Accessing mental health services for the first time: the black African and Caribbean experience.

Submitted to the University of Hertfordshire in partial fulfilment of the requirements for the Doctorate in Health Research degree.

Godfrey Tendai Muchena

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Abstract

Background: Significant disparities and complex inequalities are experienced by individuals from black African and Caribbean communities and perpetuate the formation of barriers and the perception of poor outcomes from NHS mental health services.

Aim: This dissertation explores the lived experiences of accessing mental health services for the first time by people of a black African and Caribbean background.

Methods: Qualitative phenomenological research was conducted using semi-structured interviews with a sample of 15 adult male and female participants aged 18 years and over and who resided in the southeast region of England. The participants' individual accounts were audio-recorded, transcribed and analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four superordinate themes were identified and these explored experiences in relation to: 'Psycho-social exposition and vulnerability to psychiatric morbidity' – which shows how individuals from these communities are predisposed to mentally strenuous and debilitating social disadvantage; 'Coping mechanisms in dealing with adversities' – which gives insights on how participants deployed strategies to manage psychological adversity; 'Being hospitalised in a psychiatric ward' – which speaks to the experience of being an inpatient in a psychiatric hospital; and 'Dynamics of therapeutic relationship with clinicians' – which characterises the quality of caring relationship that participants experienced with doctors, nurses and fellow service users.

Conclusion: The study contributes to a scant evidence base of qualitative research into the first-time lived experiences of accessing mental health services by black African and Caribbean individuals. Findings suggest that while there are notable positive changes that have contributed to diversity and inclusion policies within services, disparities remain evident with far reaching implications on accessibility and satisfaction for these individuals.

Implications: For clinical practice, there is need for services to embrace multiculturalism and to understand the socio-cultural aspects of these communities in order to provide universally responsive mental health interventions. Further participatory research that directly involves participants at various stages of the research process, and fosters ownership and solidarity may provide yet more insights about the subjective experiences of individuals from these communities.

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Acronyms

ADTU   –   Acute Day Treatment Unit

BAME   –   Black, Asian and Minority Ethnic

BME   –   Black and Minority Ethnic

ECHR   –   European Convention of Human Rights

SIT   –   Social Identity Theory

SSIs   –   Semi-structured interviews

SCMH   –   Sainsbury Centre for Mental Health

MHA   –   Mental Health Act

MCA   –   Mental Capacity Act

CATT   –   Crisis Assessment and Treatment Team

CMHT   –   Community Mental Health Team

CPN   –   Community Psychiatric Nurse

CRT   –   Critical Race Theory

CRHTT   –   Crisis Resolution and Home Treatment Team

CTO   –   Community Treatment Order

DOH   –   Department of Health

EIPS   –   Early Intervention in Psychosis Service

IPA   –   Interpretive Phenomenological Analysis

NMC   –   Nursing and Midwifery Council

APA   –   American Psychological Association

WHO   –   World Health Organisation

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Statement of authorship

This dissertation was written by Godfrey Tendai Muchena and I can confirm that the work presented here was solely reviewed and interpreted by myself and has the relevant ethical clearances. I can confirm that this work is being submitted in partial fulfilment of the requirements of the School of Health and Social Work at the University of Hertfordshire for a Doctorate in Health Research degree.

This dissertation carries no conflict of interest and the author is responsible for the content and writing of this report. The work has not been submitted elsewhere in any other form for the fulfilment of any other degree or qualification. The paper does not contain any material or content previously written in another publication except for where such work has been used and referenced as appropriate.

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Chapter 1 - Introduction

1.1 Study overview

The aim of this chapter is to provide an orientation of the research to the reader and to outline the contexts of the subsequent study chapters. This qualitative phenomenological study is based on Martin Heidegger's conception of Interpretative Phenomenology. It uses semi-structured, audio-recorded and transcribed interviews to explore the phenomenon of mental health service usage through the lived experiences of first-time service users from a black African and Caribbean background.

The focus of the study was to explore the participants' psychosocial circumstances, thoughts, feelings, perceptions and attitudes at various key stages of their journeys through the mental health system, from the point of initial contact through to aftercare, and to determine the circumstantial impact of these experiences on their care outcomes.

