develop an understanding of accessibility of mental health services from the perspective of third sector service providers working with ethnically diverse communities. More specifically, the research questions are as follows:

- What do third sector service providers believe an accessible service looks like?
- What can mainstream mental health services do to become more accessible?
- What are some of the barriers preventing service accessibility?

Chapter Two: Methodology

This chapter begins by detailing my selected research design, alongside my approach to data collection and analysis, with accompanying justification. I then discuss my sampling strategy, participants, recruitment and ethical considerations, before describing the interview procedure. The stages of reflexive thematic analysis are presented with a personalised description of how they were operationalised for my analysis. Finally, I will summarise the quality checks implemented and share my personal reflections and experiences in relation to the research project.

Research Design

The aim of this research study was to explore understandings of service accessibility for individuals from ethnically diverse communities, from the perspectives of third sector service providers. Due to the lack of existing research in this specific area and a focus on exploring different perspectives relating to service accessibility, a qualitative methodology was utilised. The data were gathered through the facilitation of 15 semi-structured, individual interviews and analysed using reflexive thematic analysis (Braun & Clarke, 2021c).

Methodological Approach and Justification

Traditionally, qualitative research methods were used in the exploratory stages of a research project to inform a more specific construction of hypotheses which could then be tested using quantitative, scientific methods (Willig & Rogers, 2017). Quantitative scientific studies were therefore perceived as the desired, gold-standard approach. As a result, qualitative studies were presented with structures and quality guidance aligning with quantitative epistemologies (Willig & Rogers, 2017). However, these ideas have since developed, recognising that qualitative research should not be limited to use in the preliminary stages of a wider project.

Qualitative methodologies focus on meaning and process, moving away from establishing cause and effect (Clarke & Braun, 2013). They enable social processes and psychological theories to be drawn upon and interrogated to enhance understanding about different phenomena (Willig & Rogers, 2017). Qualitative methods also give voice to selected groups of people, particularly enabling those who have been marginalised or socially excluded, to communicate their perspectives and express their understanding of experiences, which aligned with the aims of this project.

I felt a qualitative approach was the only appropriate methodology to explore the in-depth nuances of accessibility of mental health services, particularly questioning who benefits from current service structures and how accessibility could be developed (Clarke & Braun, 2013). I was also interested in the complexity of understanding accessibility and wanted to capture patterns and contradictions of meaning within this.

Approach to Data Collection

I chose to facilitate semi-structured interviews as my data collection method. This suited my research aims of exploring different understandings of service accessibility and why some services may be more or less accessible than others. Semi-structured interviews enable flexibility and promote gathering rich, in-depth data, whilst being minimally intrusive (Barriball & While, 1994; Fylan, 2005). Despite following an interview topic guide, semi-structured interviews support a conversational style, through using open-ended and variable questions. This moves away from asking rigid, predetermined questions, which could result in interesting and important ideas left unexplored (Fylan, 2005). I was aware that experiences of service accessibility for ethnically diverse communities were likely to vary considerably, which resulted in different areas requiring further exploration depending on the participant. Semi-structured interviews provided the opportunity to be guided by these complexities and possible contradictions within responses, whilst using prompts to gather further information in particular areas (Fylan, 2005). Semi-structured interviews also make space for rapport-building to support creating a comfortable and relaxed environment for participants, which more structured methodologies or questionnaires would not provide.

Participants were given the option of attending the interview in person at their current service location or virtually, using the video conferencing software, Zoom. All participants chose to attend the interview using Zoom. Video conferencing was the selected virtual method, as it allows for both audio and visual imaging in real time. This can promote connection and rapport building, whilst ensuring non-verbal communication can still be acknowledged and considered within the analysis (Gray et al., 2020). Conducting interviews remotely enabled a wider geographical reach for participants and I was able to access a national sample during recruitment. Furthermore, I was also mindful of the ongoing impact of the Covid-19 pandemic and wanted to be flexible by offering virtual interviews, particularly for those at high risk of severe illness or preferring to limit social contact. Additionally, Zoom was free to use and only required access to the internet, which it was felt most third sector organisations would have access to.

Previous qualitative research has found facilitating interviews using Zoom is a cost-effective and time-saving alternative to face-to-face interviews, particularly for participants who are geographically dispersed or unable to travel (Gray et al., 2020; Winiarska, 2017). Researchers also reported no differences in the quality of interviews facilitated either face-to-face or online and participants actually felt able to be more open online (Deakin & Wakefield, 2014). A further benefit of remote interviews is that participants can choose a place of comfort and safety to complete the interview (Saarijärvi & Bratt, 2021). I felt this was important as the study involved discussing the service participants work for, which they may not have wanted to do at the service base, where conversations may be overheard.

Recommendations for researchers facilitating interviews using Zoom include testing the software to resolve any technical difficulties, and planning for possible distractions, including uninvited people entering the interview (Gray et al., 2020; Saarijärvi & Bratt, 2021). I remained aware of these, however, found the flexibility of attending the interview at a location of their choosing meant participants were more able to have access to a protected, confidential space.

Approach to Data Analysis

Thematic analysis is frequently used within qualitative research due to its theoretical flexibility regarding epistemology and guiding philosophy (Clarke & Braun, 2018). Broadly, thematic analysis is an approach to identifying themes and patterns of meaning across a data set (Braun & Clarke, 2006). However, more recently, three distinct ‘schools’ of thematic analysis have developed. One school, namely ‘coding reliability thematic analysis’, is underpinned by a positivist philosophy, emphasising accuracy within the analysis through utilising procedures including inter-coder reliability and controlling for researcher ‘bias’ (Braun & Clarke, 2022). Themes are developed in the early stages of the analysis and often form topic summaries, as opposed to reflecting meaning. Other schools, including ‘codebook thematic analysis’, combine the ideas of the aforementioned structured approach to early theme development, whilst recognising the researcher as an important tool for making interpretations. ‘Reflexive thematic analysis,’ the final school, extends this further, emphasising the necessity of the researcher’s involvement and subjectivity in creating themes, ensuring they extend beyond a summary of participants’ responses (Clarke & Braun, 2018). Researchers are encouraged to be thoughtful and reflective in stating the philosophy underpinning the type of thematic analysis used.

Reflexive Thematic Analysis

This project utilised reflexive thematic analysis to analyse the data. Reflexive thematic analysis acknowledges there is no direct relationship between reality and a person’s experience, through which meaning can be uncovered (Willig & Rogers, 2017). Alternatively, what is of interest is the person’s account of their experiences and their interpretations, followed by my subsequent interpretations.

In contrast to other forms of thematic analysis which suggests themes are located within the data waiting to be discovered, reflexive thematic analysis emphasises the active role the researcher has in generating themes and producing knowledge. As a result, subjectivity within the coding process is not viewed as a form of bias that requires controlling or eliminating (Braun & Clarke, 2022). Alternatively, the subjectivity of the researcher is an important research tool, through which interpretations and meaning are created from the data. This differs to the concept of researcher bias which views the impact of the researcher as something to control or mitigate (Gough & Madill, 2012).

In this analysis, themes and codes were developed based on systematic engagement with the data, prioritising how meaningful, insightful and compelling they were, ensuring themes were a valid interpretation of the data (Braun & Clarke, 2022). Braun and Clarke (2019) emphasise that themes are produced by the researcher, following active and extensive engagement with the data. The themes in this study were therefore influenced by my background, values, experiences and training, so these areas needed exploration and my assumptions needed to be considered. Reflexive thematic analysis also allows for creativity from the researcher and enables incorporation of their existing knowledge, experiences and theories within the analysis (Braun & Clarke, 2022).

Reflexive thematic analysis can be used to analyse a range of research questions, such as exploring participants’ sense making of particular phenomena in certain contexts and therefore is appropriate to use for this research study. Importantly, research questions can evolve and be refined during the research process as the data collection progresses and a greater insight is developed (Braun & Clarke, 2021a). Reflexive thematic analysis also focuses on meaning across the sample, rather than meaning within individual responses, and this has been highlighted in the Participant Information Sheet developed to provide information about the study to potential participants (see Appendix A). Contrasting to a common misunderstanding, reflexive thematic analysis does not equate the frequency of a response with importance, as ideas can aid understanding of the research question regardless of the number of people who state them (Braun & Clarke, 2022).

Alternative Approaches Considered

Importantly, I did consider alternative qualitative methods of analysis, including Interpretative Phenomenological Analysis (IPA) which also explores meaning making and views researcher subjectivity as a valuable tool. However, IPA focuses on the detailed experiences and personal meaning making of homogenous samples, who have a shared experience, to consider how particular individuals interpret and reflect on their experience (Braun & Clarke, 2021a; Flowers et al., 2009). IPA also utilises an idiographic approach to focus on the unique details of each participant (Braun & Clarke, 2021a). This contrasts to reflexive thematic analysis which draws together ideas across interviews through the coding process to create shared patterns of meaning. Similarly, this study aimed to capture views of employees and volunteers in a broad range of ethnically diverse services, therefore resulting in a larger, more heterogenous sample than studies using IPA. Braun and Clarke (2021a) highlight that reflexive thematic analysis aligns with exploring how experiences are impacted by sociocultural factors and contexts rather than unique perspectives, which was key in this study.

Ontological and Epistemological Position

Despite reflexive thematic analysis being theoretically flexible, we all make assumptions about reality, knowledge and language that need to be considered and outlined within research (Malterud, 2016). This includes the process in which different experiences, beliefs, values and perspectives influence how we interpret the world (Braun & Clarke, 2021c).

Ontology relates to our beliefs regarding what constitutes reality (Braun & Clarke, 2021c). On one end of this spectrum is realism, conceptualising an objective truth which can be discovered and is uninfluenced by our subjectivity. In the contrasting position to this, relativism, proposes that there is no singular, objective reality as reality is socially constructed and changes all the time. As the researcher, my ontological stance is critical realism which is situated between these two perspectives, recognising that an external reality exists, however, our understanding and interpretations of this reality are shaped by social and individual factors including, experiences, language, culture and beliefs (O’Mahoney, 2014). Through interviewing participants, I was able to access their perception of reality, embedded within their experiences and contexts (Willig, 2013). The external reality I acknowledge is racial oppression and discrimination of ethnically diverse communities which exists across all aspects of society and institutions in the UK. This has vast, real consequences including the enactment of power imbalances, although conceptualisations of race continue to evolve, in line with socio-political activism. In discussions held in supervision, my supervisory team and I recognised how each of us have ongoing, unique experiences that impacted our interpretations of the data, which we outlined transparently together.

Epistemology refers to how reality is accessed and knowledge is produced. A positivist stance corresponds to a realist ontology and assumes that data reflects a single, objective reality which can be predicted and controlled, independent of human experience. The contrasting epistemology is social constructionism, aligning with relativism. This assumes there is no objective truth that can be accessed, alternatively, data is impacted by our beliefs, values and perspectives (Braun & Clarke, 2021c). Social constructionism states two people are likely to describe the same experience differently and both are valid.

This research project is underpinned by a contextualist epistemology, located between positivism and social constructionism. Contextualism recognises the importance of sociocultural context when interpreting and making sense of data (Alvesson & Sköldberg, 2017). Contextualism also emphasises the researcher's values and perspectives as this will shape the lens through which the data is interpreted. Therefore, researcher reflexivity is essential, as findings are dependent on the context of the researcher and participants, which enables production of situated knowledge (Madill et al., 2000). I believe we are inextricably linked to the socio-political context surrounding us, aligning with contextualism.

Sampling Strategy and Participants

All participants recruited for the study were either employees or volunteers at third sector organisations which provide mental health support for ethnically diverse individuals and communities. The decision was made to focus on the experiences of those providing services rather than service users attending or being referred. This was underpinned by discussions with an existing ethnically diverse network of third sector services, in which we considered the barriers to ethnically diverse service users participating in research. Part of this discussion outlined how recruiting service users may reinforce that the responsibility for ensuring mental health provision is accessible lies with them, which is a narrative I wanted to shift away from. Furthermore, previous research has predominantly focused on the experiences of service users and therefore there is a lack of research obtaining the perspectives of employees, which this study addressed. All participants were working for organisations currently engaging with ethnically diverse communities and were also able to share their perspectives on the accessibility of mainstream mental health services.

Previous qualitative studies using thematic analysis have aimed to use a concept known as ‘data saturation’ to determine and justify their selected sample size (Vasileiou et al., 2018). Data saturation refers to the point in analysis in which no new information, in the form of codes or themes, is ‘emerging’ from the data, suggesting an understanding has been reached and that data collection is complete (Braun & Clarke, 2021d). Within previous research, authors have proposed that between 6-16 interviews are required to achieve data saturation, yet often limited detail is provided on how this process is operationalised (Braun & Clarke, 2021d). Therefore, data saturation is imprecise and researchers conceptualise saturation differently, for example, some researchers depict saturation as repetition of content whereas others focus on repetition of meaning in the analysis (Braun & Clarke, 2021d). Furthermore, the concept and its positivist underpinnings, is not consistent with the assumptions proposed by reflexive thematic analysis, whereby data is not assessed according to its objectivity or accuracy (Braun & Clarke, 2021c). Braun and Clarke (2022) do not recommend a particular sample size for reflexive thematic analysis and since meaning is developed by the researcher, it always has the potential to be further refined (Braun & Clarke, 2021d).

However, the strength of findings developed through reflexive thematic analysis relies on the extent to which arguments are based on meaningful, compelling data, as opposed to an underdeveloped, unconvincing analysis (Braun & Clarke, 2021a, 2022). Important areas of reflection when deciding sample size are ‘information richness’ and ‘information power’ which incorporate the meaningfulness of the data, allowing sample size to be determined more subjectively (Malterud et al., 2016). Malterud et al. (2016) summarise that the more relevant and rich depth of information a sample demonstrates, the fewer participants are likely to be needed. With the support of my supervisory team, I considered factors including: practical constraints and the time-limited scope of the project; the diversity and heterogeneity of the target sample; the demands placed on participants; and the depth of responses likely to be gained from each participant, when deciding on sample size. We agreed a sample size of 8-15 would be suitable to meet the project aims, whilst enabling collection of data which produces rich, in-depth patterns of meaning and understanding (Sim et al., 2018).

Inclusion Criteria

The inclusion criteria were purposively broad to capture a range of experiences. Participants were required to either work or volunteer for a non-NHS based, third sector organisation, working with ethnically diverse communities, located in the UK. These services focused on delivering mental health support, although could also provide broader input, relating to wellbeing or social support interventions. All participants were adults, aged 18 years or older. Participants were required to speak and read in English to a proficient level and be able to verbally communicate and reflect on their experiences. This was due to financial and time constraints which meant I was unable to provide translated documents and interpreters. Fortunately, this was not a difficulty I encountered during the recruitment process, perhaps due to participants' employment in a UK-based service, and therefore no potential participants were excluded on the basis of their English ability. There was no minimum length of time required for staff or volunteers to have worked for an organisation and no required minimum number of working hours, to enable all staff and volunteers to participate.

Exclusion Criteria

The focus of this study was on services delivering mental health support and therefore physical health services or provision unrelated to mental health were not included. Comparably, services working predominantly with White service users or not focused on ethnically diverse communities were excluded. Participants working for services based outside of the UK were excluded due to significant differences in the set-up and systemic structure of mental health services in other countries.

Ethical Considerations

The project received ethical approval from the School of Medicine Research Ethics Committee (SoMREC) at the University of Leeds and adhered to their guidelines. Confirmation of receipt of ethical approval is included in Appendix B.

Informed consent

The research study was voluntary and written informed consent was obtained from all participants once they had read an information sheet outlining the aims and potential implications of the study. The information sheet was emailed to participants at least 48 hours prior to the pre-arranged interview. Before gaining consent, participants were given the opportunity to ask questions about the study, either by email or virtually on Zoom prior to starting the interview. The consent form also highlighted participants' right to withdraw from the study up to two weeks post-interview, without any negative implications (see Appendix C).

Confidentiality and Anonymity

All interviews were facilitated remotely and participants were asked to locate themselves in a confidential setting where they felt able to talk comfortably and uninterrupted. As the researcher, I also facilitated the interviews in a confidential space.

Personal information, including consent forms, demographic questionnaires and interview transcripts were all stored securely throughout the research project using my University of Leeds-One Drive account. Only myself as the researcher, my supervisory team and a consistent University approved transcriber had access to the anonymised interview transcripts. Participants were informed and consented to direct quotes from their interviews being used and shared anonymously in the project write-up.

The anonymity of participants has been maintained through the use of pseudonyms, which participants could either choose or have one assigned by myself. Additional identifying information, for example, the names and location of services where participants worked, have also been anonymised by omitting or changing details to prevent identification from others.

Data Storage and Protection

The interviews were audio-recorded following permission from participants. Specific details relating to the use and storage of the recordings were included in the participant information sheet. The audio recordings were saved directly from Zoom onto my University of Leeds-One Drive account which is permitted to store confidential data securely and privately. The University of Leeds-One Drive account also has Duo Authentication to add a further level of security.

The audio file recording was shared with the University of Leeds approved transcriber. I transcribed one interview and then the same transcriber transcribed all further 14 interviews. They also signed a confidentiality statement, outlining the required ethical principles to adhere to, before beginning the transcription process. Participant personal information was anonymised or omitted during the transcription process.

Confidential data including participant consent forms and demographic questionnaires were password-protected and stored using University of Leeds-One Drive. Upon completion of the DClinPsych programme I will complete a secure transfer using University of Leeds-One Drive to the DClinPsych programme area, with access restricted to the minimum programme research and administrative staff. All documents will be destroyed after three years by DClinPsych Research Coordinator, in line with the University of Leeds Information Protection Policy.

Risk of Harm to Participants and Self

The interviews focused on staff perceptions of service accessibility and therefore participants were not required to reflect on the experiences of service users. However, I remained aware that discussing service accessibility may be an emotive or distressing topic, with unique personal experiences related to this. I ensured participants were informed they could take a break from the interview at any point and were able decline answering questions if they felt uncomfortable or unable to answer. As the interviews were facilitated remotely, participants were able to turn their cameras off too if they preferred. No participants made use of any of these options. At the end of the interview, there was a short debrief where I answered any questions from participants. At this point I was able to signpost participants to relevant support services, however this was not felt to be required. The information sheet also included information about relevant support services.