1.2 Scope of study

The study is located within the context of health inequalities and is set in a naturalistic research paradigm focused on subjective experiences of a key life event associated with the social world and its perceptions. Guided by Heidegger (2000), Interpretive Phenomenology is applied to collating and understanding the lived experiences of the participants in order to obtain insights into their first-time exposure to mental health services as black African and Caribbean service users. Therefore, phenomenological research translates to gathering 'deep' information and perceptions from the participants through inductive qualitative methods such as interviews, and presenting data from the perspective of the participants.

Conflict Theory was the chosen theoretical approach, which provided a robust basis to adequately explore varying participants' experiences of health inequalities. Conflict theory was propounded by Karl Marx and claims that society is in perpetual conflict due to competition for limited resources (Dahrendof, 2007).

1.3 Study aim

The aim was to answer the question, 'what are the subjective experiences of black African and Caribbean people when accessing NHS mental health services for the first time?'

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1.3.1 Study objectives

To identify and critically evaluate the empirical evidence of accessing mental health services by people of a black African and Caribbean background.

- To explore the idiographic experiences of black African and Caribbean service users when they access NHS mental health services for the first time, including their attitudes and perceptions of the services.
- To deconstruct the underlying psychosocial, socioeconomic, cultural and political processes that underline black African and Caribbean people's access to mainstream mental health services and their perceived outcomes.
- To determine the relationship dynamics between mental health clinicians and service users of a black African and Caribbean background.

1.4 Scientific justification of study

In order to illuminate the research context, the referenced literature suggests that access to mental health services by the current study target population continues to be marred by disproportionate discrepancies characterised by inequality, aversive treatment, racism, denigration and other discriminatory practices (Grey, 2013). This implies that service users from these communities continue to experience mental health services negatively and have poorer outcomes, hence the need to better understand their subjective experiences.

More than two decades ago, the Acheson Report (1998) found that entrenched inequalities existed in mental health provision based on age, gender and socioeconomic status within the predominantly white communities. The report identified that black African and Caribbean communities face more disproportionate disadvantage and discrimination within mental health services and as such, this became a subject of growing concern.

A decade later, Keating (2007) observed that black African and Caribbean service users, amongst other ethnic minorities, are more often diagnosed with schizophrenia; coercively detained under the Mental Health Act; admitted as 'offender service users'; held by police under Section 136 of the Mental Health Act; transferred to locked wards from open wards; not referred for psychotherapy; given high doses of medication; referred to psychiatrists by courts; and have unmet needs or poorer outcomes. These service users are more likely to receive medication as a primary form of treatment rather than psychotherapy (NHS Information Office, 2009). Further, racism, cultural ignorance and stigma were identified as significant barriers to engagement of ethnic minority communities within healthcare settings (Latif, 2010). Therefore, the historical and contemporary positioning of these individuals within a society shapes how

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they are treated within mental health services, and the varying experiences interact to produce a downward spiral of feeling oppressed.

More recent literature (Bhui et al., 2018; Melton et al., 2017; Nazroo & Karlsen, 2016) confirms the prevalence of glaring inequalities in the provision of mental health care within the NHS, especially to black and minority ethnic communities. There continue to be persistent inequalities despite the policy measures designed to help redress these disparities, including the review of the Mental Health Act (1983), and the introduction and rolling out of culturally sensitive services. Some of these initiatives were integral to 'Count Me In' (DoH, 2010), The Black Report (2010), and several other publications that arose in response to the disproportionate disadvantages that black African and Caribbean service users experience in NHS mental health services. However, it is reported (NHS Digital, 2019; CQC, 2018) that black African and Caribbean service users remain overrepresented in mental health services and are more likely to be detained under a section of the Mental Health Act (1983) - as amended (2007).

1.5 Framework of study

1.5.1 Research location

The research setting comprised 10 community mental health teams across 10 corresponding districts of a county in the south east of England.

1.5.2 Sample and recruitment

A sample size of 15 participants recruited from service users actively under the care of community-based mental health teams was considered feasible for a qualitative research study. Convenience sampling procedure determined recruitment of the sample guided by the inclusion and exclusion criteria of the study. Care coordinators across the research setting assisted with the recruitment of the sample as they assumed gatekeeping roles of selecting potential participants from their respective caseloads with guidance from the inclusion and exclusion criteria.

1.5.3 Inclusion criteria

Recruitment of participants was regardless of gender, marital status, sexual orientation, socioeconomic status or migrant status. Participants had to be identified within the ethnic category of black African or Caribbean and be 18 years of age and over. Only service users under the care of Community Mental Health Teams and post a first psychiatric inpatient spell were considered. The admission spell had to be within two years prior to the study

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commencement and participants had to be of sound mental capacity in order to freely consent to take part.

1.5.4 Exclusion criteria

Given that I worked as a community psychiatric nurse within the service where I was conducting the research, service users who had been directly under my care were excluded in order to circumvent the dynamics of power imbalance between clinician and patient. Potential participants who could not write and speak the English language, including those who could not provide written consent or were likely to relapse into an acute phase of mental ill health during the study, were excluded. Similarly, those who lacked mental capacity were not considered for participation.

1.5.5 Ethical issues

Stipulations that were commensurate with the conditional favourable opinion from the Health Research Authority - Ethics Committee and other governing stakeholders were adhered to throughout the study period. In addition, all my undertakings were guided by a confluence of statutory legislature, policies and guidelines which include the Nursing and Midwifery Council Code of Professional Conduct (2015) - essential responsibility for protecting all information about individual circumstances; Human Rights Act (1998) - protecting 'Dignity' and 'Privacy'; Core Principles of Social Research and Research Governance Framework for Health and Social Care; NHS England Confidentiality Policy (2014); and Data Protection Act (2018).

Participants' names and personal identifiable information were anonymised for confidentiality purposes. Number codes were used in place of the participants' actual names. Audio records and subsequent transcriptions were kept in a locked cabinet where only the researcher had access. All word-processed transcriptions were stored on an encrypted NHS computer.

1.6 Researcher subjectivity

By virtue of being a mental health professional, the researcher had a general insight of the BAME service users' experiences in mental health services. Therefore, I declared my own pre-understandings acquired from clinical practice experience, and through my own historical and socio-cultural context as being a black African, by reflexively acknowledging the attributes researcher subjectivity has on the study participants' experiences. In line with the ontological standpoint, this helped to minimise researcher bias and to increase the rigour and validity of the research process.

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1.7 Ontological assumptions

Declaring researcher subjectivity dovetailed with the ontological assumptions made in this study. The ontological perspective holds that we understand the phenomena by being bound in it rather than by taking a step back to have a subjective view. Therefore, ontological assumptions are relativist in nature and support the belief by Heidegger (1999) that there is no absolute truth but that all truth is co-constructed by humans and situated within a historical moment and social or cultural context (Wolff, 2017). In this study, ontological assumptions relate to the acknowledgement and acceptance that multiple meanings and realities exist for perhaps the same data narrated by the participants. Therefore, researchers embrace different realities just as the participants being researched and the readers of the research study so do. As such, it was essential to acknowledge in this current study that each participant understood reality from a personal perspective, which reflected on diversity and variation of lived experiences.

1.8 Data collection

Semi-structured interviews were used for data collection and an independent mental health service user focus group contributed towards the development of the interview topic guide. Specialist professional opinion was also sought from the local staff BAME networking group to help validate and refine the interview schedule.

Interviews commenced soon after the potential participants were identified and had consented to take part in the study. The interview topic guide questions included: access to primary care services before admission; involvement of community-based teams; involvement of statutory powers in hospital admission (police, courts); Mental Health Act; length of stay as inpatient; and choice and involvement in care planning, amongst others.

Semi-structured interviews were used for data collection because they align with a general principle of phenomenological research of fostering minimum structure and maximum depth (Kvale, 2009). In contrast to other methods, semi-structured interview was most appropriate for gathering deep information about individual lived experiences in a one-to-one encounter that helped to facilitate flexibility and immediate feedback for clarity. The interview venue was at the participants' local community mental health centres where interview rooms were pre-booked via the respective team administrators.

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1.9 Data analysis – Hermeneutic Circle

The concept of hermeneutic circle was used for the data analysis process. This was conducted within the parameters of Interpretive Phenomenological Analysis, which enabled a vision of the whole text as the reality that is situated in the detailed experience of everyday existence by an individual (Gadamer, 1994). This means that understanding evolved based on pre-existing structures that allowed for the initial interpretation of phenomena to occur and develop through the iterative coding processes of the transcripts.

1.10 Contribution from the study

While the causal mechanisms for the inequalities and discrepancies experienced by black African and Caribbean mental health service users remain significantly unexplained, awareness of these negative experiences has predominantly been raised in quantitative studies. Therefore, this current study endeavours to shed more light and facilitate a deeper understanding of the service users' experiences within mental health services, and to contribute towards a qualitative literature database. This level of understanding could not be achieved by singularly relying on quantitative research methods. Therefore, I believe this approach helped to answer the research question by exploring and explaining the subjective experiences of accessing mental health services by black African and Caribbean service users.