Interviews with participants were facilitated during standard working hours and took place remotely which minimised risk to the researcher. I also informed my research supervisors in advance of the dates and times of the scheduled interviews. I maintained my wellbeing during the research process through regular contact with my research supervisors.

Involvement of People with Personal Experience

Involvement of people with lived experience in research supports addressing power imbalances that have existed throughout the history of health research, whilst also generating valuable connection and collaborative knowledge with those for whom the findings are likely to have the largest impact (Groot et al., 2022). During the development of this study, I attended two meetings with an established network working in services accessed by ethnically diverse communities. We discussed my research proposal and the group agreed there was a clear rationale for the study. Group members raised issues of accessibility known to them, including stigma and shame surrounding mental health difficulties in ethnically diverse communities. Developing trust and working collaboratively were also highlighted as important focuses for mainstream mental health services. As mentioned previously, in the section titled ‘Sampling Strategy and Participants,’ this network felt interviewing employees of third sector organisations and charities would be most feasible for a research project of this scale and would enable identification of the systemic factors related to accessing mental health services.

Throughout this project, I had continued, regular involvement from an expert by experience, who identifies as a Black African woman and works for a charity providing mental health support for Black African women. Following a preliminary meeting about the research project, she agreed to remain regularly involved throughout the research project and we developed an honorary contract summarising and confirming this. Her role involved attending and contributing to supervision meetings, particularly considering the practicalities and current social context surrounding the project, as well as providing feedback on documents produced for the project. For example, we discussed the evolution of language relating to ethnicity and the generalisations made across cultural groups and ethnicities. She drew on her personal experiences to encourage mindful use of language, whilst sharing that a lack of experience and fear of mistakes should not prevent engaging in conversations about ethnicity. Our meetings increased my awareness of narratives and stereotypes I had been exposed to about particular ethnically diverse groups that I had not previously questioned or recognised the impact of. We discussed the importance of maintaining an ongoing learner stance, looking for opportunities for development and growth.

She also commented on written documents produced for the project, including the Participant Information Sheet, Participant Consent Form, a Recruitment Poster, and Interview Topic Guide. Her input ensured these documents were sensitive and clearly outlined the research aims for potential participants. She provided positive feedback, referencing the use of inclusive and clear language, without jargon. She also suggested improvements, including clarifying how participant data will be stored and how long it will be kept for within the Participant Information Sheet, which were actioned. Following her feedback, I also added prompts to the Interview Topic Guide to ensure different aspects of service provision were represented, for example, recruitment, assessments and interventions (see Appendix D).

She continued to provide input throughout my analysis, offering reflections and interpretations of my codes and themes. This enabled me to consider some of the wider implications of the analysis, for example, how feeling pressured to fit into systemically racist structures and services is experienced more widely than within mental health services. Her valuable experience working for a charity also helped me to consider how mental health services can feasibly increase integration with third sector organisations to bridge the gap and build trust of mainstream services.

Recruitment Procedure

In order to identify and recruit participants for the study, a snowball sampling strategy was utilised. This initially involved making use of already known organisations through the University of Leeds, who I had previously met with regarding the project. I also sent emails with an attached recruitment poster to third sector services and charities that were known to my expert by experience. The recruitment poster outlined the overarching aims of the research project and provided my contact information for interested participants (see Appendix E).

Alongside this process, I made use of publicly available email addresses and contact information from websites of services and charities working with ethnically diverse communities to identify further participants. Once potential participants responded to my initial email with the attached recruitment poster, I emailed the participant information sheet. If individuals remained interested, we then arranged a suitable time for the interview, providing the option of meeting online using Zoom, or in person at their service base. The recruitment process occurred across nine months, due to initial delays in receiving responses. After facilitating the initial four interviews, I accepted participants' offers and willingness to continue circulating information about the study to organisations they were aware of through their work. I continued this process of recruitment until 15 participants responded and agreed to participate. The interviews took place between May 2022 and January 2023.

Interview Procedure

Data collection involved facilitating 15 semi-structured interviews using open-ended questions and utilising follow-up prompts to ascertain a greater understanding in particular areas. The interview topic guide is included in Appendix D and was guided by the study's aims and the current literature, alongside input from my research supervisors and expert by experience. Questions included asking: 'What do you believe an accessible service for ethnically diverse individuals looks like?' and 'How does the service you work for facilitate accessible care for ethnically diverse individuals?' The interview topic guide had six main questions, which aligned with previous recommendations for semi-structured interviews, with a number of prompts relating to each question, which were used only if relevant (Fylan, 2005).

All interviews started with informal rapport-building, which involved asking participants general information about themselves, their work and how long they had been in their job role. The aim was to explore their social context, as well as to support participants and myself as the researcher, feel at ease and comfortable.

The first two interviews formed a pilot of the topic guide, as recommended in the literature (Fylan, 2005). These interviews were a valuable part of the data collection and I spent time following the interviews reflecting on how I felt questions were received, particularly attending to questions that required further clarification and why that may be. I also reviewed whether the focus of the interview was addressing the research aims. Upon transcribing the first interview, I reviewed my interview technique and received feedback from my supervisors to incorporate their suggestions of development points. My supervisors drew my attention to missed opportunities to probe for additional information and noticed times I had led the respondent by, for example, giving options in relation to answering a question. They also outlined ways the interview could have been more conversational, for example, asking participants to “tell me more about that” or “what does that look like?”

Following the pilot interviews, I added a new opening question to the topic guide, asking participants: “It would be great to hear about the service you work for and what it is like to work there?” I also used more verbal and non-verbal probes to convey my interest and enjoyment. This included nodding and smiling where appropriate, and using verbal encouragements such as “that sounds great, tell me more” and “really? What happened next?” Importantly, semi-structured interviews can be conducted flexibly, so I asked questions in different orders and changed their wording depending on the responses given by participants. This supported developing my individualised interview technique as a researcher.

As the interviews progressed, I became more confident and felt less reliant on the interview guide. As a result, interesting and relevant ideas were explored that were not included in the topic guide. I also became more comfortable with leaving silence and space for the participants to collate their thoughts and reflect before answering a question.

The interviews lasted between 41 minutes and 89 minutes, with the average length of interview being 56 minutes. Immediately following each interview, I noted my personal reflections in a journal, including my comments on rapport and emotive responses I noticed in myself and participants or non-verbal communication that seemed important.

Analysis

In order to facilitate the reflexive thematic analysis, I followed the six-step method for analysing data developed by Braun and Clarke (2006). Importantly, these stages were recursive, with repeated movement between them, alongside taking time away from the analysis and then revisiting it with renewed energy, interest and creativity. These stages were used as flexible guidelines, rather than rules to be followed rigidly (Braun & Clarke, 2021b).

The first stage is defined as familiarisation and immersion in the data set, produced by in-depth engagement with the interview transcripts. I was really excited to begin this process and I listened to the audio recordings of interviews, alongside reading the transcripts. During this process, I noted my thoughts and reflections on the data set in its entirety, whilst keeping in mind my initial reflections at the time of the interviews. Braun and Clarke (2021c) recommend balancing a deep closeness and familiarity with the data, whilst maintaining sufficient distance to be critically reflective. This involved remaining attuned to how each participant made sense of service accessibility, the assumptions they made, the ways I reacted to the data and potential reasons why I had these reactions. In particular, I noticed my persistent anger whilst hearing the familiar narratives of ethnically diverse communities not having access to knowledge about mental health services and interventions. I also aligned with participants who referenced the inaccuracy of widely adopted, blaming terminology, such as ‘hard to reach groups’ used to describe ethnically diverse communities. Despite this sense of allyship and recognition of these common experiences of powerlessness, I remained mindful of my own identities, both as a White person and as a trainee clinical psychologist employed by the NHS. Therefore I visibly represented the groups of people maintaining many barriers to accessibility. I noticed my shock whilst engaging with the transcripts, repeatedly digesting participants’ experiences of both covert and overt racism, which I had not reflected on in as much detail whilst facilitating the interviews. I reflected that my shock was likely rooted within my absence of personal experience of some of the barriers mentioned and I felt drawn to represent and voice these examples explicitly in the analysis. In this stage I also began making links between the data, previous literature, and psychological theories I was aware of. This involved making interpretations beyond the surface level content and considering the meaning of responses within a wider context.

The second phase of analysis involved working systematically through the data set, noting meaningful quotes and interesting ideas to form initial codes. A combination of a top-down and bottom-up approach to coding was implemented, therefore the process was both inductive and deductive. I remained curious throughout, particularly noting connections between the data and existing literature relating to service accessibility, aligning with a deductive orientation. However, I also remained interested in understanding new experiences and ideas from the data, correlating to an inductive approach. During the coding process, I worked with both hard copies of transcripts and annotated Microsoft Word documents, using the comments function. This offered different insights and ways of engaging with the data, supporting me to maintain focus. I noticed my tendency to code at a semantic level initially, whereby my codes were largely descriptive and closely aligned with the content of the transcripts. As the analysis developed and my confidence increased, I began coding at a latent level, utilising greater interpretation and reaching beyond the literal meaning of the data. Each code label was succinct and captured a single idea, relating to either a small or large chunk of text. An example of a coded data extract is included in Appendix F. This process initially formed over 300 codes, although many of these were slight variations of the same concept. I therefore combined these to form a more workable and condensed number of coherent codes whilst keeping codes specific. This enabled me to more readily notice shared meanings in the data and use existing codes for multiple sections of data to capture repetition of meaning. The coding process was also facilitated by both my supervisors and my expert by experience, with the aim of discussing different interpretations and to share a richer, more in-depth insight into the data, rather than aiming to seek a consensus. This involved each of us individually coding the same transcript, then meeting together to discuss our different interpretations and meaning made of the data. Coding was stopped after systematically working through the data set and refining codes. I acknowledged that the coding process could never be completed as there is no fixed end point, instead I made a situated judgement to start theme development (Low, 2019).

The third stage of analysis involved collating and connecting codes to form preliminary themes, which are patterns of shared ideas and meaning. This included creating visual thematic maps to cluster codes, which together supported addressing the research question and captured multiple aspects of a centralising idea. Within this stage, the code ‘knowledge is power’ was promoted to a theme, through noticing there was variation and complexity within this idea. There was also clustering around the idea of connection, both on a human level but also at a systems level of the physical integration of services. This phase involved letting go of some ideas, ensuring all coded data was relevant to addressing the research question. I found this particularly difficult, and felt pulled to report all experiences of racism or discrimination, despite these not always relating to service accessibility. In this phase I noticed the clustering of codes around defining inclusivity of services appeared contradictory, and this complexity began to form the basis of a theme.

Phase four incorporated refining and developing the themes to ensure they were supported by the data and formed a meaningful, logical interpretation of the entire data set.

At this stage, I reviewed themes to form a coherent story in relation to the research question. This process once again involved letting go of data that did not relate to the core concept of themes. I began establishing the boundaries of each theme, ensuring there was sufficient data to support the theme without it becoming too diverse or all-encompassing. Creating subthemes supported this process, although I ensured subthemes represented separable parts of the theme and were not overused as this can be indicative of an underdeveloped analysis (Braun & Clarke, 2021c). The themes were distinct, but in combination told a wider story, for example, the theme, ‘building on a weak foundation,’ incorporates aspects of other themes including increasing knowledge and proactivity of NHS services. At this point, I considered the relationships between the themes and existing psychological theory more explicitly.

The fifth phase involved refining, defining and naming the themes. I began this by writing a brief summary paragraph of each theme, defining the core concept and outlining the different aspects of the theme. This process helped to clarify in my mind what each theme focused on. I also considered how each theme contributed to the overall analysis and what each was communicating to the reader. This helped to structure the themes in an order which supported the telling of the story. I grappled with selecting theme names, often changing them, yet enjoying the creativity of developing names. For example, I initially had the theme name ‘connection,’ yet realised this did not provide information about what about connection was important. What became clear was the importance of meaningful, in-depth connection which was more than just a surface level joining up of services. Braun and Clarke (2022) outline that theme names should capture the meaning of each theme and as a result, one word theme names should generally be avoided.

The sixth phase is writing up the themes, which forms a core part of the analysis. Writing up the analysis involved ensuring it was accessible and convincing to a broad audience. To address this, compelling data extracts were highlighted from across the entirety of the data set, representing all participants, whilst balancing the number of extracts with my interpretative narrative (Braun & Clarke, 2022). Conventionally, reference to the wider literature would then form a separate discussion chapter, however, to prevent repetition and to aid clarity, I presented links to literature and theory alongside the themes within the analysis chapter. I felt that highlighting the immediate connections between the data and wider context was more meaningful and the effectiveness of this structure has been demonstrated by Braun and Clarke (2021c).

Quality Checks

Braun and Clarke (2021c) outline that a number of universally established qualitative research quality criteria are not applicable to reflexive thematic analysis, due to their positivist underpinnings. This includes avoiding researcher bias, facilitating member checking or including frequency counts when reporting themes (Elliott et al., 1999). These concepts are not consistent with my contextualist epistemological stance. However, it is imperative to reflect on the quality of my analysis and my engagement with the research process. In order to structure this, I have followed Yardley's (2015) theoretically flexible set of four principles, which encourage considering research quality more generally.

Sensitivity to Context

Sensitivity to context involves demonstrating an awareness of the sociocultural context surrounding the research project, in order to account for what participants may talk about and why (Yardley, 2015). To address this, I have outlined the current landscape of mental health service accessibility and relevant literature in relation to health inequity and potential explanations, to situate the research. I have also included a summary of relevant participant demographic information, including the type of service participants worked for and information about their role in that service, to capture how their context may shape their understanding of accessibility. In addition, I have considered socio-political influences on my personal beliefs and expectations within the self-reflexivity section.

Commitment and Rigour

Commitment and rigour are demonstrated through detailed, in-depth engagement in the data collection process and developing skills in the selected form of analysis (Yardley, 2015). Rigour particularly emphasises the completeness of the research. In reference to these areas, I listened to all audio-recordings of participant interviews to ensure they aligned with the transcripts and to familiarise myself with the data set. All codes and themes developed were evidenced by the data and I have provided examples of direct quotes from all participants, so the reader can appraise my interpretations and make their own too. The analysis was further supported by monthly research supervision meetings. My supervisors' feedback encouraged me to see different interpretations and enhanced reflexive engagement with the data. My personal and professional commitment to this research area is demonstrated by detailing the barriers to accessibility I have noticed within my clinical practice alongside my ongoing responsibility to address these.

Transparency and Coherence

Transparency and coherence relates to clarifying each stage of the data analysis and detailing how my interpretations have been made to enhance their strength and persuasiveness. The aims of this project have been clearly outlined and detailed stages of the analysis have been described. Since personal reflection is central to reflexive thematic analysis, I have documented mine using an online journal during the process of facilitating the interviews and analysis. I also recorded voice notes capturing my initial feelings, emotional responses and actions immediately following each interview. All research decisions were made alongside my supervisors and I wrote in first person to own my decisions.

Impact and Importance

This encourages reflection on whether the research knowledge is useful and impactful in terms of its practical and clinical implications. Yardley (2015) argues it should be clear who the research affects and how. I feel my research project is hugely relevant due to the established understanding of mental health inequity and the link between racism and poor mental health (Mensah et al., 2021). Recent socio-political movements, alongside my discussions with experts by experience highlights this project's necessity. There has been little change in the accessibility of mental health services over the last 50 years, so hopefully this project provides clarity on some of the actions that need to be implemented (Mensah et al., 2021).

Researcher Reflexivity

Reflexive thematic analysis encourages the researcher to consider how their personal positioning, privileges, assumptions and values have informed the research topic, as well as their relationship to the participants (Wilkinson, 1988; Willig, 2013). Due to my active role in creating themes and the impact of my experiences on the research project, it is important for me to be transparent about my social context and identity. It is also valuable to critically reflect on my experiences to aid the analysis. Berger (2015) defines reflexivity as turning the focus onto the researcher, to understand their role in the creation of knowledge. Reflexivity involves taking responsibility for how one's position impacts all research decisions, for example, the questions asked, the data collected and interpretations made to enhance the credibility of the analysis.

I am also conscious that I occupy multiple identities, many of which are overlapping. These identities have been shaped by my social context and wider constructs in my environment. Reflexivity is therefore not static, and I have noticed over the course of this research project, my perspectives have evolved and changed.

I am a White British woman, currently living in Yorkshire with my husband, although I grew up in the South of England. I completed a four-year integrated Masters degree in Psychology at the University of Birmingham and I am currently training to be a Clinical Psychologist at the University of Leeds. This has incorporated working in a range of mental health services across Yorkshire, as well as completing academic and research-based work.

When I qualify as a Clinical Psychologist, I plan to work in forensic services and my experiences of working in a secure service during training, alongside many other clinical experiences, informed and enhanced my interest in the accessibility of mental health services.

I have worked in NHS mental health services since 2018, although before starting clinical training, where I believe I have developed a more critical and reflective approach, I largely accepted services at face value. I remember not attending to and therefore not challenging the origins or justifications of decisions I observed in health services. This meant I was subconsciously impacted by exposure to widely accepted narratives relating to why different groups of individuals were underrepresented in particular services. These included labelling certain groups as ‘not ready to engage’ or suggesting that services were not ‘set up’ to support them due to their complexity. This introduced me to the concept that NHS mental health services were not meeting the needs of all groups of people equally and fairly.

In my personal life, the privilege afforded by my White ethnicity and middle-class status, meant I grew up trusting medical professionals, perceiving what I now know to be subjective opinions, as objective facts. This view started to shift in adulthood when I experienced first-hand feeling dismissed and not listened to by primary care services. I wondered if this could be attributed to my gender and the associated stereotyped assumptions. I noticed the simultaneous lack of prioritisation of research regarding women’s health and began to have a greater awareness of the limitations within health services. In particular, the bias of medical professionals towards particular groups of people and the unequal distribution of knowledge shared with service users.

During my placements on this training course, I became aware of the under and over-representation of ethnically diverse individuals, depending on the service I was working in. I felt shocked by the significant over-representation of ethnically diverse individuals in both my inpatient placements. This contrasted to working in community services, where almost the entirety of my caseload had been White individuals. I started considering the reasons for this and concluded that exploring accessibility of NHS services was fundamental.

Working in community mental health services, I observed the impact of rigid, inflexible structures that disproportionately impacted accessibility for ethnically diverse individuals. For example, many services imposed strict discharge policies and sent opt-in letters to service users who had not attended appointments. These were written only in English and required a response, an absence of which would be used to inform their discharge. Other barriers included subjective assessments of readiness for therapy, strict inclusion/exclusion criteria, and restricted appointment availability. This often resulted in premature discharge of ethnically diverse services users and cultural and religious practices were rarely accommodated. I felt angry and attempted to resist some of these barriers in small ways, by working collaboratively with families of service users, facilitating home visits, and working flexible hours.

Furthermore, I began exploring with ethnically diverse service users in therapeutic sessions the impact stigma, structural racism, culturally inappropriate care, and discriminatory experiences had on their trust of NHS services. These conversations are likely to have been informed by my now established views of mental health difficulties existing systemically, rather than being located within an individual. I experienced useful, collaborative conversations about service accessibility as a result, exploring our differences and the impact these had clinically. In contrast to this, I noticed a broader hesitancy amongst mental health clinicians to approach areas of difference with ethnically diverse service users, perhaps through feeling disempowered or ashamed of their perceived inability to change service structures, or fearing saying the wrong thing. I observed mental health services that seemed to be driven by cultures of blame and anxiety, which, in part, appeared to maintain service accessibility inequity and prevent open conversations and reflections.

Importantly, when considering service accessibility barriers for ethnically diverse communities, I recognise that I have not experienced racism or discrimination based on my ethnicity. As a trainee clinical psychologist, I am also part of the NHS mental health system that my research is focused on. I am mindful of this and wondered whether participants may have viewed me as an outsider and a representative of the systemic difficulties they were raising. I particularly felt this could impact on developing rapport and trust with participants. However, my experiences did not reflect this and I was overwhelmed by participants who expressed their appreciation that a White professional had noticed accessibility disparities and wanted to research these. I felt moved in an interview where a participant stated *"through your research you have proved we are not hard to reach because you have made the effort to reach us."* Another participant commented that this project allowed *"our voices* *to be heard and all it took was willingness to listen."* Holding this in mind has instilled my responsibility to participants, to convey their views and share their stories in a powerful and meaningful way. I also remembered learning that shame can paralyse us into silence, which inhibits action (Partridge & McCarry, 2017).

Despite experiencing guilt and shame around my ability to ignore racism and discrimination for most of my life, I did not want these feelings to prevent me from exploring this area and changing my future practice. I felt it important to unpack the ways in which White privilege has been prevalent in my life and the unconscious biases I hold resulting from the culture and institutions surrounding me. To do this, I found, McIntosh's (1990) illustration of the invisible backpack helpful, through attending to not only how racism leads to disadvantage, but the consequent advantage White people have experienced. McIntosh (1990) depicts White privilege as comparable to a backpack full of unearned assets that have remained invisible and unquestioned. I reflected on aspects of this unearned privilege in relation to working in NHS mental health services, including: seeing people of my ethnicity widely represented in senior leadership positions; not wondering if decisions about me are made due to my ethnicity; and understanding that if I make mistakes at work, these will not be attributed to my ethnicity. These are examples of belonging and services operating in my favour that ethnically diverse communities have often not been afforded.

Throughout this research project, I have sought guidance from, and worked closely with, my thesis supervisors. As part of this, we considered our social identities, specifically that both my thesis supervisors and I identify as White British women. We have therefore not experienced racism or discrimination due to our ethnicity. We reflected on our responses to researching service accessibility for ethnically diverse communities, particularly our ability to have overlooked many barriers for much of our lives due to them not impacting us directly. We discussed our individual and combined areas of privilege, as well as noting areas of development which we were learning more about and self-reflecting on during the project. A uniting position of the research team was the identification and recognition of institutional racism across the different services we work in. We drew similarity on our views of racism existing across all aspects of society and the requirement of a systemic approach to begin addressing oppressive structures.

I also found the involvement of an ethnically diverse network and regular meetings with an expert by experience invaluable during the research process. My experiences, and those of my supervisors, impacted how I wrote research documents and asked questions during the interviews, so receiving feedback was essential. I shared my fears about using culturally insensitive language or inappropriate terminology with my expert by experience and she encouraged me that engaging in these conversations is more important than my fear of using clunky language.

Whilst facilitating the interviews I aimed to maintain an empathetic and curious approach, for example, clarifying my understanding of responses and communicating to participants that their experiences are greatly valued. I highlighted the knowledge and expertise participants had of the research area through asking if they felt anything was missing from the interview guide. I hoped maximising the input from participants could reduce the potential power imbalance within interviews.

However, I noticed the impact of my professional identity when facilitating the interviews. I struggled to initially navigate my role as a researcher and not a trainee clinical psychologist working in a clinical context. In the initial interviews, I was conscious of building rapport and conveying my interest in participants' thoughts and ideas. I also felt drawn into the emotion of conversations, wanting to provide validation and encouragement, through disclosure of my personal feelings and responses. At times, this meant I was guiding the interviews, through expressing my alignment with particular ideas participants were sharing, or providing non-verbal expressions of agreement. Having this noticed by my supervisors enabled me to reduce this impact in future interviews. I was also mindful of my limited research experience, so being shown examples of leading questions and opportunities to ask follow up questions was helpful.

The above section details my personal relationship to the research project and the impact this had throughout the process. These reflections are important as I have not approached this research as a blank slate and my past experiences have impacted all stages of the project. It is through this lens that I will now outline my analysis.

Chapter Three: Analysis

This chapter begins by situating the data through describing the participants and organisational settings they worked for. I then present my thematic analysis, outlining the five main themes and accompanying subthemes, alongside my interpretations, with supporting quotes. Within my analysis, I have related each theme to relevant literature and social context. I have chosen to integrate my analysis and discussion of the wider context to immediately and meaningfully detail these connections in a coherent structure.

Situating the Sample: Participant Demographic Information

Fifteen participants took part in the study and all were adults, aged between 25 and 66. Eleven participants identified as female, three identified as male and one identified as nonbinary. Participants worked in the third sector, including charities and community interest companies across the UK, representing 14 organisations in total. All organisations provided mental health support to ethnically diverse communities, although some were more specific than others in relation to the communities worked with and interventions provided.

All participants were given the option of choosing a pseudonym, which a number chose to do. Others opted to choose from a list of names I provided, whereas the remaining participants expressed no preference for their pseudonym. I felt it was important to choose pseudonyms that aligned with each participant's heritage and cultural background to capture this aspect of their identity. Demographic information relating to participants and their job roles are outlined in Table 1.

Table 1

Demographic Information of Participants

Participant Pseudonym	Self-description of Ethnicity	Self-description of Gender	Role in Service: Management/ Founder, Employee or Volunteer	Type of Service
Luna	Black African	Female	Employee	Charity for a specific ethnic group
Amara	Black African	Female	Management/ Founder	Community interest company for

				ethnically diverse women
Rani	British Asian Indian	Female	Management/ Founder	Third sector organisation
Tula	Black African	Female	Management/ Founder	Charity for a specific ethnic group
Chidera	Black African	Male	Employee	Third sector organisation
Eshal	Kashmiri British	Female	Management/ Founder	Charity working with many ethnically diverse communities
Satvinder	Punjabi	Male	Management/ Founder	Charity for a specific ethnic group
Yetunde	Black African	Female	Management/ Founder	Charity for a specific ethnic group
Oni	Black African	Female	Employee	Charity for a specific ethnic group
Lavindeep	Sikh	Female	Management/ Founder	Charity for a specific ethnic group
Shahzad	British South Asian	Male	Management/ Founder	Community interest company for a specific ethnic group
Hiranur	Turkish	Female	Employee	Charity working with many ethnically diverse communities
Khalil	Black African and White British	Nonbinary	Employee	Charity working with many ethnically diverse communities
Falaq	South Asian	Female	Employee	Charity for a specific faith group
Zarina	Not disclosed	Female	Employee	Charity working with many ethnically diverse communities

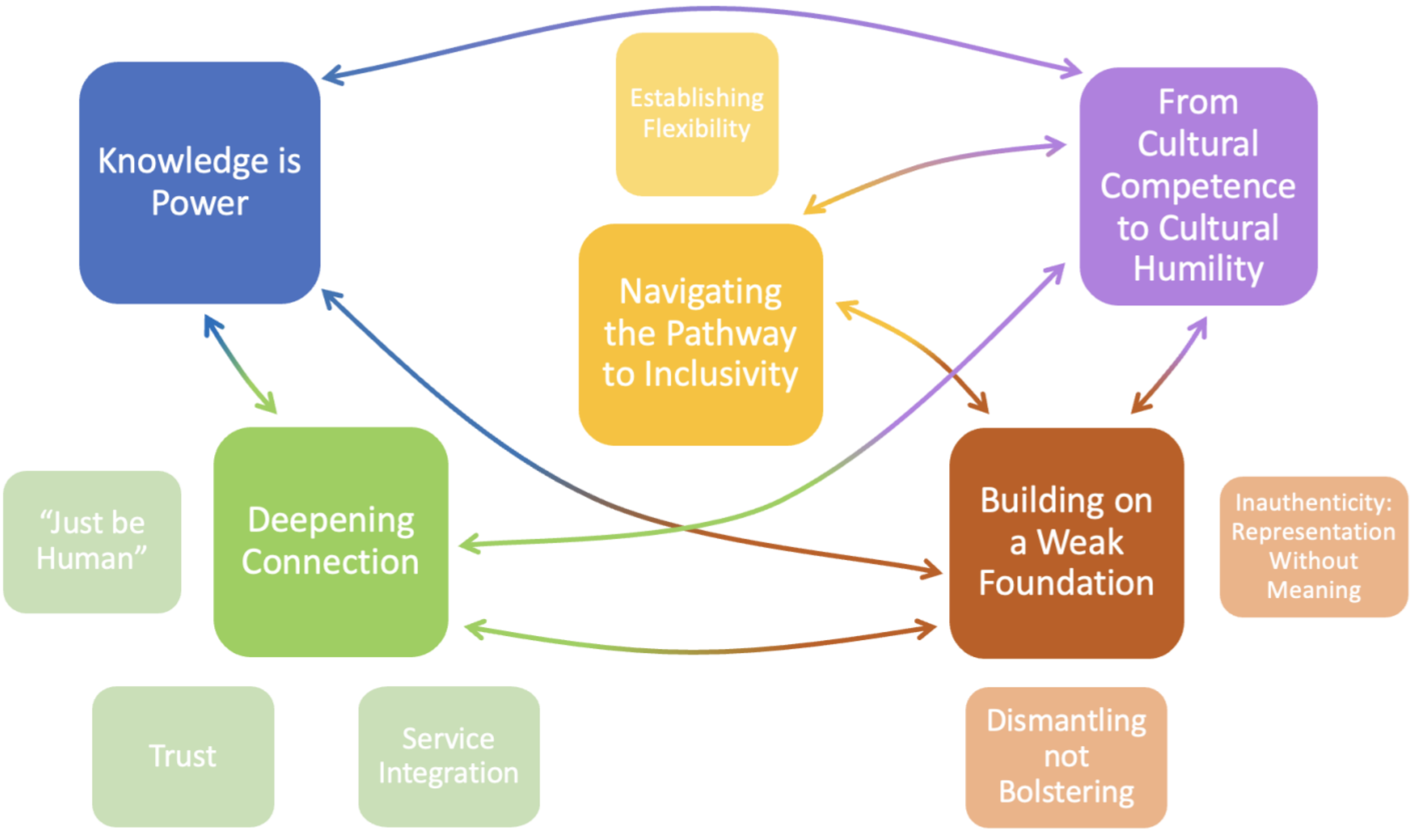
Qualitative Analysis

This study aimed to explore understandings of accessibility of mental health services from the perspectives of employees and volunteers working at third sector services providing mental health support for ethnically diverse communities. Participants reflected on their experiences of providing accessible care, what mainstream services could do to become more accessible, and barriers to accessibility. A total of five themes and accompanying subthemes were developed. The five themes are named: ‘knowledge is power,’ ‘navigating the pathway to inclusivity,’ ‘from cultural competence to cultural humility,’ ‘deepening connection,’ and ‘building on a weak foundation’. Figure 1 demonstrates a visual depiction of the themes, subthemes and the arrows illustrate the two-way relationships between themes.

There are many links between themes, however, in this section I will present each theme in turn with an accompanying discussion referring to relevant literature and context.

Figure 1

Thematic Map



Theme 1: Knowledge is Power

Knowledge is power is formed of three distinct, yet connected, parts. The first relates to participants' depiction of the necessity to know what mental health services are available in order to access them and how this knowledge is not equally distributed. The second part suggests that services should take responsibility for making themselves known to ethnically diverse communities. The third aspect refers to the power in language used within services, particularly the understanding that specific use of language enables access to relevant, appropriate support.

Inequity in the Knowledge of Services

Participants highlighted that understanding the breadth and depth of mental health services available is the prerequisite to making services accessible, emphasising the power in knowledge. As a result, not knowing what services are available, or how to access them, creates immediate disadvantage for many ethnically diverse communities. Knowing about services appeared to be the initial stage of accessibility and there was an implication that this assumed, often unquestioned knowledge, is not equally learned.

*"Information could be out there, but you don't know where to find it; you don't know who to ask, and sometimes that information you first get is hearsay, it can take you years even ten years to get there when people don't know what is available to them." (*Amara*)*

In the extract above information relating to services is located as something to "find," implying it is hidden from ethnically diverse communities and the process of sourcing information can be extensive. Immediately, this highlights the power which works to privilege White British communities. Participants captured how ethnically diverse communities do not experience the same level of exposure to information about mental health support available and how to access it.

"there's so much against us and that includes not being able to understand how to manoeuvre the system and what they can access, what they can't access" (Tula)

It therefore seems even knowledge of services is exclusive and discriminatory, as service existence is unequally learnt.

'Hard to Reach' or 'Seldom Heard' Communities

Participants indicated that mainstream mental health services should take responsibility to highlight their support, and who can access it, to actively increase awareness within ethnically diverse communities. This requires proactivity and transparency to provide reassurance to those wary of services.

“quickly on the hard-to-reach perspective: really, really dislike that term. The hard to reach versus hardly reached, or seldom heard. And so, for me that shift in paradigm of phrasing is really important…we need to think about the barriers of access rather than just placing blame on communities themselves. (Satvinder)

“the hard-to-reach communities which in my humble opinion is the most bullshitting thing you can say. The reason being is because it shows to me that you aren’t making the effort. It's not hard to pick up the phone like you did. It's not hard to send an email” (Shahzad)

The extracts above communicate that reshaping mental health support is not currently viewed as a priority, highlighted by the lack of proactivity of mainstream services and through externalising blame away from services. The phrasing of ‘hard to reach’ suggests there is an intention from individuals to not access services and acts as a way of mainstream services placing responsibility within communities for the underrepresentation of ethnically diverse individuals. The connotations attached with the label ‘hard to reach’ are also problematic, dismissing the power held within services. Many accounts detailed how often the only known avenue of mainstream mental health support for ethnically diverse communities is the GP and so increasing wider accessibility requires persistent engagement, often through word of mouth.

Participants implied that genuine effort is required to make services known, using considered and thoughtful approaches. For example, extending beyond attending community events, as presence alone does not address accessibility.

“they’ll go to places of worship, or have a stall, and then wait for people to come. That's just not how it works” (Lavindeep)

Participants used third sector organisations as a point of contrast, in which staff representatives not only chose to be present at community events but engaged with people and prioritised making their service known.

“I went along to existing other community organisations, and spoke to people to talk about what [name of group] was and who I was, rather than just expecting people to come to us” (Khalil)

The process of reaching out is presented as straightforward and established, yet has not been replicated by mainstream services. This maintains power imbalances between those who know about services as well as understanding the referral process, and those who do not.

Power in Language

Another aspect of the ‘knowledge is power’ theme is navigating the language used within services, which extends beyond an understanding of the English language, and refers to knowing the nuances which lead to appropriate onward mental health referrals. As a result, there seems to be power in the language used and responded to within services, which continues to maintain discrimination and reinforce disadvantage of some ethnically diverse communities. Many participants referenced a necessity to use the ‘right’ words to receive appropriate referrals for specialist mental health support, a language they had not been exposed to or taught.

“there’s almost like the buzz word, what do you say to the GP. What do you say to the gatekeeper to get in – to let you into the services that you need, and my people don’t know the right words.” (Lavindeep)

There also seems to be consequences linked to not knowing what to say which led to experiences of being ignored, dismissed or being given unhelpful information when reaching out to NHS services, thereby indicating the power that speaking the right language affords. As a result, key decisions are not made collaboratively, nor do they consider all relevant information.

“it feels like if I get these questions wrong through my lack of understanding I might not get the help that I need.” (Chidera)

As well as language being linked to the type of care received, participants also referenced ongoing language change, including the evolution of terms used to describe ethnically diverse communities. Participants inferred that the intention behind language use is more important than the words chosen.

“language changes so people just never know, is it offensive, is it not offensive, even in my time things have shifted it’s good just to make sure that we’re not offending anybody but really it’s as long as the intention is good” (Oni)

Participants suggest language is a social construct, which evolves and changes, but continues to be a tool to enforce discrimination. In addition, participants referenced some mental health terms which cannot be translated across languages.

“in the language I speak, there’s not even a word for the word depression.”(Shahzad)

This emphasises the power within language especially when it cannot be communicated universally. Language complexity extends further than a direct translation issue as participants also mentioned the cultural expectations and social norms attached to particular language use. For example, the implied stigma and societal impact of ethnically diverse communities attending a mental health intervention named ‘suicide support group’ as opposed to a ‘community support group’. Participants gave suggestions of ways of reframing mental health interventions to enhance accessibility for ethnically diverse communities.

> *“try changing the language to increase access, instead of calling it therapy, call it a support session or community support group as this terminology is less intimidating” (Hiranur).*

This indicates that addressing the power within language use requires considering the acceptability of terminology within ethnically diverse communities, as language can have tangible consequences for people, including feeling more able to access support.