A snapshot of the study findings shows that black African and Caribbean mental health service users experience complex and destabilising psychosocial and socioeconomic circumstances that make them vulnerable to psychiatric morbidity. These individuals carry the risk of being culturally misunderstood by both clinicians and law enforcement agencies, and may end up by being wrongly diagnosed and disproportionately detained under the Mental Health Act. Participants in this study held well-formed negative opinions about mental health services prior to their initial contact, and this helps to explain the emergence of some of the barriers to their accessing help in a timely manner. They experienced procedural and legal coercion within services, which led and contributed to their strained relationships with the clinicians. Disengagement tendencies increased with the perception of being misunderstood, discriminated against on treatment options, and being excluded from care planning and management - including decisions about medication.

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1.11 Overview of the chapters

1.11.1 Chapter 1 – Introduction

This Chapter states the purpose of the study and narrates what motivated the researcher. The chapter also outlines the scope of the study, gives the context as well as the background. The research aim, objectives, rationale and theoretical constructs are explained.

1.11.2 Chapter 2 – Literature review

This chapter reviews related and relevant literature pertinent to accessing mental health services by people from a BAMEbackground, especially the black African and Caribbean individuals. Historical and background literature is also discussed before focusing on the contemporary issues surrounding experiential narratives about accessing mental health services by black African and Caribbean people. Issues reviewed include: differential psychosocial, socioeconomic and cultural factors; the nature and availability of family support; complexity in pathways to care often involving law enforcement agencies; being disproportionately detained under the Mental Health Act; experiencing discriminatory care within services; being segregated against upon racial lines; and difficulty relating to clinicians.

1.11.3 Chapter 3 - Methodological perspectives and procedures

In this chapter, explanations of methodological theories and frameworks are provided before proceeding to identify the study population, research design and ethical issues arising from the study. In addition, an explanation is provided on the data gathering process backed by supportive literature on the methodology choices made. The chapter also briefly introduces data interpretation and analysis while demonstrating how rigour and validity was integral and achieved. The chapter is divided into two parts: the first part explains the methodological concepts, and the second part details the methodological procedures.

1.11.4 Chapter 4 - Data analysis

This chapter describes the data analysis process using the Interpretive Phenomenological Analysis framework. Themes emerging from the iterative coding of participants' interview transcripts were developed and categorised into a hierarchical order of superordinate, subordinate and low-level themes, and this is where the meaning-making is derived.

1.11.5 Chapter 5 – Results of the study

Chapter five presents the results of the study obtained from the analysis process. These are presented in category subheadings formulated during data analysis and are supported by direct quotes from the transcripts, representing what the participants said during interviews.

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1.11.6 Chapter 6 – Discussion of the study findings

This chapter provides the scope of discussions carried out in relation to the study results and, in the process, forges links to relevant and appropriate established literature including theoretical concepts. Any significant findings that could not be linked to the existing literature were either explained within the contexts of theoretical frameworks or highlighted as emerging new learning.

1.11.7 Chapter 7 – Conclusion

In this final chapter, the study findings summary is presented together with implications for practice and future research, while acknowledging the strengths and limitations of the study.

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Chapter 2 - Literature Review

2.1 Literature search strategy

To search the literature, I adopted a framework that provided guidance in activities at four key stages. The stages included: identifying main concepts of the study topic; consideration of a selection of library sources and other online databases; searching the resources; and refining and reviewing the results. The time frame for literature review was restricted to publication years between 2005 - 2015 and later adjusted to up to 2020.

The study topic was divided into elements of key words and abbreviations like 'Black, Asian and Minority Ethnic groups or BAME', 'Access to mental health services', and 'black African 'and' Caribbean – Mental Health'. This involved broadening the conceptual map to include synonyms by using Boolean, proximity and adjacent operators to truncate the search, and wildcards to cater for all possible words and spelling variations, especially between UK and USA English. Comprehensive search terms that included, 'MeSH' and 'Thesaurus' variations, in combination with 'Boolean operators' such as 'and', 'or', 'not' were also used to search Medline, Ovid online, and Web Science databases.