Discussion

Overall, the theme ‘knowledge is power’ illustrates the inequity regarding the availability of knowledge about mental health services and the ‘correct’ language to use, particularly disadvantaging ethnically diverse communities. The relationship between power and knowledge forms the defining theory of the work of the philosopher, Foucault, proposing that it is impossible to exercise power without knowledge (Foucault, 1979). Knowledge can therefore function to give power to particular groups of people, as each society accepts certain knowledge as truth. Foucault’s theories are closely related to the work of Bourdieu (1991) outlining the wide-reaching impact of group membership and how both knowledge and language can convey membership to a particular social group. Knowledge of services and the breadth of language available to an individual can therefore be depicted as forms of capital. Capital, according to Bourdieu (1986), is what makes up your position in society. Two forms of capital which relate to this analysis are: cultural capital, which incorporates what you have and know, including your accent and speech; and social capital, relating to who you know and how known networks can lead to opportunities for growth and success (Bourdieu, 1986). Capital can be gained and shared socially, resulting in collective capital, which generates more power. The unequal distribution of social capital within society, results in differential distribution of power (Bourdieu, 1986).

These concepts help to explain participants’ reflections that for White British individuals, information regarding service availability may be considered widely held knowledge, thereby illustrating their cultural and social capital. In contrast, participants suggested that for many ethnically diverse communities this information is not known and connections to people with this knowledge may be limited, which maintains a social imbalance of power. The lack of available knowledge of mental health services has been highlighted in previous research reporting that Black men were unaware that GPs are the first point of access for receiving mental health support, alternatively perceiving GPs to only treat physical health difficulties (Myrie & Gannon, 2013). Comparably, ethnic minority individuals felt GPs did not refer them to appropriate onward mental health support (Memon et al., 2016; Rabiee & Smith, 2013). This aligns with the current study, whereby participants expressed difficulties navigating services, alongside a lack of proactivity from services to support this process. Previous research has made the distinction between service users who are UK citizens and those who are seeking asylum, with African asylum seekers and refugees less aware of mental health services available (Rabiee & Smith, 2013). This corresponds with research by Memon et al. (2016) suggesting that individuals from an ethnic minority background, who do not have access to family or social support, may not know where to go or who to contact if they are experiencing mental health difficulties. Participants in the current study addressed how services should be proactive in more widely distributing knowledge of mental health services.

Language used and responded to within services can also maintain institutional power and participants in this study described language having implications beyond simply a form of communication. According to Bourdieu's (1986) depiction of cultural capital, Western society privileges particular accents, and education. Individuals with comparable forms of cultural capital develop a collective identity which can hinder the social mobility for people who do not 'fit' these areas of privilege. This suggests why participants in this study identified certain language and 'buzzwords' as a gateway to onward referrals. Therefore, access to specialist mental health services is controlled by those who have power within social systems. This includes individuals who hold titles such as 'doctor' and can maintain institutionalised cultural capital by preventing mental health interventions for ethnically diverse individuals. An illustration of this is Black service users being more likely to be prescribed antipsychotic medication and ethnic minority service users less likely to receive cognitive behavioural therapy interventions, compared to White service users (Das-Munshi et al., 2018). Arday (2022) suggested that enacting power in this way results in a lack of trust and ability to communicate openly with leaders within organisations. In relation to this, previous research suggests the views of medical professionals are privileged over service users' descriptions of their mental health, which resulted in feelings of helplessness (Memon et al., 2016).

Bourdieu (1991) also developed the concept of symbolic power, which outlines how power hierarchies are maintained in society. This can take subtle forms, for example, knowing the right language to use in mental health services maintains social status and particular use of language enables societal advancement. Participants in this study described not knowing this language and not being exposed to the language that grants access to services or onward support within services. Similar findings have been replicated by Arday (2018), whereby Black and minority ethnic University students reported a barrier to disclosure as being misunderstood or misinterpreted. As a result, Black and minority ethnic participants often choose not to disclose psychological difficulties due to the fear healthcare professionals will manipulate their words (Arday, 2022).

The power in knowledge of services reinforces an ‘us and them’ narrative which relates to social identity theory, outlining how group identity can result in ‘ingroups’ perceiving those outside this group as inferior (Haslam et al., 2009). In this study, the ‘outgroup’ refers to ethnically diverse communities, who have a lesser degree of knowledge about mental health service availability. Participants referred to how the term ‘hard to reach’ is used to justify the lack of proactivity and effort made to enable service access for ethnically diverse communities.

In addition, participants in this study outlined the significance of using language for mental health interventions that is accepted and able to be translated across different cultures. McEvoy et al. (2017) illustrated comparable conclusions and reported that using more acceptable terminology for mental health interventions within Jewish culture such as ‘self-improvement interventions’ enhanced accessibility for this community. One participant in their study recommended avoiding using mental health conditions such as ‘anxiety’ or ‘depression’ within the names of interventions as these can be stigmatising and become a barrier to access (McEvoy et al., 2017).

Theme 2: Navigating the Pathway to Inclusivity

Defining inclusivity of mental health services, how inclusivity links to accessibility, and the ways it can be operationalised, formed a seeming contradiction within the data. More specifically, participants differed in their views of whether inclusivity corresponds to broadening or narrowing the focus of services, and in turn, which of these approaches supports increasing accessibility. Participants had unique and often contrasting ways of talking about inclusivity and what it meant to them, in the context of accessibility for ethnically diverse communities. A more uniting idea seemed to be paying attention to the reach of the service, how the service can be adapted to meet each person’s individualised needs and the ability to be flexible within service aims and processes.

Need for Exclusivity

When discussing accessibility, some participants suggest that for a service to be inclusive, there needs to be initial specificity within third sector organisations. This incorporates staff members who are trained to work with specific ethnically diverse communities, can relate to their experiences and have an understanding of the unique barriers that may have impacted them.

"I'd say there's a pressure to be inclusive at the surface level. Because ultimately our service is very inclusive and reflective to folk with different experiences but all within [specific ethnicity] communities. But if you push that inclusivity at the first level, that can come at a detriment to the folks that you're really trying to work with." (Satvinder)

Participants alluded to a misunderstanding or unhelpfulness of the term inclusivity as referring to reaching a wide cohort of people, but without expertise or in-depth knowledge of how to work with them effectively. In the extracts above and below, Satvinder and Shahzad illustrate that to fully embody inclusivity requires an enhanced understanding of specific cultures, focusing on depth of support, instead of breadth.

"I'm not gonna try and deliver a service for [specific ethnicity] people because I can't, you know I wouldn't be qualified"(Shahzad)

In order to create accessible services, participants expressed that there needs to be opportunities for ethnically diverse communities to access exclusive services, which value representation, relatability, and culturally congruent thinking, to enhance connection.

"People want someone who looks like them, who've been through a similar situation to support them or somebody who understands and can support them through the system." (Tula)

A further key idea relates to establishing equity, recognising that developing accessible services does not equate to offering everyone the same type of service and intervention. This again critiques broadening inclusivity at a general level, as this could overlook distinct cultural needs within different communities.

"Access isn't about everyone getting the same, it's about everyone getting the appropriate help."(Chidera)

How Exclusivity Promotes Inclusivity

Many participants reported that the underpinning values of third sector organisations, which include representation of service users' cultural background and specific knowledge of possible barriers, results in increased accessibility. I reflected whether meeting the specific cultural needs of ethnically diverse service users then led to these services being perceived as welcoming and accessible to individuals with ethnic identities wider than the original focus of the service. This may suggest that prioritising initial exclusivity results in movement to inclusivity.

"it was initially a charity to support [specific ethnic group] but like I said we now work with anyone who needs crisis and support. If someone is coming to ask for help, most of the time they really need it and it's taken a lot for them to come here." (Luna)

Luna seems to indicate that to be inclusive involves responding to individuals who have initiated support, acknowledging the complexity and difficulties associated with attending services.

"it's diversity in every sense, we are of every colour you can think of, we are multilingual, we are diverse, we are inclusive. We try to match our clients up with the right clinician for what they need" (Eshal)

The positions of Luna and Eshal initially appear contradictory to the previous views of Shahzad and Satvinder, contrasting in whether inclusivity and exclusivity are mutually exclusive concepts and which services should aim for. Inclusivity seems to be complex to define, with differences in whether specificity is more important than working with everyone. Within the participants' narratives there was an underlying assumption that third sector services enact an ethos which draws people in. These services were used to illustrate that meeting the needs of a particular ethnic group appropriately and effectively, encourages access for broader ethnic groups, due to responding to the inclusive foundation of the service. Perhaps this theme captures that investing resources and time to adapt services for ethnically diverse communities promotes accessibility, which is observed by people from a range of communities.

Subtheme: Establishing Flexibility

Despite the potential contradiction regarding whether specific or broad service inclusion is most effective, this subtheme captures how service flexibility appears to be synonymous with inclusivity. This differs from targeting a service to all individuals, but prioritises accommodating the needs of particular communities. Flexibility seems to be an overarching idea, reflecting that it is not possible to predict the type of clinician or intervention someone may prefer.

"sometimes people like to work with a therapist who are the same cultural you know or language as them, but sometimes they don't want to see people from same culture or same background, and or same racial background and we give the people choice"(Hiranur)

Current mainstream services were described as lacking flexibility with strict, discriminatory inclusion criteria, alongside loopholes preventing inclusion and restricting access.

"*Other services have too many protocols, you know, processes and all that. So, we try as much as possible not to be too rigid in our approach." (Yetunde)*

Discussion

This theme captures the complexity of defining and enhancing inclusivity within mental health services. Interestingly, participants suggest that creating services which meet and understand the cultural needs of specific ethnically diverse communities in the form of exclusive third sector organisations, seems to attract individuals from other cultures too.

In the first part of this theme, inclusivity is referred to as service users having the opportunity to work alongside mental health clinicians who can relate to a collective group identity in the form of shared ethnicity or cultural background. Participants suggested this is achieved through the provision of specialist third sector services with culturally informed staff. Turner (1982) described how experiencing and understanding collective discrimination can promote the formation and maintenance of group identity. This, in turn, encourages working collaboratively to address injustices (Turner, 1982). In this study, participants outlined the importance of relatability, which supported providing equitable, accessible services. Participants outlined how shared membership within services and common understanding enables ethnically diverse service users to process their experiences.

In previous research, mental health interventions across cultures were deemed more effective if there was an acknowledged, shared understanding amongst service users and clinicians (Cooper et al., 2003). The importance of shared group membership has also been referenced in research which outlines that racially minoritised service users report improved communication, rapport and health outcomes when meeting with healthcare professionals identifying as the same ethnicity (Moore et al., 2022). As a result, the majority of participants in the study reported a preference for racial concordance within mental health services (Moore et al., 2022). More specifically, when racial discrimination has been experienced within health care settings, ethnically diverse individuals prefer to see professionals who identify as the same ethnicity as they can relate to the impact of these experiences (Malat et al., 2010; Memon et al., 2016). A possible explanation of this suggests that relatability, in the form of shared ethnicity, acts as a protective factor against assumptions and harmful stereotypes portrayed about ethnically diverse communities (Moore et al., 2022).

Uniting both perspectives in this study, participants highlight the importance of developing a collective identity, with culturally capable staff, despite differences in whether services should form this exclusively or across all different ethnicities. Creating a shared identity has been shown to enable those who have been disadvantaged or stigmatised to access services (Iyer et al., 2009). Participants in this study identified how third sector organisations prioritise relationships and celebrate diversity, which attracts access for those wider than the service aims. Comparably, Bhui and Sashidharan (2003) suggest voluntary services ensure cultural, spiritual and religious beliefs are incorporated into all aspects of care, whereas these areas are often ignored or neglected in mainstream services. Many participants interviewed in this study outlined how third sector foundations of investing in individualised, adapted care, enable accessibility for diverse groups of people.

The subtheme outlining the importance of flexibility and its absence within mainstream mental health services also aligns with previous research. In contrast, third sector organisations utilise greater creativity and embed flexibility within their structures to address aspects of mental health challenges which mainstream services have failed to provide (Newbigging et al., 2017). Newbigging et al. (2017) describe how flexibility, including enabling service user led decisions, supports third sector organisations being more trusted among Black and minority ethnic communities. In particular, these organisations recognise the importance of understanding cultural heritage and previous experiences of discrimination.

By way of contrast, participants in this study described mainstream mental health services as rigid in their approach. This aligns with previous research recommending the need for greater flexibility, rather than enforcing a generalised approach to care, in which all service users are offered the same interventions (Acle et al., 2021; Memon et al., 2016). The foundation of person-centred care supports shifting from a ‘one-size-fits-all’ approach, to recognising the need for tailored interventions which meet the preferences of different service users (Bechtel & Ness, 2010; Sewell, 2008). Participants in this study implied that, through their attention to cultural differences, many third sector organisations lend themselves to person-centred care.

These findings are particularly pertinent as evaluations of the effectiveness of ethnicity-specific, specialist mental health services is limited. This means the benefits of holistic, relationship focused and culturally congruent support are not highlighted or widely disseminated within the literature (Bhui & Sashidharan, 2003). The ultimate goal should be that specialist services are no longer required, particularly if mainstream services implement the recommendations outlined in policies and deliver equity within mental health care (Department of Health, 2005). Through the data analysis, I interpreted that separate services are not the desired outcome but are currently necessary for some ethnically diverse communities to receive support. This theme brings to light many systemic factors continuing to make mainstream services inaccessible, rather than suggesting ethnically diverse communities have specific mental health difficulties, for which there is little evidence (Bhui & Sashidharan, 2003). Culturally aware and capable services are required across mental health service provision, as highlighted by participants in this study recognising that people of all cultural backgrounds are drawn to third sector organisations which enact these values.

Theme 3: From Cultural Competence to Cultural Humility

The identified need for service flexibility to meet individual preferences extends to the desired practice of staff making up mental health services. An overarching idea within the data related to engaging in continuous, active education regarding the experiences and preferences of different ethnically diverse communities. Alongside this, participants suggested being mindful of not making generalisations and considering the unique perspectives of individuals. These ideas are captured in the need to shift the focus of mental health services from achieving cultural competence towards developing cultural humility.

Recognising Cultural Stereotypes and Assumptions

Many participants outlined their observations of clinicians interpreting mental health difficulties within ethnically diverse communities through the lens of their existing beliefs. This has wide-reaching consequences, including misinterpreting cultural norms for symptoms of mental health difficulties or dismissing mental health difficulties due to the enactment of pre-existing assumptions.

"learning about different cultures became part of the covid food parcel distribution: One of the counsellors said, 'Oh, you know there's really no large number of [ethnicities] accessing this food.' and I said, 'Do you know why?' they said, 'Oh maybe they already have food.' I said, 'No. You should have done your research to find out why these people who on benefits are not accessing the food.' I said, 'because they don't eat this type of food." (Yetunde)

The assumption outlined by Yetunde that ethnically diverse communities seeking practical support, in the form of food parcels, may just 'have food' represents naivety and privilege. A lack of effort and implied care is communicated, whereby clinicians working within mainstream services provide explanations for behaviour which align with their existing beliefs and remain unchallenged. The consequences of assumptions extended to the provision and interventions offered within mental health services.

"because we talk with our hands we look like we're being aggressive. And we'd get the strongest drugs because of this." (Oni)

Participants outlined how cultural stereotyping and viewing experiences from a 'White' lens led to experiences of racism being dismissed or overlooked by mental health clinicians.

"some people have had therapists make assumptions about their cultural or religious backgrounds. And if they're speaking about something that's happened to them that they perceived as racism; sometimes therapists can say 'oh, you know they probably didn't mean it like that, or are you sure they were being racist'" (Khalil)

Failure to recognise assumptions also seems to result in inappropriate mental health interventions, dismissing that some ethnically diverse communities view mental health difficulties differently and attribute different causes. There is a need to acknowledge differences in cultural understandings of mental health, the acceptability of certain behaviours and interventions.

"therapists sometimes giving them suggestions of what to do, but they're not able to do that in their culture, you know if they're like 'why don't you confront your parents about this'. That's disrespectful and not possible for some people" (Khalil)

Participants referred to the current lack of education experienced in mental health services, including the unwillingness to consider cultural norms, which may be different from their own. Alternatively, different expressions and behaviours were interpreted through their existing beliefs.

"she got handover from a White colleague who said this lady here has been pulling out her hair; she's been speaking gibberish and she refuses to eat…What the woman was doing was removing her braids and doing her braids over, she was fasting, and she was praying…nobody bothered to ask why" (Tula)

Similar depictions of falsely attributing cultural or religious practices to result from mental health difficulties were described by other participants. The fault of this absence of education was described as existing systemically, through services designed to process information from a Western lens.

"Because the system has not provided them with a place to understand where an [ethnicity] woman is praying and shouting to God this doesn't mean she's got mental health issues." (Yetunde)

More broadly, this subtheme reinforces the enactment of power within systems, for example, staff not asking service users why they are engaging in certain practices symbolises a lack of willingness to have their views challenged, nor an openness to learn.

Developing a Broad Awareness of Cultural Differences

Participants referred to the importance of mental health professionals developing a broad understanding of differences between cultures in relation to mental health difficulties and how these may impact service accessibility. This includes acknowledging acts of discrimination and racism experienced by ethnically diverse communities. Participants described the necessity for education regarding how poor service accessibility is rooted in the history of racism within NHS services.

"having open and frank conversations about what has happened historically in the NHS and why there's mistrust, rather than brushing over it. People want to move forward, but you can't move forward without looking back and there's a reason for mistrust"(Chidera)

There seems to be an implied overall goal of mainstream services to move forward, disregarding what has gone before, in favour of covering up and starting afresh. This approach however, is dismissive and prevents exploring what has led to inequity within service provision.

Another aspect of participants' reflections relates to recognising discriminatory experiences within wider institutions. As a result, some ethnically diverse communities may be reluctant to talk about their mental health in NHS services, due to fears of being judged, mistreated, or misdiagnosed, which have been exacerbated by different institutions.

"we can't detach people's experiences of other parts of the state and institutions from their experiences of the NHS… there's a trust that needs building because you're not entering the space in a neutral perspective" (Satvinder)

There is an indication that acknowledging experiences of discrimination is part of accessibility and forms the responsibility of services. This involves an active stance of learning from ethnically diverse communities alongside maintaining motivation and effort to apply this learning.

"a lot of cultural information isn't just there, you need to go out and seek it." (Luna)

A lack of engagement in enhancing cultural awareness and addressing assumptions can result in ethnically diverse service users having to navigate additional hurdles that White individuals do not have to consider. In the following quote, Eshal describes an ongoing fight against harmful practice that is necessary to even survive within services.