These key words were entered into the subject search box of a few databases that include The Nursing and Allied Health Database (CINAHL), US National Library of Medicine Database (Medline), British Nursing Index (BNI), Allied and Complimentary Medicine Database (AMED), NIMHR, Mental Health Foundation, The King's Fund – (Reading List), Mental Health – Black and Minority Ethnic Communities. This held a convenient reading of a substantial number of articles in relation to the search terms covering the period 2014 - 2017. These publications had abstracts which meant I could quickly scan through anything that was of interest then proceed to access the full text. Ovid Online was accessed via the Athens account, and this held all these databases. Cochrane Database of Systematic Reviews (CDSR) was searched for control-based research articles but I did not yield much from this database. CINAHL, PubMed, MEDLINE, Blackwell Publishing, and Sage Online were most helpful. I also found valuable articles via the following websites: Department of Health, National Institute of Mental Health Excellence, MIND, The AFIYA Trust, Lankelly Chase Foundation, Health and Social Sciences, and Social Care Institute for Excellence which provided an updated list of latest science research briefing, with abstracts. Journal articles mostly accessed were British Medical Journal, British Journal of Psychiatry, International Journal of Psychiatry, Sociology of Health and Illness. Articles that were less specific to the research question were excluded: those with the full text available on-line were saved on a free Mendeley account, and those

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without full text I manually searched for their hard copies through the university catalogue in the library. The time span for searching the literature was inadvertently prolonged due to circumstances that were beyond my control, and it felt like I did the exercise twice in order to keep abreast of the newer publications.

My observation was that research involving only black African and Caribbean people's experiences of mental health services is a growing body of evidence. Furthermore, there are limited literature sources that focus on first-time experiences of accessing mental health services by black African and Caribbean individuals. However, most resources accessed tended to focus on the experiences of all ethnic minority populations but with extracts specifically dedicated to black African and Caribbean individuals. This seemed to confirm general discourses about the scarcity of the evidence base on these target populations. Halvorsrud et al. (2018) claims that research endeavours with these populations have often been dogged by small sample sizes, poor uptake and reluctance to participate.

Available literature has also portrayed black African and Caribbean experiences within a broader spectrum of inequalities experienced by all minority ethnic communities within mental health services. Therefore, sources used for literature review have been significantly based on studies that examined all BAME experiences within mental health services, but with a particular focus on black African and Caribbean individuals. In addition, the literature was also drawn from a few sources outside of the UK context. The rationale behind this broader inclusion rests on the commonality of experiences by black African and Caribbean people across mental health services within developed countries including in Europe, America and Australia. The term 'Afro-Caribbean' is used to describe a "West Indian person of African descent". Afro-Caribbean people are descended from West Africans who were either captured or transacted by European slave traders and shipped to European colonies in the West Indies, starting from around the 16th century up and until the abolition of the slave trade in the 19th century.

2.2 Conceptual terminology

In reviewing the literature, my aim was to access a sound evidence base with literature that addressed issues surrounding the research topic aim and objectives. Given the inextricable link of my study topic to wider socioeconomic, historical and political issues surrounding ethnic minority communities in the UK, it was necessary to review this from the outset. I proceeded to define and contextualise some of the key terms, including explaining concepts like race, ethnicity and culture in order to set the scene for my study, and contextualising these within a

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mental health perspective. The remit of the study was to explore the first-time experience of accessing mental health services by individuals of a black African and Caribbean background.

Therefore, some of the key concepts used in this study needed anchoring to avoid meanings being misconstrued. For this reason, and to establish a shared understanding with the reader, Sewell (2006) provided some useful definitions based on a framework adopted from Fernando (1991) to describe these three terms: he described *race* as characterised by an individual's physical appearance which is determined by genetic ancestry and perceived as a permanent genetic or biological make-up; he described *culture* as characterised by behaviour and attitudes that are determined by an individual's upbringing and choice and perceived as changeable through assimilation and acculturation; and *ethnicity* was described as a sense of belonging that is related to group identity and determined by social pressures and psychological need that is viewed as partially changeable. In the context of mental health, Moodley and Palmer (2006) proceeded to include insights on colonialism and social Darwinism, which used biological concepts to select and stratify humans as advocated by sociologists such as Herbert Spencer. I went on to unpack these terms separately before demonstrating the link to mental health services.

2.2.1 Race

Race is historically located in the systematic racial forms of oppression like slavery which were based on the historic assumptions that race is biogenetically constructed. However, this position has since been challenged as flawed by newer scientists who advocate for the dismantling of the concept of linking race to genetics (Saini, 2019). Therefore, the argument gaining momentum is that race cannot be reliably used as a basis for biogenetic explanations of behavioural trends and patterns by individuals with similar characteristics. Daily encounters and interactions between people are categorised based on a racial divide as it serves to accentuate Marxism social order, which promotes inequality and socioeconomic disparities (Chappelow, 2019). This stratification is based on the complexities of inferiority and superiority, as elaborated by Wright (2006), who illustrated that whenever black and white people live in close proximity within the western countries, white people always adopt a dominant or superior position.

Sewell (2009) maintained that race and racism exist as portrayed in everyday life injustices, despite the several discourses that question its existence. For mental health services, therefore, it is paramount to recognise that any negative trends or patterns associated with black people are a product of how they were initially perceived by their communities. Given this premise, and the fact that race is a fixed characteristic on an individual, further prejudicial assumptions are made about their ethnicity, culture, and sometimes their class. Therefore,

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racism should be understood as discrimination based on one's race rather than one's ethnic or cultural background. Racism is understood to have created the social stratification of different races, and singled out white people as more powerful than any other races. This means that it is essential to understand race as it affects both how people are perceived and the accompanying stereotypes that are ascribed to them within mental health services. The failure to recognise these effects results in institutional racism that is propagated through misunderstanding of these concepts by clinicians who work within mental health services. Such misunderstandings can potentially cause strained relationships between mental health clinicians and the black service users whom the former purport to serve.

Furthermore, clinicians may find it challenging to fully comprehend the unique experiences of black people which then compromises the analyses of problems that these individuals present with. Sewell (2009) further observed that people from minority groups hold negative stereotypes about their own ethnic groups. This internalisation of negative attributes is juxtaposed to the wish of having a positive sense of self within an adopted community. The fact that mental ill health is generally stigmatised means that black individuals experience double jeopardy when they are further racially discriminated against within mental health services. The concept of 'Othering' has emerged to aid the understanding of these explanations.

2.2.2 Othering

'Othering' or 'Otherness' is adequately captured not only by the varying expressions of prejudice based on group identities but also provides a clarifying frame that reveals a generalised set of common processes, structures and conditions that underpin and maintain group-oriented domination, exclusion, marginality and persistent inequality (Powell & Menendian, 2016). While 'Othering' serves as a constant reminder of those who are different from us, it is not a status that people achieve but a state of difference that is imposed (Udah, 2018). Mainstream groups are not 'Other' by the very definition of the concept of 'Otherness' nor defined by difference that gives primacy to whiteness - an identity and invisible privilege - at the direct expense of culturally and linguistically diverse non-mainstream groups.

When individuals or groups are racialised and 'Othered', they are labelled according to perceived differences often emanating from stereotypes that are imagined about a social group (Lippmann, 2018). These perceptions are structured sets of unjustified beliefs about a group or individual that are constructed by the perceiver's organised knowledge, beliefs, biases, assumptions, prejudices, fantasies, myths, distortions, or overgeneralisations without a valid basis for those claims. This means that once a group or an individual is labelled as different based on stereotypical imaginary representations, the group or individual becomes

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stigmatised. Once stigmatised, full social acceptance and integration for these groups or individuals becomes difficult because their different characteristics are contextualised into 'Otherness' (Udah, 2018).

Post-colonial feminist and cultural studies suggest that 'Othering' is an apparatus of power made real during discourses and regimes of meaning through which racialised subjects and bodies make sense of their lived conditions, act on them, and then place limitations on themselves (Foucault, 1970; Said, 2016). The concept is rooted in Hegel's account of the 'master–slave' relationship and has been used to analyse the lived experiences and oppressions of colonised, enslaved, marginalised, misrepresented and exploited people (Said, 2016). This translates to the colonial legacy of white privilege and structural racism seen in contemporary UK societies and service provisions (Bhopal, 2018; NHS England, 2019). Disparity in outcomes - in the criminal justice system, health services, and policing systems, including social mobility - is a defining characteristic of institutional racism and depicts how whites have been systematically favoured over time. Contemporary racial and 'Othering' practices occur at group and individual levels (Udah & Singh, 2019). Though these practices tend to be less blatant, they constitute a cumulative threat to the well-being and quality of life for those perceived as different. Therefore, to understand the specific nature of contemporary racial and 'Othering' practices, it is necessary to proceed from the level of individual attitudes to the larger economic, political and ideological processes in everyday interactions in society (Bonilla-Silva, 2014). Therefore, the consequences of 'Othering' can be very detrimental to black individuals in the UK as this can negatively impact on overall health, well-being and, generally, participation for the marginalised 'Others', based on racialised identity constructions and the mediating effects of skin colour.