"You're gonna have to jump through double the hoops because of your colour, you've got that disadvantage. You're taught that at the beginning that to survive you have to fight harder than your White friends" (Eshal)

Participants mentioned the usefulness of clinicians understanding how cultural narratives can impact accessibility in ethnically diverse communities. This includes possible experiences of pressure to conform to gender norms, suggesting in certain cultures there may be 'right' and 'wrong' ways of expressing mental health difficulties.

"and then as women, we're supposed to be resilient, and men are supposed to be macho. So, you can't tell your wife, 'I think I need help.' 'I need a break.' 'I need a rest.' so, even resting, is seen as a lazy person"(Tula)

In addition, certain mental health difficulties are associated with greater stigma in various ethnically diverse communities. Namely, self-harm was linked to distinct stigma that services should be educated about as there may be associated barriers for ethnically diverse individuals seeking support for self-harm. This includes feelings of blame and shame which further prevents access to services.

"some people still don't want to talk about it; because in our culture they won't say you know this is some mental health issue. And that's a stigma; they don't want to let know anybody know." (Zarina)

"Self-harm often comes presented as something else, but it ends up as that. And even talking to me there's a shame aspect about it and the guilt. So, sometimes I have to really reassure people." (Oni)

Commitment to Continual Learning

There was a general distinction between learning about broad cultural differences in beliefs and practices, whilst not enforcing stereotypes or boxing people in, due to taking shortcuts. Participants described the education process as understanding how culture may impact the expression of presenting difficulties, whilst being guided by service users in a person-centred way. Many participants made reference to third sector organisations navigating this in practice, making necessary and thoughtful changes to their practice due to their willingness to be sensitively curious.

"People need to understand different cultures and not just make generalisations, assuming they've seen people before. Instead they need to be like "what are things that you do culturally that mean a lot to you" or "what is normal, what is considered abnormal in your culture." (Luna)

Illustrating examples of how to approach conversations about culture were described with ease and simplicity, highlighting how they can be incorporated universally in services.

This theme captures the balance of remaining open to learning new things and recognising the ongoing need to have our assumptions challenged. Some participants recommended adopting a continuous learner position to educate oneself about cultural norms, whilst engaging in self-reflection of individual biases and prejudices.

"look at your prejudicial judgement cause we're all brought up with certain ideas, attitudes and judgements really unless you work through these things. You may have assumptions of other people or other races and cultures that can keep discrimination going."(Hiranur)

Reflecting and creating space for an awareness of internalised judgments are presented as necessary, due to the consequences of unchallenged prejudices, namely the maintenance of discrimination.

Participants referred to the evolving and complex nature of culture, which requires exploration on an individual basis, contrasting to the common depiction of cultural competence equating to a static end point.

"Don't make me fit your narrative cause you went on a course three weeks ago." (Rani)

Rani implies that using education and training to justify assumptions, can lead to White staff members maintaining their power in services through claiming an expert position in relation to service users. Alternatively, the learner posture needs to continue alongside a commitment from clinicians to remove oneself from an expert position and recognise that learning about one culture through training does not equate to understanding diverse populations.

Enhancing service accessibility seems to involve recognising each person as an individual, with unique backgrounds and experiences. Participants recommended a holistic approach, rather than fitting people into preassigned boxes or attempting to address mental health difficulties in isolation. Participants repeatedly referred to how third sector organisations promote engagement and trust through considering how an individual's culture may lead to experiencing services differently which is valuable to explore.

"I think we look at the issue in a holistic way; we see the person as a whole. We see the person in the context of their family, their culture and we like to understand their issue in their community"(Hiranur)

In contrast, homogenising cultures and backgrounds leads to overgeneralising, or presuming similarity based on inaccurate ideas, which can be inaccurate and harmful.

"they've got like an idea in their head that Black people are a certain way." (Oni)

The interviews highlighted that an individualised approach is effective, being led by what the individual wants to share and actively listening. This includes enabling the individual to choose how prevalent culture, race and ethnicity are within their care.

"she saw me for me, she was the first person – she was White – but she listened to me and spoke about what I needed to without the assumptions. And she seemed to appreciate the impact my race, religion and culture were having, but she never made it the forefront" (Rani)

A way of demonstrating an ongoing commitment to the education process seemed to involve giving choice to service users, actively shifting the unequal power dynamic and preventing generalisations.

"We'll talk to them first and say do you wanna do this? If you don't, it can be changed? We work with them; we don't say yes to anything unless people actually want to do it. Whereas I think in NHS services it's more like okay, this is what we're going to do with these people. Or this is what we want to do."(Khalil)

Discussion

The first part of this theme draws attention to the enactment of cultural assumptions and stereotypes that can occur within mental health services, often due to a lack of education regarding cultural difference and values. It is widely recognised that humans take shortcuts to categorise people, but these were presented by participants as a barrier to accessibility. A lack of willingness to learn about different cultures was described as leading to homogenising and incorrect conclusions about the nature of mental health difficulties.

Participants referred to an unwillingness of clinicians to learn about different cultures, alternatively interpreting behaviours of ethnically diverse service users in line with their existing beliefs. This relates to the notion of confirmation bias, whereby individuals seek out and prioritise information that aligns with their existing beliefs and disregard contradicting or alternative views (Kassin et al., 2013; Nickerson, 1998). Many examples of confirmation bias were expressed by participants and previous research suggests mental health services often apply Westernised knowledge universally, with an absence of service user involvement and collaboration (Bulhan, 2015; Fernando, 2004; Oppong, 2019; Vernon, 2011). Rabiee and Smith (2013) discuss similar findings to the current study, including how spiritual beliefs expressed by Black African and Black Caribbean participants were either misunderstood or disrespected, and at times used to indicate they were 'mad.'

The position of privilege which enables mental health clinicians to overlook differences in cultural practices reinforces the principles of Critical Race Theory (CRT). These principles outline the ordinariness of racism and how normative standards of 'Whiteness' are deeply embedded within services (Trahan Jr & Lemberger, 2014). CRT asserts that continually misinterpreting cultural norms as mental health difficulties is a manifestation of racism that can be difficult to identify and address due to its discrete nature (Crenshaw et al., 1995). Participants in this study inferred there is also a lack of conscious effort made by clinicians to notice and reflect on their assumptions.

This theme illustrates how participants depict the concept of cultural humility and what it looks like in practice. Cultural humility is presented by participants as a necessary, ongoing journey of development, which contrasts to cultural competence, in which the emphasis is on a destination. Cultural competence refers to developing the skills and knowledge to attend to similarities and differences between cultures, including how culture influences expressions of distress and help seeking (Bhui et al., 2007). Cultural competence is therefore content-focused, proposing necessary learning which can enhance therapeutic relationships and communication (Shepherd, 2019). Participants in this study did address the importance of developing a broad understanding of different cultures to support increasing accessibility for ethnically diverse communities. This included recognising the impact of discriminatory and racist experiences within services and wider institutions. A further area of understanding participants referred to was recognising the impact of stigma associated with particular mental health difficulties and cultural norms, which may impact help-seeking. This has been reported in previous findings, suggesting that ethnically diverse service users may ignore or dismiss mental health difficulties due to the impact seeking support may have on their community and reputation (Arday, 2018; Memon et al., 2016). Participants expressed how self-harm is linked to greater stigma in specific ethnically diverse communities, which can result in shame preventing accessing support. Previous research has echoed this, suggesting that self-harm is often internalised and associated with reduced help-seeking (Bathje & Pryor, 2011; Fortune et al., 2008; Goldston et al., 2008).

However, concerns have been raised that focusing on developing the knowledge of clinicians reinforces that power lies with those employed by institutions (Lekas et al., 2020).

Cultural competence has therefore been critiqued due to its susceptibility to reproduce stereotypes, and maintain power imbalances between clinicians and service users, through situating cultural knowledge as a goal to complete (Kirmayer, 2012). The critiques of cultural competence were drawn out by participants in the study, indicating that clinicians make ethnically diverse service users 'fit their narrative' following the completion of training. This reinforces that a problematic bi-product of cultural competency training may be the perception that mental health clinicians know more than the service users they are working with (Lekas et al., 2020). Participants in this study referenced how attending training does not equate to understanding any ethnic group and instead a person-centred approach is required to understand the intersecting aspects of identity. This has been demonstrated more widely by studies suggesting that cultural competence training enhanced the knowledge and skills of clinicians, but did not translate to increases in service user satisfaction or outcomes (Truong et al., 2014; Watt et al., 2016).

Another questionable underlying assumption proposed by the term cultural competence, is that cultural understanding is something to achieve, whereas cultures continue to evolve and do not align with a fixed set of beliefs (Lekas et al., 2020). Cultural humility contrasts this by positioning the service user in the expert position, with the clinician committing to ongoing learning and self-reflexivity to enhance their care (Hook et al., 2013). The importance of cultural humility has been referenced in the literature, incorporating mental health clinicians' effort to understand the ethnic background of service users (Moore et al., 2022). Furthermore, the willingness to continually educate oneself about the cultural norms of different communities, alongside an ongoing commitment to self-reflection, facilitates growth in therapeutic relationships within mental health services (Moore et al., 2022).

Cultural humility relates to recognising the multiple and unique identities of each individual, aligning with person-centred care (Lekas et al., 2020). This is important as different aspects of identity intersect and may be deemed more relevant than others when seeking support. For example, some individuals have expressed a preference for matched gender over matched ethnicity within mental health services (Moore et al., 2022). Participants in this study referred to the importance of clinicians recognising the multifaceted nature of identity and recommended asking each service user about relevant aspects of their identity they feel comfortable to share. Comparably, previous reports suggest that person-centred and meaningful interventions which align with an individual's belief systems increase engagement with mental health services (Hall et al., 2021). Therefore, clinicians recognising that ethnicity is not the only way in which identity is defined can support forming deeper connection. Considering ourselves to have one identity can also be problematic and cause conflict between groups perceived to be different (Fernando, 2012).

An aspect of cultural humility many participants referred to is clinicians committing to unpacking their own biases and assumptions, considering how these may impact on interactions with ethnically diverse service users. This involved an enhanced awareness of the self, to then learn from the service user, engaging in sensitive curiosity. In previous literature clinicians' ability to engage in self-reflection and conversation about culture is limited, with them being described as insensitive and lacking understanding (Memon et al., 2016). In addition, research has described clinicians avoiding discussions about ethnicity and culture, often blaming this on fear of making mistakes, causing offence or feeling uncomfortable (Beck, 2019; Mensah et al., 2021; Naz et al., 2019). Moore et al. (2022) discuss how Black participants recalled wanting to feel safe to share their experiences openly, without fears of offending White clinicians. The necessity for clinicians to learn about their implicit biases and reflect on their preconceptions was a central theme within a recent systematic review, recognising the inevitability of getting it wrong on occasions, but not using this as an excuse to leave racism unexplored (King, 2021).

Theme 4: Deepening Connection

The theme 'deepening connection' depicts a core idea that prioritising forming and maintaining connection underpins accessibility, though connection was expressed in a number of ways. One aspect of this theme refers to the relational element of connection between clinicians and service users, highlighting that relationships need to be authentic and genuine between people. These relationships also need to be rooted in trust which recognises a necessary depth of connection. A further aspect of deepening connection is more practical in focus through integrating services and increasing joined up working of mainstream and third sector services.

Subtheme: "Just be human"

One of the most highlighted ways participants reported to increase accessibility of services was through prioritising connecting with each other authentically. Participants described the value of listening and validating difficulties, rather than proposing quick attempts to fix or mask difficulties.

"And I think when a person's genuine, experiences comes out authentically, it enables other people to actually say, 'It's okay, you are not the only one that's going through this or

facing this.' They don't have to be Black; it's just letting people know that it's ok to talk and we're here" (Oni)

Naming that accessible mental health support does not always require someone to be the same ethnicity illustrates that visual representation is not always essential for building a connection. Alternatively, investing in relationships supports anchoring a person to a service. This suggests the act of coming together can transcend language and cultural differences as compassion and humanness can be translated universally.

"If everybody could just learn to be more compassionate from a human perspective, then you could find a way of healing each other." (Eshal)

In this extract, Eshal further implies that compassion alone can be a mental health intervention and that emotional difficulties can be supported through connecting with a shared humanity.

Participants expressed a sense of disconnect and superficiality when meeting with clinicians in mainstream services, noticing a gap between head and heart connection.

"I am just talking to a wall that this person is putting up… is their heart even in it?" (Amara)

Perhaps this disconnect serves a protective purpose as the volume of service users both within mainstream services and on waiting lists, alongside clinicians experiencing burn-out and fatigue, may reduce their ability to authentically show compassion. Genuine care seems to require an emotional investment and putting up walls restricts the natural process of being human together. Emotional connection seems to be at the core of services run by staff who are able to express their humanness and, in turn, make others feel invested in. Helping is implied to be an innate process for enabling community, however mainstream services often prioritise medicalised approaches which lack a human response or even engagement.

"They were being very, very medically termed in their terminology. And they weren't even talking to me by the way. They were talking to my husband who couldn't speak a word of English who was sat next to me."(Eshal)

Within this quote, Eshal depicts another possible barrier to meaningful connection which is that the clinician was addressing her male partner, perhaps making an assumption about the role of gender in her culture. This experience could also be interpreted as dehumanising and prevent genuine connection.

Participants recalled that emotional connection has been achieved within third sector services through prioritising sharing stories and capturing the reality of living with mental health difficulties.

"I don't need you to tell me how up to date you are with my community, it will reflect in how you engage with me…enhance relatability through sharing stories and emotion. I think story sharing can be really beneficial, making it real and not just throwing a pamphlet in someone's face." (Rani)

In the extract above, Rani expresses how stories can be an effective means of forming connection. A central element of most stories is conveying emotion, suggesting this is fundamental for an authentic exchange.

Participants evoked the idea that the answer to accessibility is already enacted in the structure and format of many third sector organisations. Participants used third sector organisations as a point of contrast to mainstream services, where those who have been marginalised and dismissed, are valued.

"here provides the opposite space, where there is a community, you are seen for who you are… they are received with open arms." (Luna)

Overall, participants suggested that continuing to recite information or gain knowledge without showing humanness is ineffective. Despite accessibility initially being aided by knowledge, connection is required to build integrated services and to maintain ongoing support structures. This theme of connection also suggests that focusing too much on difference can be detrimental, and there is a need to identify areas of similarity and relatability.

"And the similarities bring unity, that although we may not look the same, there is a lot of similarities in the way we grew up or the beliefs that we share or the beliefs our communities share." (Luna)

Enabling relatability was addressed by a number of participants to illustrate how connections are deepened through a sense of unity and two-way sharing. This moves away from the expected role set up of 'clinician' and 'patient', challenging the inherent power imbalances within services.

"I went to a stop smoking clinic about seven years ago. And the woman said to me, 'Oh, yeah, the first few weeks are really hard.' and I was like, 'Are they? When did you quit?' She goes, 'I've never smoked!' I'm not coming back here again. How can you tell me the first two weeks are really hard when you've never even had a fag!" (Rani)

Discussion

This subtheme outlines the value of connecting on an authentic, human level, suggesting that care is more accessible when delivered by clinicians who draw on their personal experiences to enhance therapeutic relationships. This is unsurprising given that therapist self-disclosure about their ethnic background and experiences of discrimination relates to increased satisfaction in psychological therapy interventions (Chang & Berk, 2009). Wider research also affirms how therapist self-disclosure bridges potential social and power imbalances that may occur in cross-racial dyads (Berg & Wright-Buckley, 1988). Self-disclosure can effectively communicate empathy and understanding, by expressing how clinicians are not immune from distress and participants in this study highlighted the value of shared humanity (Aggarwal et al., 2016). Comparable research suggests that service users value discussing areas of similarity as well as difference to establish shared, common experiences that can enhance therapeutic relationships (Gurpinar-Morgan et al., 2014). Participants in this study discussed the importance of authenticity within interactions. This correlates with previous findings suggesting when ethnicity is mentioned too early in mental health interventions, it appears to be a service requirement rather than a genuine and meaningful interest (Gurpinar-Morgan et al., 2014). In addition, feeling understood by therapists who show empathy is beneficial, aligning with participants in the present study who described being able to tell if a clinician's 'heart' and emotion were present in the interaction (Gurpinar-Morgan et al., 2014).

Forming authentic connections through exploring similarities indicates that belonging may be a significant step towards addressing culturally inappropriate mental health support (Offermann et al., 2014). More specifically, if a person identifies with others who provide stability and purpose this can lead to improvements in their own mental health (Haslam et al., 2009). This relates to participants' descriptions that compassion from mental health clinicians can be a form of intervention, independent to any clinical approach. Forming a shared identity through connecting on similarity of experience, or 'humanness,' can enhance trust, communication and collaboration, all of which seem to link to service accessibility (Ellemers et al., 2004). On the other hand, perceived rejection or difficult relationships experienced within services can lead to a deterioration in mental health. (Haslam et al., 2009).

Increasing relatability and connection has formed recent developments in mainstream services, aligning with suggestions from participants that this is a fundamental aspect of provision. For example, some NHS services have recruited peer support workers with lived experience of mental health difficulties, who are willing to share some of their personal experiences with service users to support them (Gillard & Holley, 2014). In contrast, previous research has demonstrated the reluctance of mental health nurses to share their experiences of mental health difficulties due to perceiving the topic as a 'taboo' and concerns about blurring boundaries between professionals and service users (Oates et al., 2017). However, others described being able to manage this balance, alongside a sense that 'being real' and drawing on shared experience led to greater understanding and empathy (Oates et al., 2017). More broadly across research, self-disclosure is largely infrequent, whereas silence is commonly reported in the context of discussing mental health disclosures (Moll et al., 2013).

Subtheme: Trust

Also central to forming connections is trust, and many participants outlined the necessity of trust within services, even indicating that without it, all other attempts of enhancing accessibility are meaningless.

"*You can have a team of the best trained, trauma-informed, culturally aware, competent folks. But if you're not getting people through the door because they're unable to build that initial trust with you then it just won't work."(Satvinder)*

As discussed in the previous theme, participants reiterated the necessity for clinicians to understand past experiences of racism within services and their wider impact in order to develop trust. Participants outlined how mistreatment and deception of ethnically diverse communities in mainstream health services has impacted their ability to be open and honest.