2.2.3 Ethnicity

The concept of ethnicity draws on a range of factors that are used to identify individuals, and these include language, geographical origin, skin colour, religion and cultural practices (Sewell, 2009). Ethnicity is a dynamic concept that is based on self-definition, hence the concept is difficult to define and often is associated with negative factors such as disadvantage and inferiority for minority ethnic groups (Chakraborty et al., 2013). This means that minority ethnic groups do not have collective universal characteristics, neither are they homogenous groups. Therefore, from a mental healthcare perspective, it is incorrect for clinicians to make inferences from one ethnicity to another as they assess, plan care and discharge their duties for black African and Caribbean people. Across the minority ethnic groups there are variations of socioeconomic statuses and disparities associated with housing, employment and education (Office of National Statistics, 2021). The implication to mental healthcare is that clinicians need to be cognisant of the individual variations of empirical information based on

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an individual's minority ethnic group and background, in order to expedite accuracy and responsiveness in assessments, care planning and delivery. The issue of ethnic inequalities in accessing NHS mental health services, and the disparities of the resulting outcomes, is well documented (Halvorsrud et al., 2018). The phenomenon has been around for many years despite decades-long efforts to diffuse these imbalances. Ethnic inequalities are often controversial, resulting in scientific disputes about the cause and the remedy of these inequalities. However, in relation to mental health care for BAME populations, these have been largely looked at in the context of compulsory treatment, criminal justice system involvement, police contact, and admissions to secure psychiatric hospitals where black patients were overrepresented (Anderson et al., 2014; Singh et al., 2013).

2.2.4 Culture

Culture is described as a subject of cohesion between people based on shared beliefs, and non-material structures, rules and habits that govern a way of life for the members who subscribe to that belongingness (Bhui et al., 2013). A culture is not static, especially when viewed in a cosmopolitan community where different cultural groups interact, adapt and assimilate to more dominant cultures.

Berry (2017; 2019) provides an explanatory framework for these observations through his works on 'cross-cultural and intercultural' psychology with indigenous Africans and other ethnicities. He observed that cultural groups and their individual members adapt their customs and behaviours to the ecological contexts in which they have developed, and their adopted homes. He explains this ecocultural perspective by asserting that individuals develop and acquire their behavioural repertoire in various ecological contexts and cultures. Therefore, the habitat of a cultural group is linked to their social institutions and practices, including settlement style, social stratification, and socialisation practices that shape the various microlevel individual behaviours within specific cultural groups - such as perception, cognition, social behaviours and lifestyles.

Berry (2019) further examined the psychology of acculturation and intercultural relations and developed the concepts of acculturation strategies and acculturative stress. In acculturation, he refers to varying ways in which groups and individuals seek to live together, using the concepts of integration, namely: assimilation - engaging both cultures; separation - engaging only one or the other culture; and marginalisation - engaging neither culture. These forms of intercultural lifestyles have resulted in three distinct forms of adaptation: psychological wellbeing; sociocultural competence; and intercultural relations. The concept of acculturative stress was developed as an alternative to culture shock; this concept uses the stress, coping

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and adaptation framework to describe the challenges encountered during the acculturation process.

Having reviewed some key terminology used in this study, and the implications these had on the vulnerability of black people, it was necessary to explain how these were conceptualised in line with the study aim and objectives. The aim was to answer the question, 'what are the subjective experiences of black African and Caribbean people when they access NHS mental health services for the first time?' Underneath this overarching study aim, the study objectives were focused on reviewing the literature on various aspects of accessing mental health services and the psychosocial, socioeconomic and cultural circumstances that surrounded these experiences. This included evaluating the evidence on predisposing vulnerability factors to psychiatric morbidity and the initial referral or contact with mental health services, while locating the role of carers/families and primary care services in the pathways to care. I proceeded to review the literature on perceptions and attitudes of black mental health service users towards services where compulsion and coercive procedures were used in the engagement processes, including the involvement of police / courts and use of the Mental Health Act. I also evaluated the literature on the nature of mental health service provision and management in relation to black African and Caribbean people's experiences of inappropriate care, misdiagnoses and perceived lack of BAME managerial representation within services. This expanded to include a review on the quality of relationships between black service users and the professional staff, and how these were characterised by cultural stereotypes and inferences that result from misdiagnoses of black African and Caribbean individuals. This literature gave useful insights into why this target population is often overrepresented in mental health services and is treated coercively, as well as being discriminately subjected to the Mental Health Act.