"You go to your GP to say I'm going through abuse. And they ask you, 'Oh, is it affecting your children?' and as a mother you say 'yes, it's affecting my children; my children cry'. Then what happens is social services. They can take your children. Now when a lady has experienced that how many do you think will go back to tell their GP same thing. No. So, that lack of trust is there." (Yetunde)

A lack of trust may contribute to why some ethnically diverse individuals prefer to discuss physical health problems, rather than their mental health. In addition, this subtheme encompasses that to understand the root of a person's difficulties, trust has to be built to enable the discussion of specific mental health difficulties, which may be masked underneath what someone is initially presenting with.

"Because of the mistrust there's a case of I want to talk about the physical aspects of the issue, that I can't sleep, give me tips on how to sleep better because there's a safety in talking about that, rather than talking about some of the deeper stuff where they could feel vulnerable." (Chidera)

Discussion

This subtheme firstly suggests that trust needs to form the foundation of mental health services, which has been recommended across recent policy aimed at addressing racial inequity across mental health services (Joint Commissioning Panel for Mental Health, 2014; Sewell et al., 2021). In order to do this, participants implied that clinicians should have an awareness of past experiences of discrimination across health and social care services, and referred to experiences known to them, which have led to a lack of trust. The history of racism and acts of discrimination within health research are widely documented and unsurprisingly impact service accessibility (Shavers et al., 2002). Participants in this study referenced greater safety in discussing physical aspects of mental health difficulties, potentially as a way of preventing further discrimination, which has been replicated in previous research (Memon et al., 2016). Participants suggested understanding the reasons for mistrust should be used to form contrasting new experiences with ethnically diverse service users in which they are believed, listened to and shown compassion.

Developing trust has previously been explored with suggestions that clinicians who listen to and respect the views of service users, and involve them in their care, lead to greater trust (Rabiee & Smith, 2013). Comparably, recent systematic reviews outline that therapeutic factors, including establishing rapport, trustworthiness and being non-judgemental, facilitated access to mental health services (Planey et al., 2019; Sass et al., 2022). One approach to actioning participants’ recommendations to develop trust is through enabling service users to tell their stories, alongside a willingness from mental health clinicians to give away some of their power to listen from a compassionate stance. These ideas are centralised in the Power Threat Meaning Framework (PTMF), which acknowledges how discrimination within services can be traumatising and lead to mistrust. Withholding information or focusing on the physical aspects of mental health difficulties are likely to have formed necessary survival strategies for some ethnically diverse service users. The framework supports service users to share why mistrust has occurred, often in response to trauma and the ongoing threat of oppression, aiming to reduce their feelings of blame (Johnstone & Boyle, 2018). Shifting the responsibility for mental health difficulties away from the individual and locating them within services may support developing trust within therapeutic encounters and empower ethnically diverse service users.

Subtheme: Service Integration

Enabling connection can also be more practically focused, incorporating joining up services and collaborating via two-way knowledge sharing. This involves acknowledging the strengths of different services, both mainstream and third sector, and the skills within them. This idea of learning from and equipping each other extended across many interviews and involved organisations working together, recognising the limits and values of different services.

"there are gatekeepers to different communities so it's about building partnerships with charities and organizations that are already on the ground, doing the work. So the NHS can build the trust with these organizations that already have the trust with diverse groups of people." (Chidera)

Some participants referenced how many ethnically diverse communities prioritise seeking support at community organisations, religious organisations, or places of worship due to their ease of access, and familiarity, which transcends across geographical locations.

"what we realised is by working with community leaders and Imams, they're the first point of access for a lot of people who are struggling. Cause there's that level of trust there; that's what you've been told from a young age is that if you have a question you have to go to your religious leader, you have to go to your Imam in the mosque." (Falaq)

The ease of access to community organisations, particularly religious institutions, due to preestablished relationships of trust, was referred to by several participants. However, participants acknowledged that many community-led organisations have not been trained or equipped with skills to explore mental health difficulties. Two-way knowledge sharing demonstrates that NHS services have skills regarding mental health interventions to offer third sector organisations too.

"you walk past a temple or mosque which tend to be quite busy most days, we just need to now train up faith leaders, cause people go to faith leaders, but their advice may not be helpful so you need to work with them as people will always take the faith leader's view" (Rani)

The necessity of services working collaboratively is supported by the underlying idea that both types of services should take dual responsibility for accessibility difficulties. This was founded based on participants stating that all mental health services are united by a shared goal.

"just to make it like collaborative cause we're all trying to do the same thing. We're all trying to help people who need help." (Falaq)

Connection of services also involves engaging in conversation about race and culture that may be overlooked or minimised within mainstream services. Connection needs to embrace difference and explore similarity, through integrating with community organisations, and places of worship, to create new streams of accessibility. A common connecting idea across themes, was the effort required by mainstream services to increase connection. As a point of contrast, participants expressed that third sector organisations are already using their resources, to support those most in need.

“we are open-minded. We have struggled through it but we feel we’re really trying to get to those people who really need us the most” (Falaq)

Community integration and forming connections also relies on revisiting who mental health services are for, and whether their views and preferences are at the centre of the service.

“You can’t say that something’s for the community if it’s not, they’re not informed by the people you’re trying to serve.” (Shahzad)

The effort made by third sector organisations aligns with the foundational idea that integration of services is a desired outcome for the future. Alongside participants’ reflections were ideas about how to practically build connections across services.

“My dream is to have a community centre where people can access information to be able to connect with services, the NHS, the local authority…a centre where information can be passed on and easily translated for people to understand. That's my greatest dream.” (Satvinder)

Discussion

Within this subtheme, participants addressed how service integration and collaboration could support increasing accessibility of mental health services for ethnically diverse service users. Participants referred to third sector organisations as trustworthy and open minded, whereas mainstream services have vast knowledge about mental health interventions. Therefore, collaboration could enhance both types of services. Previous studies have outlined the benefits of integrating statutory and voluntary services, as voluntary services are associated with greater trust and reduced stigma (Rabiee & Smith, 2013). Suresh and Bhui (2006) recommend a two-way skilling up of different types of service to exchange expertise, whilst noting their limitations. For example, third sector organisations often develop trust and engagement with ethnically diverse service users, but are restricted by a narrower range of mental health interventions available compared to mainstream services.

Third sector organisations also tend to lack thorough standards around the delivery of interventions which means during times of crisis, mainstream services may be more suitable. This relates to McEvoy et al. (2017), who reported accessibility improvements for an Orthodox Jewish community after establishing a leadership team made up of NHS and third sector representatives, including Jewish religious organisations. The combination of local knowledge alongside mental health expertise proved beneficial and enhanced relationships which meant both services were open to new ideas to meet the needs of the community (McEvoy et al., 2017).

Service integration has also been promoted by Kolivoski et al. (2014), suggesting how mainstream services can engage with charities and religious organisations to develop knowledge of specific needs for different populations and offer mental health care in non-conventional settings. Involving local communities within the provision of mainstream care may support addressing imbalances of power through developing inclusive leadership with ethnically diverse communities informing service agendas and policies (Keating et al., 2002). These suggestions align with a review by Christie (2003) which explored how third sector organisations had worked alongside Black and minority ethnic service users, ensuring their rights were central to the aims of the service. Service integration also helped identify ways of preventing referrals to mainstream services or more controlled aspects of mental health systems.

Participants in the current study suggest locations where all services can be represented would be a valuable approach to increasing service accessibility. Enabling greater service integration relates to the idea of permeable group boundaries, referring to how group boundaries which are perceived to be fixed, lead to greater alignment with a singular, existing group identity (Haslam et al., 2009). Participants in this study contrast this through describing group boundaries as flexible and permeable, which allows for movement between groups in the form of different services. Creating fluidity between ethnic groups can support service integration across third sector and mainstream mental health services. Comparably, intergroup contact theory suggests that frequent social connection between different groups can reduce prejudiced attitudes aimed at those in certain outgroups and increase positive perceptions of them (Allport et al., 1954). The reduction in prejudiced attitudes is more likely if there is a common goal between groups and an ability to work together, both of which are central to this subtheme of service integration.

Theme 5: Building on a Weak Foundation

The theme ‘building on a weak foundation’ encapsulates the service-related, systemic considerations to accessing mental health support for ethnically diverse communities which requires redesigning the foundations services are built on. The first aspect of this theme ‘Preliminary Considerations for Structural Change’ relates to participants’ descriptions of systemic barriers impacting the accessibility of mainstream mental health services and how third sector organisations have addressed these. The subtheme ‘inauthenticity: representation without meaning’ relates to tokenistic changes observed within mainstream mental health services and how these correspond to surface level change, with limited correlation to increasing accessibility. The final subtheme ‘dismantling not bolstering’ reflects how mainstream services require large-scale change, through dismantling and then rebuilding services with stronger foundations.

Preliminary Considerations for Structural Change

This part of the theme refers to participants’ recognition of structural changes and service-related barriers restricting accessibility. Structural barriers seemed to relate to a multitude of factors, including poor funding, resource limitations, long wait times and navigating complex systems.

“I’ll just figure it out myself because by the time you get seen, well if it was a broken leg, it would have to be gone and amputated.” (Luna)

The long wait times within services, described by Luna, work as a deterrent to seeking support, resulting in mental health difficulties amplifying and reaching crisis level before an intervention is initiated. Systemic barriers including poor funding and resources were referenced by many participants.

“a massive barrier at the moment is waiting times, it’s just an absolutely huge one at the moment.” (Satvinder)

“you could ring, you’re number 19 in the queue and who can hang on?” (Zarina)

Participants considered the physical set up of services, including the tone and formality of support. Many conveyed the value of ensuring ethnically diverse communities feel comfortable, acknowledging this may look different for different people, depending on their past experiences. This also relates to how a service looks visually and the connotations attached to particular presentations of clinics, for example, a clinical space versus an informal space.

"the waiting rooms are not the most welcoming. It's a huge room, it can be quite overwhelming when you go in. And I've noticed in most places like GPs you talk to, and everybody can hear everything, and that's not ideal, especially if they're saying I don't want the community to know what's happening in my life and my family. So, it doesn't always feel that practical and obviously you know nine to five is when NHS services are open and people are working." (Lavindeep)

Another participant spoke about the contrasting set up and structure of the third sector organisation they work for, which serves the community using holistic, whole-person approaches.

"There's an increased sense of actually, this service is designed to serve local communities, there's multiple functions for it." (Satvinder)

A repeated idea across the data was that many third sector organisations had solutions to systemic barriers existing in mainstream services signifying these goals are achievable.

"there's something about making the pathway more straight. Charities and other organisations seem to do it but I'm wondering why the NHS can't." (Chidera)

"It's just not conducive to be on a waiting list and even though we have quite a small team of counsellors like nothing comparable to the NHS, we've still had so many people come in and been able to get quicker service, I would say." (Falaq)

Participants alluded to feeling frustrated about the lack of willingness of mainstream services to make changes to improve accessibility. Participants also seemed unclear as to the reasoning behind this lack of change as many third sector organisations had enacted clearer pathways to mental health support.

Subtheme: Inauthenticity: Representation Without Meaning

Inauthenticity captures the doubts participants expressed regarding the motivations underpinning current attempts to increase accessibility. There was an implied lack of depth within these attempts, with mainstream services generally doing little more than increasing visible representation of ethnically diverse employees in a tokenistic way. This subtheme highlights that transformative change requires meaning, and words without action is inauthentic.

"'We're very diverse' What does that mean; you've got one brown person sitting on your board." (Rani)

"who's the face or the faces of the service or organisation. Are they reflective of the people that you're hoping to serve. And can people see themselves or see friends or family in the people who are delivering these services." (Satvinder)

Participants indicate that although visible representation is important, it needs to have a motivation beyond filling a diversity quota.

Increasing accessibility was presented as embracing different cultures, using their ideas and a willingness from services to give up power so representation can have a meaningful impact. In contrast, increasing diversity without purpose appears tokenistic and can actually be detrimental to systemic change.

"*it's a mainstream service, catered to the mainstream, which is White British, cisgender, straight people and anyone outside of that is getting a different quality service because it's not designed for them, and it's not adapted for them either" (Khalil)*

"I think we have a lot of [ethnicity] that work in the NHS you know, but they aren't policy makers, and they don't sit on boards and all that." (Yetunde)

Participants referenced that quick fix solutions such as employing more ethnically diverse individuals are insufficient and services alternatively need a cultural shift which considers all aspects of identity in their design and interventions.

"You follow the norms and culture wherever you work, even if you are from a diverse culture, if you work for the NHS you have to adopt their culture and structure as you can't change that, the whole system would need to change. We are getting more user representation and getting better at understanding the needs of different cultures, but structurally they still remain the same, the issue of racism is still embedded within the service. We can have forums for diverse people but nothing changes when the structure stays the same and this is why people go to other organisations" (Hiranur)

There appears to be a reluctance to shift the underlying culture of mainstream services, and representation is presented as a positive process so long as ethnically diverse individuals are willing to slot into the existing service values and principles.

"when you're a mental health nurse you join a templated system where they tell you when this happens, this is what you do." (Tula)

Discussion

Participants highlight how visible diversity without meaning is futile and dismisses the acknowledgement of a templated service ethnically diverse communities are expected to join and fit into. Similarly, Patel and Keval (2018) suggest that diversity agendas fail to acknowledge the historical and current racism embedded within services. They do not address the power within services which juxtaposes the push for inclusivity. Patel and Keval (2018) powerfully depict the notion of visible representation without meaning as ‘window dressing.’ This aligns with the suggestions of participants in the current study that mainstream services are doing ‘just enough’ to communicate increases in diversity, without risking altering the foundation of services.

Participants suggested that simply employing more ethnically diverse people in NHS services is tokenistic and tackles issues on an individual rather than systemic level. Fernando (2012) argues that tokenistic employment represents a move away from progress and increases in diversity solely at a numbers level is confirmed by statistical data. The 2022 NHS Workforce Race Equality Standard (WRES) data analysis report across NHS trusts detailed an overall increase in the number of staff from Black and Minority ethnic backgrounds, from 19.1% in 2018 to 24.2% in 2022 (NHS England, 2022). Despite a corresponding increase in Black and minority ethnic staff in senior management positions over the last year, when unpacking the more specific findings, 34% of staff working in Band 5 positions were from Black and minority ethnic backgrounds, compared to 10.3% in senior management positions (NHS England, 2022). Poor representation of ethnically diverse communities within senior management positions and board level roles in the NHS has remained consistent for the last twenty years (Esmail et al., 2005). In nearly all NHS trusts, Black and minority ethnic staff were also more likely to experience harassment, bullying or abuse from staff. This corresponds to participants’ descriptions of ethnically diverse communities having to join the templated culture of NHS services with an inability to influence deep-rooted cultures formed on White British norms.

This subtheme relates to CRT, in which White people will support attempts to increase ethnic diversity so long as their power is maintained and White culture remains the norm (DiAngelo, 2018). This aligns with conclusions from the Joint Commissioning panel for mental health (2014) acknowledging that increasing ethnic representation has not led to greater cultural adaptation of mental health services. Kalathil (2008) states that meaningful involvement of Black and minority ethnic communities requires hierarchies to be restructured, to enable new ways of working, alongside changes in institutional power structures, resource allocation and decision making.

More widely, participants’ depiction of the fixed culture of NHS services aligns with research suggesting that the behaviour of mental health clinicians is predicted by the extent to which they have internalised the identity of that professional group (Falomir-Pichastor et al., 2009; Haslam et al., 2009). This seems to indicate that White British mental health clinicians form a group membership that dictates acceptable behaviour within NHS services and participants in this study suggests this maintains institutionalised racism.

Subtheme: Dismantling Not Bolstering

Many participants suggested that the changes required to ensure mental health services are accessible are too extensive for small-scale adaptations and require wider systemic change. A seeming lack of importance placed on genuinely supporting mental health needs can promote despondency, rather than encouraging ethnically diverse communities accessing further support. Therefore, to meaningfully enhance accessibility participants stated structures and policies need to be dismantled, rather than bolstering or adding on ideas. Interestingly, solutions to increasing accessibility placed emphasis on reform, requiring re-establishing the foundations on which mainstream services are formed.

"Sometimes we have to look at our service and see how it's built and that means some dismantling has to happen and I don't think people feel comfortable dismantling things, it's almost like let's try and bolt something on. Ultimately, the system fundamentally doesn't work." (Chidera)

An overarching idea across the data seemed to imply that the changes mainstream mental health services are willing to make do not align with current needs, nor support increasing accessibility. Participants expressed this through outlining the intersecting nature of presenting difficulties experienced by individuals which overlap and require holistic approaches. Mental health services were described as currently addressing difficulties in isolation, rather than offering holistic care.

"it is never one simplistic problem, a person could be having issues with employment, their money, parenting, raising their children without any support networks." (Amara)

This links with the notion of whole system approaches, whereby the aims of services become more collaborative, wide reaching, and intersecting, working with other existing organisations. Alongside this, participants outlined that if essential survival needs are not being met first, it is impossible for interventions relating to mental health to be approached.

"I need food. I need clothes. So, until that is met nobody can even talk about their emotion... if I'm poor and I've got my £5 I'm not spending it on travel to come…and if they can't get there the NHS will think, oh, we offered her this and she hasn't come." (Tula)

Participants' responses relating to systemic complexities surrounding mental health difficulties also poses the question of whether mental health distress is caused or exacerbated by structural inequalities faced by many ethnically diverse communities. The narrative described by participants is that mainstream services do not take responsibility for enabling physical access to services, resulting in financial and travel barriers being ignored. As a result, assumptions should not be made regarding poor attendance as there are vast reasons for this. Participants expressed how an individual's level of systemic disadvantage is directly correlated to their experience of service accessibility.

"it's hard enough for anybody regardless of race, religion, culture, sexuality, gender to come forward and seek support for their mental ill health. But I think the more layers you add, I call it holding up umbrellas; the more umbrellas you hold up, the harder it gets to seek that support because there's more barriers in place." (Rani)

Discussion

Participants highlighted how the current structures of mainstream mental health services are not fit for purpose and solutions do not lie in doing more of the same, continuing to build on top of weak foundations. Alternatively, they propose a necessity to work holistically, considering the multifaceted difficulties experienced by ethnically diverse communities, which impact accessing mental health services. Rabiee and Smith (2013) discussed that mental health services working with African migrants should consider and provide support for a range of needs, including housing, welfare, and employment, which were often deemed a greater priority than mental health difficulties. Working holistically incorporates mental health services placing the service users at the centre, contrasting to delivering dehumanising services which are unable to understand all aspects of human difficulties (Fernando, 2012).

Participants in this study suggest mental health services require a reformed structure, laying new foundations for services to be built on. Mainstream services need to expand their outlook on the cause of mental health difficulties through acknowledging how racism infiltrates all areas of a person's life. There is an absence of research detailing services which have achieved these changes, perhaps indicating the lack of structural change currently occurring within mainstream mental health services.

Chapter Four: Discussion

In this chapter I draw together the five themes to consider the broader links between them and how they contribute to the literature in their entirety. I will then detail some of the strengths and limitations of the current study and the wider clinical implications the analysis supports. I conclude this chapter with my personal reflections and final conclusions.

Revisiting Research Aims

This research project aimed to explore understandings of mental health service accessibility for ethnically diverse communities from the perspective of third sector service providers. Data was collected through the facilitation of 15 semi-structured interviews, which were analysed using reflexive thematic analysis. The focus of data collection was to address three research questions:

- What do third sector service providers believe an accessible service looks like?
- What can mainstream mental health services do to become more accessible?
- What are some of the barriers preventing service accessibility?

Collective Discussion of Analysis

The analysis addresses all three research questions through developing five main themes, named: ‘knowledge is power,’ ‘navigating the pathway to inclusivity,’ ‘from cultural competence to cultural humility,’ ‘deepening connection,’ and ‘building on a weak foundation’. The interconnected nature of these themes draws together key service accessibility considerations for ethnically diverse communities.

Captured within the theme ‘knowledge is power,’ participants situated knowledge of mental health services as the first stage of service accessibility. However, through highlighting how this knowledge is unequally distributed, it forms a tool to maintain power, as many ethnically diverse communities have limited exposure to service availability. A lack of knowledge of service availability within ethnically diverse communities has been widely documented, making the pathway to mental health support challenging (Memon et al., 2016; Rabiee & Smith, 2013). Addressing this power imbalance requires proactivity from mainstream services, through taking responsibility for disseminating awareness and partnering with ethnically diverse communities. This links to the theme ‘deepening connection’ whereby integrating services can address the unevidenced ‘hard to reach’ label ascribed to ethnically diverse communities. Practical collaboration of services incorporates sharing skills and equipping each other, recognising the dual responsibility for achieving the shared goal of providing accessible care.

Participants differed in their perceptions of how inclusivity within services should be attained, with some advocating for specialist services led by clinicians with a specific, shared cultural understanding. Others suggest that a willingness to adapt services to meet different cultural needs creates a service ethos that is attractive to all. Uniting perspectives was the need for service flexibility to accommodate individual preferences and promote belonging, recognising that ethnically diverse communities are not homogenous. This closely links to the underpinnings of cultural humility which centralise individualised approaches, with clinicians engaging in ongoing exploration of diverse understandings of mental health difficulties. The theme ‘from cultural competence to cultural humility’ acknowledges how making assumptions and interpreting difficulties through the lens of clinicians’ existing beliefs forms a barrier to service accessibility, a finding that has been widely supported (Rabiee & Smith, 2013).

The analysis highlights that broad education and awareness of cultural norms are required to address stigma and develop trust with ethnically diverse communities. This links to the power of language outlined in the first theme, whereby participants recommended ensuring the terminology used to describe mental health interventions is accepted across cultures. Respecting differences in cultural values, alongside considering the intended audience of interventions, should guide decisions regarding language used within services. These themes collectively introduce that power is not equally distributed within services and addressing this requires moving away from White British culture being the accepted norm and all other groups forming the contrast (Parekh, 2019).

A clear idea uniting aspects of the analysis is the significance of belonging and the necessity for mental health services to promote acceptance. Belonging aligns with journeying towards cultural humility, through working collaboratively, whilst being led by service users, positioning them as the experts of their experiences. Participants indicate that to aid accessibility clinicians should adopt a continuous learning stance, self-reflecting on the impact of their internalised prejudice, whilst not using increased knowledge to reinforce their power. Participants depicted cultural humility as attending to all aspects of a service user’s identity and this has formed the conclusions of previous research (Lazaridou & Heinz, 2022). Cultural humility also transcends across both individual and systemic level recommendations for change.

A closely linked product of cultural humility is deepening connection, which forms another theme. Participants centralised ‘being human,’ which is achieved through authentic, genuine connection built on compassion and trust. Building rapport and recognising the individualised preferences of service users, without being hindered by judgement, transcended across the analysis. Focusing on cultural humility involves considering the impact of racism within services and empowering service users to share their stories, to reframe where power and responsibility for mental health difficulties lies.

The final theme, ‘building on a weak foundation,’ outlines how although small-scale considerations, including shortening wait-times and forming clearer intervention pathways, contribute to increasing accessibility, mainstream mental health services need rebuilding with anti-racist foundations. The suggested foundations tie together most themes, including embracing cultural humility, increased service integration, belonging and holistic provision of care. Participants referenced current tokenistic change, which lacks meaning and does little more than shift the numerical structure of the NHS. Participants suggested that holistic, whole system approaches need to form the heart of structural change, by promoting those with diverse cultural experiences into positions of leadership. Service accessibility reform needs to consider how institutional racism maintains socio-economic barriers to access, including the complex interaction of difficulties, such as poverty, leading to an inability to access services. Institutional racism impacts all themes in the analysis, prevents the enactment of person-centred care and is applicable across systems in the UK. Participants suggest structural change to create services where all service users are valued and belong, providing a holistic, person-centred approach to care.

Strengths

To my knowledge, this study is one of the first to explore understandings of mental health service accessibility from the perspectives of UK-based, third sector service providers, working with ethnically diverse communities. Through recruiting 15 participants representing 14 ethnically diverse services, the inaccuracy of the ‘hard to reach’ terminology has also been addressed. This will hopefully promote ongoing engagement with third sector organisations within ethnically diverse communities, enacting the recommendation to increase service integration.

Through shifting the focus of this study from service users to service providers, I was able to access system-level barriers and facilitators to accessibility which can support systemic change. Capturing a breadth of viewpoints enabled me to access many perspectives of accessibility, such as whether enhancing inclusivity corresponds to broadening or narrowing the focus of services. Since mainstream services are commissioned to meet the needs of all service users, establishing the effectiveness of holistic, person-centred care is a strength of this study which may not have been identified through exploring accessibility needs of more specific ethnic groups (McEvoy et al., 2017; Rabiee & Smith, 2013). Comparably, the analysis highlights common themes and comprehensive factors to enhancing service accessibility which extend beyond considerations at an individual level.

Within this project, I have been transparent about how my cultural background and biases impacted my interpretations of the data. I reflected on my personal and professional experiences of mainstream mental health services and how my ethnicity, which differed to all participants, influenced the conclusions I developed. There are potential strengths of noticing areas of difference, particularly when facilitating interviews. For example, when researchers and participants have similar identities or experiences, participants may hold back information or overlook aspects of their experience, due to assuming the researcher will be familiar with them (Daly, 1992). The continued input from people with personal experience of providing services for ethnically diverse communities ensured the study discussed all aspects of service provision in a sensitive, appropriate way.

Limitations

Whilst the findings offer rich insights into participants' perceptions of service accessibility, studying the perspectives of broad ethnically diverse participants meant I was unable to establish unique aspects of accessibility existing within specific communities. As a result, this study does not offer specific recommendations for services, nor outline a checklist of necessary requirements to achieve accessibility.

Additionally, due to participants' preferences to participate virtually using Zoom, this meant I did not have the opportunity to visit services in person. Consequently, I was unable to observe the discussed areas in practice and experience how the examples illustrated in interviews had been operationalised. Facilitating observations of different services could have provided a complimentary form of analysis, enabling consideration of how the physical appearance of services impacts accessibility.

In this study, participants shared their reflections on factors they believe impact service accessibility for ethnically diverse populations, but these may not equate to the experiences of those accessing services. This study can therefore only comment on the views of service providers. Exploring service accessibility for ethnically diverse communities is also a continually evolving research area and these findings are time-stamped, situated in the current context, which will continue developing as understanding and service development increases.

Clinical Implications

The perspectives of participants in this study translates into many recommendations for mental health services. In order to structure the clinical implications, I have been guided by Bronfenbrenner's (1977) ecological systems theory, which outlines five interrelated levels of influence. The theory was originally developed to depict the complex interaction of relationships, environments and systems which impact a child's development. However, the theory also illustrates the multidimensional nature of mental health service accessibility for ethnically diverse individuals, ranging from individual to environmental and societal considerations.

The first level outlined by Bronfenbrenner (1977), corresponds to the immediate environment surrounding an individual, known as the microsystem, involving those they have direct relationship with, including family, peers, clinicians, and the self. Participants referred to necessary areas of self-reflection for clinicians working with ethnically diverse individuals, including unpacking racial biases and assumptions. Further accessibility implications included clinicians enabling service users in individual interventions to share their unique stories and attending to them with curiosity, aligning with previous research advocating for increased cultural humility (Tervalon & Murray-Garcia, 1998). Service accessibility seems to increase when clinicians recognise they cannot be experts of cultures to which they do not belong, demonstrating a willingness to alter power imbalances within therapeutic relationships. Participants reflected how authentic connection, utilising appropriate self-disclosure, can instil trust and maintain service access.

Additionally, introducing racially trauma informed pathways for service users attending mainstream mental health services can support attending to service users' experiences of racial trauma and discrimination. This could include clinicians engaging in anti-racist practice on an individual level, for example, using culturally adapted assessments and outcome measures which incorporate the role of culture, as well experiences of racism and their impact on mental wellbeing. One outcome measure developed to assess the impact of racial disparity is the Everyday Discrimination Scale (Williams et al., 2008; Williams et al., 1997). Once used with service users measures need to be evaluated through encouraging feedback from service users to ensure further adaptations are made where recommended.

Relevant aspects from these measures can then be incorporated into service users' formulations and interventions. Adapting practice in this way and making reasonable adjustments to support individuals is also included within the updated HCPC guidelines outlining the standards of proficiency for practitioner psychologists (Health and Care Professions Council, 2023). Psychologists are required to recognise the impact of culture on psychological wellbeing and practice in a non-discriminatory manner, reflecting on their own beliefs and personal biases, including those that may be unconscious.

The second level, termed the mesosystem, captures interactions which occur between microsystems, forming social networks and broader connections (Bronfenbrenner, 1977). Participants illustrated how accessibility can be navigated within this relational level, through developing relatability and exploring shared aspects of identity. This incorporates moving away from viewing identity as fixed and one-dimensional, instead recognising that ethnic identity is one of many identities an individual holds (Fernando, 2012). Deepening connections provides a foundation for belonging which, alongside benefiting therapeutic relationships, also improves engagement, creativity and productivity of NHS staff, suggesting that belonging is fundamental across service provision (Kline, 2019). Similarly to participants in this study, previous outcomes highlight different views regarding the importance of matched ethnicity in therapeutic interventions (Gurpinar-Morgan et al., 2014; Rabiee & Smith, 2013). Therefore, it is recommended that clinicians prioritise flexibility within services to meet the individualised preferences of each service user, shifting the power in therapeutic spaces. A further aspect of increased flexibility could include greater involvement of service users' families, carers and communities within mental health interventions to capture the importance of wider support for some ethnically diverse individuals.

The next level, named the exosystem, incorporates the influence of wider agencies and social structures, such as neighbourhoods and workplaces, which may indirectly influence an individual. There were many service level implications addressed by participants, including integrating mainstream and third sector services. To achieve this, mainstream services need to engage proactively and creatively with ethnically diverse communities, for example, partnering with religious organisations and attending community events (McEvoy et al., 2017). This could also include a broad range of services, both mainstream and third sector, as well as physical and mental health services, joining together to form shared interventions which holistically meet the needs of ethnically diverse service users. The NHS long-term plan aligns with a number of findings from this study, advocating for greater integration of services, with improved information sharing, and offering personalised, trauma informed, mental health care (NHS, 2019). Recently, NHS organisations have begun working in partnership with local authorities, forming Integrated Care Systems, to enable more cohesive, joined-up approaches to care and to take collective responsibility for tackling inequity (NHS, 2019). Additionally, participants suggested involving service users in service development and enhancing collaboration within all aspects of mental health care can reduce stigma associated with accessing mental health support. The benefits of facilitating collaborative care have been recognised in governments reports, such as the ‘no decision about me, without me’ clarifying that shared decision making needs to be at the centre of services (Department of Health, 2012). However, this study highlights that all services need to be enacting co-production meaningfully and creatively.

The established society and culture surrounding individuals, including their socioeconomic background, forms the next level, called the macrosystem. This incorporates wider systemic change, which is a key aspect of participants’ understandings of service accessibility. Many referenced the need to rebuild mental health services, with strengthened foundations which promote person-centred care, flexibility and belonging. Participants detailed small-scale service recommendations, including addressing waiting times, however recognised that to fully address service accessibility requires service reform. Forming new services prevents the tokenistic changes currently occurring and provides opportunity to incorporate the cultural ideas of diverse communities.

In addition, participants recommended mainstream services consider holistic approaches, recognising the breadth of difficulties ethnically diverse service users may be experiencing. This includes attending to practical barriers to accessing support, including financial difficulties, that lead to an inability to access transport to services, or individuals needing to prioritise their physical health difficulties over their mental health. Services need to adapt to wider socio-cultural movements and events, for example, maintaining awareness of the current cost of living crisis, the impact of war and conflict, and climate change. These events will impact on mental wellbeing in different ways and may be heightened for individuals who have also experienced racial oppression and discrimination. Therefore, certain groups are likely to be more affected and services need to be responsive to cultural events that may not be able to be changed, but their impact can be considered and explored within mental health services. Structural reform that aids accessibility should become the focus of policy and initiatives, alongside raising awareness to support ethnically diverse communities to navigate services. Commissioners need to take responsibility for investing funding into, and disseminating information about, their services, echoing recommendations from comparable research (Memon et al., 2016; Rabiee & Smith, 2013). There is currently limited research regarding building new services, however this study provides some fundamental starting points. These include those with lived experience of racial discrimination being employed in senior positions where they can exert greater influence. Diverse representation within NHS service leadership is necessary to meaningfully inform anti-racist policy and movement towards cultural humility.

The final level, the chronosystem, focuses on environmental changes and possible socio-political transitions that occur across a lifetime. The implications of this research suggest the need for ongoing social reform, embracing principles of social justice and activism to continue addressing systemic racism. A useful tool may be the role of the media, which could support shifting the narratives of services. This could be achieved by not only highlighting racism in mainstream services to enforce accountability, but also through reporting examples of successful, collaborative services enhancing accessibility (Rabiee & Smith, 2013). Collaborative, community led, leadership needs to be promoted, working alongside communities rather than externally to them. Within this level of influence, participants also addressed the importance of holistic approaches, prioritising redistributing power within services and honouring the voices of ethnically diverse communities to increase service accessibility.

Future Directions for Research

Exploring the perspectives of third sector service providers has developed new insights into understanding mental health service accessibility. However, future research should establish whether the perspectives of service users align with those of staff, to build on these findings. In particular, focusing on service users who only attend third sector services, as opposed to mainstream services, could develop the evolving understanding of accessibility barriers. Due to the nature of not attending services, it may be challenging to represent the views of individuals who do not currently feel able to access mental health services, however their perspectives are valuable and necessary. Through this study actively disproving the efficacy of the term ‘hard to reach groups,’ it may be possible to recruit those underrepresented in health research, through researchers engaging in proactive recruitment methods.

Since these findings suggest community support and integration, often in the form of wider family and religious organisations, is integral to accessing mental health services, future research could explore their perspectives too. This may elucidate further ideas relating to developing cultural adapted services, representing voices which are largely neglected in both research and clinical practice.

Future research could also utilise different methodological approaches, for example, ethnographic studies, to observe third sector mental health services to establish how the ideas raised in this study have been operationalised. Facilitating ethnographic studies can also support developing trusting relationships between different services. Keating et al. (2002) described visits to services specifically addressing the needs of African and Caribbean communities and commented on the physical appearance of services, such as brightly painted walls and cultural artefacts (Keating et al., 2002). Developing this area of research could enhance the specificity of recommendations for the physical structuring of accessible mental health services.

As this research area continues to evolve, research needs to be ongoing to capture changes and build on developing knowledge to holistically understand service accessibility. These findings are time stamped, so it would be valuable to revisit a qualitative exploration of service accessibility in the future to establish whether growth and change is occurring in the areas highlighted in this study. This includes unpacking whether the foundations of new services are working effectively towards cultural humility, alongside enabling meaningful change, to restructure power within mainstream services.

Personal Reflections

At the beginning of this project, I questioned whether I was the right person to explore this research area, doubting whether ethnically diverse people would participate due to my lack of knowledge and personal experience of many barriers to service accessibility. Yet the willingness of participants to share their reflections and personal experiences instantly confirmed the nonsensical terminology of ‘hard to reach groups’. It was disheartening and angering to repeatedly hear about racism and discrimination occurring in mainstream mental health services. At times, I felt overwhelmed and distressed by the scale of how embedded racism is within mainstream mental health services and the inexhaustible areas it infiltrates. This became reflected in my approach to the thesis write-up, feeling unable to convey the magnitude of systemic change required within services that participants demonstrated.

However, I remained motivated by the importance of sharing the experiences I heard in the interviews and the privileged opportunity to share these understandings of accessibility.

I have learnt about injustices in mental health services and the importance of accountability, whilst holding onto hope for future change and progression.

Facilitating the interviews and immersing myself in the analysis highlighted the power of meaningful connection and belonging that transcends this project. This has inspired me to continue striving for these in my clinical role. I connected to the narratives of participants who believe there is hope for an equitable and anti-racist future of mental health services. However, this requires acknowledgement of institutional racism, alongside prioritisation and investment to rebuild the foundations of mental health services. Finally, I have been taught to continue the ongoing journey for social justice, guided by cultural humility, self-interrogation, and reflection.

Conclusion

Mental health service accessibility for ethnically diverse communities is multifaceted, requiring close consideration of the overt and subtle expressions of power that prevent accessibility. Developing services where ethnically diverse communities are valued and belong, through cultivating person-centred, authentic connection, should be prioritised. Increased integration of services can support restructuring racist power hierarchies and enable critical examination of both individual and service level biases which restrict access for many ethnically diverse communities. This study demonstrates that barriers to accessibility exist systemically within NHS services, as opposed to being located within ethnically diverse individuals or communities. Participants evidenced the multitude of ways third sector services are effectively engaging with ethnically diverse communities, through centralising person-centred, integrated care, that is flexible and holistic, whilst illustrating how this contrasts to current mainstream mental health service structures. This study makes a significant contribution to the literature regarding mental health service accessibility, identifying that change should be led by the continuous and proactive, service-level journey towards cultural humility.

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Appendices

Appendix A: Participant Information Sheet

Study Title: An Exploration of Accessibility of Services for Individuals From Ethnically Diverse Communities Who Self-harm.

You are being invited to take part in the above research project. Before you decide if you would like to take part, it is important to explain the purpose of the project and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. You can contact the researcher, Harriet Lawrence, using the details found at the end of this sheet if anything is unclear or if you would like more information. This research is being completed as part of the qualification of the Doctorate in Clinical Psychology at the University of Leeds.

What is the purpose of the project?

Research studies show that individuals who self-harm and are from ethnically diverse communities are under-represented in health research and services, contributing to the maintenance of power imbalances, marginalisation and the widening of inequalities. Some studies have suggested this may be because services are not accessible. Therefore, the aim of this research is to gain an understanding of the factors that may impact accessibility of services for individuals from ethnically diverse communities, from the perspective of those working in third-sector organisations.

Why have I been chosen?

This research project aims to explore best practice examples of providing accessible, inclusive services and can do this by speaking to individuals who work within these, to find out how they operate. Therefore, individuals who work for organisations and services that are currently supporting and aiming to meet the needs of ethnically diverse individuals who self-harm have been invited to take part in this study.

Do I have to take part?

Taking part in this study is voluntary and it is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. During the interview, you can decline to answer particular questions should you wish and you can ask to stop the interview at any time. Once you have completed the interview you can still withdraw your data up to two weeks post-interview. You can withdraw by emailing the researcher, Harriet (see contact details below) and do not have to give a reason for this.

What will happen to me if I take part?

If you agree to take part, you will be invited to attend an interview which is likely to last between 30-60 minutes. The interviews will take place either at your place of work or using an online platform called Zoom. We can also arrange telephone interviews if that would be more suitable. Before the interview begins, you will be asked to complete a written consent form and to return this to the researcher, to confirm you have agreed to take part in the interview. You will also be asked to complete a short questionnaire to provide basic demographic information about yourself, such as your age and ethnicity.

The interview will be audio-recorded and more information about how we will protect your identity and interview data can be found in the section below titled ‘Will I be recorded and where will my data be stored?’ If you do not consent to your interview being audio-recorded you can still take part in the study and written notes will be taken instead.
After the interview, your responses will be combined with those from other participants to help us understand a collective view of service accessibility for individuals from ethnically diverse communities who self-harm.

What are the possible benefits of taking part?

Whilst there may be no immediate benefits for those who participate in the research project, it is hoped this research will support increasing the accessibility of mental health services for individuals who self-harm, from ethnically diverse communities. The research findings will hopefully provide new insights into appropriate care and inclusive service access.

What are the possible disadvantages and risks of taking part?

This research project is not intended to cause distress, however discussing service accessibility may raise some emotive responses for you. If this occurs at any time, you will be able to take a break from the interview. If you feel it would be helpful to talk in more depth after the interview, I will be available and can signpost you to relevant support services.

What will happen to my personal information?

Your full name and signature will be required to complete the consent form. Completed consent forms will either be stored in a locked filing cabinet at the University of Leeds or will be stored online using One Drive-University of Leeds which is permitted to use to store confidential data securely and privately, for a maximum of three years. The One Drive-University of Leeds account also has Duo Authentication which adds a further layer of security to online accounts. Your personal information will remain confidential and transcripts will be anonymised through the use of pseudonyms and removal of identifiable information. The information you give will only be used for the purposes of this study and will not be shared publicly.

Will I be recorded and where will my data be stored?

The interviews will be audio-recorded using a password-protected Dictaphone. Audio files will be transferred onto a secure university storage area on the day of recording, and will then deleted from the recording device. Interview recordings will be made and stored in line with the University Data Protection Policy which can be found at: ***https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf.*** A copy of the audio recording will then be sent to a University of Leeds approved transcription service. The transcription service has signed a confidentiality agreement with the University and will destroy the copy of the audio file once the interview has been transcribed and anonymised. The audio recordings made during this research will be used only for analysis. Once the data from the interviews is analysed, I will also write and talk about the results in a written report as part of the Doctorate in Clinical Psychology at University of Leeds. When sharing the findings I will use short quotes from the interviews but will not include any identifying information. All data will be destroyed after three years.

What will happen to the results of the research project?

The findings from the research will be written up in a thesis report which will be submitted to the University of Leeds as part of my Doctorate in Clinical Psychology. The thesis will be held by the University of Leeds Library and will be available to read at the following link: ***https://etheses.whiterose.ac.uk/cgi/search/advanced***. Anonymised results may also be written for publication in online journals and be presented at conferences in the future. You will not be identifiable in the final report or any other publication of the research. The data collected during this project may also be used to inform subsequent research, however this will not include any of your personal information.

Who is organising and funding the research?

The research project is being organised by the Doctorate in Clinical Psychology course at the University of Leeds. The study has been reviewed by the School of Medicine Research Ethics Committee at the University of Leeds and the study reference code is MREC21-036.

Contacts for further information:

If you are interested in taking part in the study, have any further questions or would appreciate additional information please contact:
Lead Researcher: Harriet Lawrence, Psychologist in Clinical Training, umhla@leeds.ac.uk
Research Supervisor: Dr Cara Sass, Leeds Institute of Health Sciences, c.sass@leeds.ac.uk
Research Supervisor: Dr Cathy Brennan, Leeds Institute of Health Sciences, c.a.brennan@leeds.ac.uk

What if there is a problem?

If you have any concerns about any aspect of this research, please speak to me and I will do my best to answer your questions. If you would like to make a complaint about the research, details about this process can be obtained from: Clare Skinner (Head of Research Integrity and Governance) at governance-ethics@leeds.ac.uk. Dr Skinner is independent of this research project.

Services and organisations providing mental health support:

- **Samaritans:** This organisation is available 24 hours a day for anyone needing mental health support. Calls are kept confidential and the contact number is: 116 123.
- **Mind Infoline:** The Mind team can provide a range of non-urgent information relating to mental health support and services that are available to you, call: 0300 123 3393 or visit www.mind.org.uk.
- **Rethink:** Provides mental health support and can be accessed online at www.rethink.org or by calling: 0300 5000 927
- **Leeds Mental Wellbeing Service:** This service provides support and therapy for difficulties including, stress, anxiety and depression. You can self-refer yourself to this service online or use the telephone number: 0113 843 4388
- **MindWell:** This is a mental health website providing information and support for adults in Leeds. https://www.mindwell-leeds.org.uk

Thank you for taking the time to read through this information sheet and for your interest in this study.

Appendix B: Confirmation of Conditional Ethical Approval

Dear Harriet

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

MREC 21-036 - An Exploration of Accessibility of Services for Individuals from Ethnically Diverse Communities who Self-harm

The committee would like to thank the applicant for considering the concerns raised.

The above research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and I can confirm a conditional favourable ethical opinion based on the documentation received at date of this letter and *subject to the following condition/s which must be fulfilled prior to the study being implemented:*

1. ***Application Form*** *– It would be helpful to specify on the ethics application form whether there is a plan to send reminder emails in the event of non-response. e.g. a reminder email sent after 2 weeks? And perhaps a second (final) reminder after that?*
2. ***Supervisor Signature*** *- Can see the supervisor signature on the PDF, however unfortunately it still appears as a black rectangle on the Word document. We would suggest that a final, updated PDF version of the form is submitted that includes the signature.*
3. ***Reviewers Comments Form*** *- Similarly, there is space for the supervisor to sign the response form – please ensure that a signature is included here.*
4. ***Patient facing documents*** *- Please share the revised poster and topic guide documents with the co-ordinator so that they have the latest/final versions on file. (We believe that it is only the addition of a version number/date that has changed here from those previously submitted).*

The study documentation must be amended where required to meet the above conditions and submitted for file and possible future audit. *Once you have addressed the conditions and submitted for file/future audit, you may implement the study and further confirmation of approval is not provided. Please note*, failure to comply with the above conditions will be considered a breach of ethics approval and may result in disciplinary action.

Please retain this email as evidence of conditional approval. Once you have met the conditions and submitted for file/audit, the study may be implemented with immediate effect.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please contact the Research Ethics & Governance Administrator for further information (FMHUniEthics@leeds.ac.uk)

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study continues to go well.

Best wishes
Sou
On behalf of Dr Naomi Quinton, CHAIR SoMREC

Appendix C: Participant Consent Form

Consent Form **Title of Study: An Exploration of Accessibility of Services for Individuals From Ethnically Diverse Communities Who Self-harm** Once you have read the participant information sheet and are happy to participate in the research, please read the items listed below and add your initials next to each item.	Add your initials next to the statement if you agree
I confirm that I have read and understand the Participant Information Sheet (V2, 24/01/2022) explaining the above research project.	
I have had the opportunity to think about the information and ask questions. If I had any questions, these have been answered to my satisfaction.	
I understand that my participation is voluntary and that I am free to leave the interview at any time, without giving any reason. In addition, should I not wish to answer any questions, I am free to decline. I understand that I can withdraw my interview data up to two weeks post-interview. After this time the analysis will be complete and it will not be possible to remove my interview data. If you have any further questions about this or would appreciate additional information please contact Harriet Lawrence (Lead Researcher) at umhla@leeds.ac.uk	
I understand that members of the research team at the University of Leeds involved in this study may have access to my anonymised responses. I understand that I will not be identified or identifiable in the report that results from the research. I understand that my responses will be kept confidential.	
I understand that words I use in the interview (quotes) may be included in documents published from this study, but no identifiable information will be included at any time.	
I understand that the data collected from me may be stored and used to support future research in an anonymised form.	
I give permission for the interview to be audio-recorded for the purposes of data collection and analysis. I understand that a University of Leeds approved transcription service will be used to transcribe my interview data.	
I agree to take part in the above research project.	

Name of participant	
Participant’s signature	
Date	
Name of lead researcher	Harriet Lawrence

Signature	
Date*	

*To be signed and dated in the presence of the participant.

Appendix D: Topic Guide

Interview Topic Guide

- It would be great to hear about the service you work for and what it is like to work there?
    - Prompts: What are the aims/reach of the service? Is there a consistent work base? How diverse, in relation to ethnicity, is the service, including the staff and service users?

- What do you believe an accessible service for ethnically diverse individuals who self-harm looks like?

- How do you find ethnicity and culture are incorporated into the service where you work?
    - Prompts: Training/education, recruitment, assessments, interventions, evaluation?
    - Are experiences of racism discussed within the service and interventions provided?

- How does the service you work for facilitate accessible care for ethnically diverse individuals who self-harm?
    - Prompts: What adaptations or considerations are made for ethnically diverse individuals? In your experience, what are services implementing to ensure they are culturally appropriate?

- From your experience, what are the barriers to creating and delivering accessible services for ethnically diverse individuals who self-harm?
    - What do you feel an inaccessible service looks like? What makes current services inaccessible?

- What can mental health services do to become more accessible for ethnically diverse individuals who self-harm?

Appendix E: Recruitment Poster

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Exploring Accessibility of Services for Individuals From Ethnically Diverse Communities Who Self-harm

Do you work or volunteer for a service that supports individuals from ethnically diverse communities who self-harm?

Are you passionate about increasing accessibility of mental health services for ethnically diverse communities who self-harm?

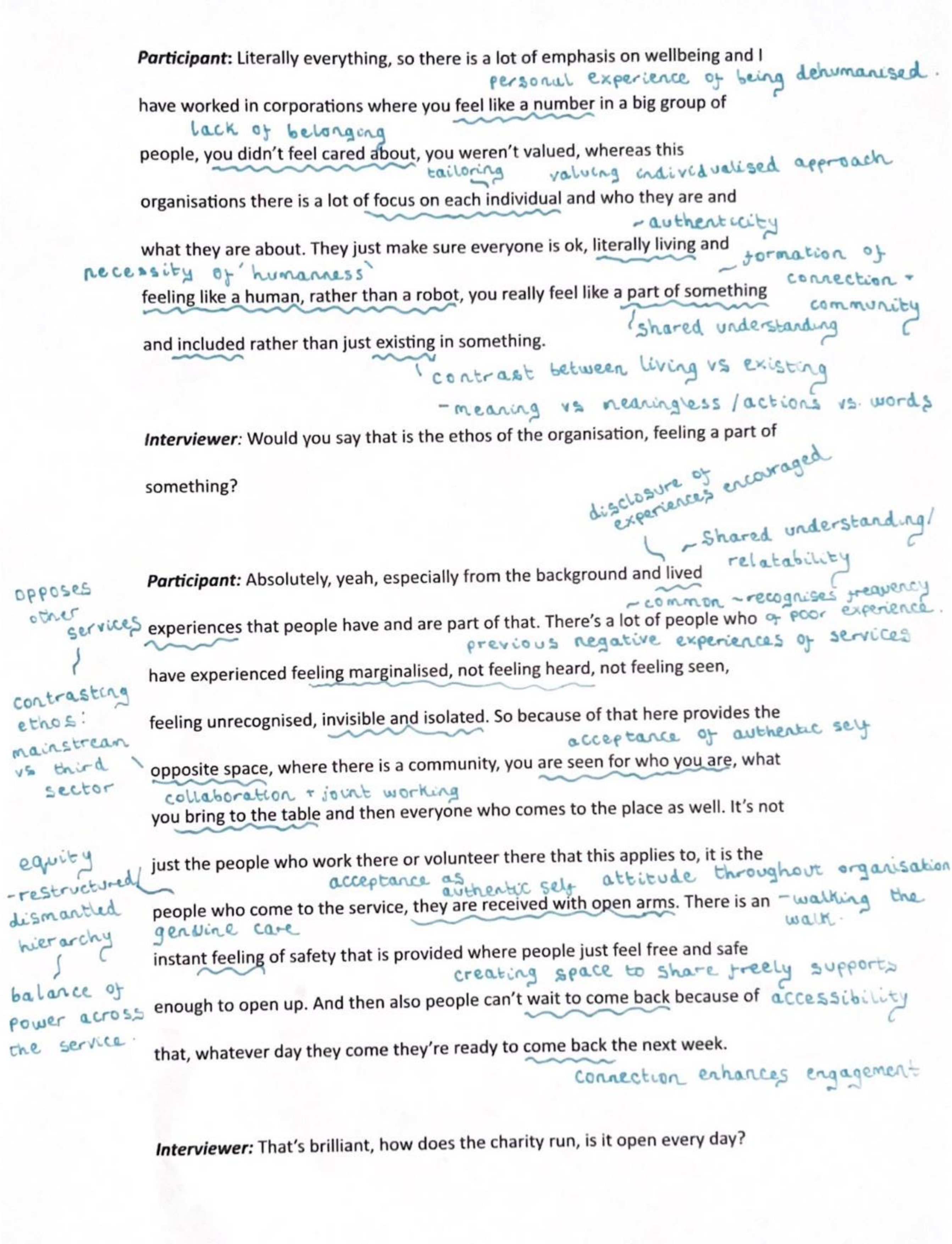
Research studies have shown that individuals from ethnically diverse communities who self-harm are under-represented in health research and services. This maintains power imbalances, marginalisation and the widening of inequalities. When we use the term self-harm, we mean acts like cutting or burning your skin, hitting or injuring yourself in some way. We also include eating/drinking something that might be poisonous, like an overdose of tablets.

Importantly, ethnically diverse individuals who self-harm should have access to culturally appropriate services and it is currently unknown to what extent existing services are achieving this.

I am hoping to gain an understanding of the factors that impact accessibility of services for individuals from ethnically diverse communities, who also self-harm, from the perspective of those working in charities and third-sector organisations. Therefore, the focus of this study is on the experiences of services providing accessible support for ethnically diverse individuals.

If you are interested in sharing your views in a confidential setting, please contact me using the details below for further information:
Harriet Lawrence, umhla@leeds.ac.uk

Appendix F: Example of Anonymised Coded Data Extract



Participant: Literally everything, so there is a lot of emphasis on wellbeing and I

personal experience of being dehumanised.

have worked in corporations where you feel like a number in a big group of

lack of belonging

people, you didn't feel cared about, you weren't valued, whereas this

tailoring valuing individualised approach

organisations there is a lot of focus on each individual and who they are and

~authenticity

what they are about. They just make sure everyone is ok, literally living and

~formation of connection + community

necessity of 'humanness'

feeling like a human, rather than a robot, you really feel like a part of something

shared understanding

and included rather than just existing in something.

contrast between living vs existing

~meaning vs meaningless / actions vs. words

Interviewer: Would you say that is the ethos of the organisation, feeling a part of

something?

disclosure of experiences encouraged

~Shared understanding/ relatability

Participant: Absolutely, yeah, especially from the background and lived

opposes other services

~common ~recognises frequency of poor experience.

experiences that people have and are part of that. There's a lot of people who

previous negative experiences of services

have experienced feeling marginalised, not feeling heard, not feeling seen,

contrasting ethos: mainstream vs third sector

feeling unrecognised, invisible and isolated. So because of that here provides the

acceptance of authentic self

opposite space, where there is a community, you are seen for who you are, what

collaboration + joint working

you bring to the table and then everyone who comes to the place as well. It's not

equity ~restructured/ dismantled hierarchy

just the people who work there or volunteer there that this applies to, it is the

acceptance as authentic self attitude throughout organisation

people who come to the service, they are received with open arms. There is an

~walking the walk.

genuine care

instant feeling of safety that is provided where people just feel free and safe

creating space to share freely supports

balance of power across the service.

enough to open up. And then also people can't wait to come back because of

accessibility

that, whatever day they come they're ready to come back the next week.

connection enhances engagement

Interviewer: That's brilliant, how does the charity run, is it open every day?