2.3 Predisposing and vulnerability factors

In the quest to understand the experience of accessing mental health services by people of a black African and Caribbean background, there is need to consider the intersectionality of other aspects such as identity, and shared social circumstances like age, gender, religion, disability, health and location (Elliott, 2016).

Among other minority ethnic populations, black African and Caribbean populations often occupy positions of disadvantage in the UK (Grey et al., 2013). Glaring inequalities are evident across all indices of economic and social wellbeing where black African and Caribbean young men are disproportionately affected by these inequalities (Stewart-Brown et al., 2015). It was

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observed that boys of a black African and Caribbean descent are three times more likely to be excluded from the education system than their white counterparts (Elliott, 2016).

The World Health Organisation indicated that socio-economic and political factors carry direct implications for anyone's mental health (WHO, 1986; Equality and Human Rights Commission, 2016). Several studies spanning three decades from the 1970s highlighted that African-Caribbean people experienced racist insults and abuse and about 20,000 were reported to suffer physical assault yearly (Modood & Berthoud, 1997).

Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status. This is driven by a wider social context in which structural racism can reinforce inequalities among ethnic groups - for example, in housing, employment and the criminal justice system - which in turn can have a negative impact on their health. Evidence shows that racism and discrimination can also have a negative impact on the physical and mental health of people from ethnic minority groups. Unpicking the causes of ethnic inequalities in health is not clear cut. Available evidence suggests a complex interplay between deprivation, environmental, physiological, behavioural and cultural factors (Office for National Statistics, 2021).

Unemployment was reported to be 10-20% higher in black African and Caribbean people and other minorities from mixed backgrounds than in the native white populations (Institute of Race Relations, 2019). Poverty is higher among all black and ethnic minority ethnic groups than among the majority white populations. There is evidence to suggest that men and women from ethnic minority groups are averagely remunerated less than their white counterparts who have similar qualifications and experience (Joseph Rowntree Foundation, 2016). Whilst 25% of white seven-year olds were found to be living in poverty, a disproportionate 50% of black African and Caribbean seven-year-old children were found to be living in poverty (The Poverty Site, 2014).

BAME populations are more likely than others to experience homelessness. A review of the homeless carried out in 2011 reported that, while Black and Minority Ethic people constituted 26% of the total population of Wolverhampton, 40% of homeless cases reported by the respective authorities were from the BAME population (Rabiee & Smith, 2013). Similarly, 27% of homelessness cases reported by London homeless day centres were from BAME populations, compared to only 11% nationally (Homeless Link, 2011). Social class, social and economic conditions have a correlation with health status; also referred to as the social causation of disease (Link & Phelan, 1995).

Das-Munshi et al. (2012) argue that health status in later life is determined by circumstances surrounding early life. They describe social class at any given point as a partial indicator of a

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whole sequence of events. The events need to be understood in their totality in order to determine the effects of social environment on health. Long-term illness and/or poor 'health capital' in early life constrains social mobility and maintains health inequalities in later adulthood (Powell, 2019).

2.3.1 Epidemiology of race and ethnicity in mental health

Several comparative studies have reviewed the prevalence of common mental health disorders between ethnic groups and their white counterparts. It was observed that black African and Caribbean people were more often diagnosed with depression than with anxiety (Singh et al., 2013; Fernando, 2017); similar results were found for gender specific constructs in relation to postnatal depression (Edge et al., 2010; Warfa et al., 2012) where black women were described as having a generally higher prevalence rate of mental disorders. The comparison studies showed a relative difference in that the prevalence for black African and Caribbean women was more pronounced than that of their white British counterparts.

Psychiatric epidemiology has traditionally evolved from service utilisation, hence the profession has developed based on the relationship between diagnoses and presumed need for contact with mental health services (Gajwani et al., 2016). Therefore, service usage has been significantly shaped by the investigations of need for services rather than symptomatology per se. In contrast, social epidemiology links mental health problems to broader social and economic influences, but these vary from person to person. This finding is consistent with the fact that the job security for black, rather than white, men appears to be a more important preventative factor for depressive symptomatology or other psychiatric morbidity (Kelly et al., 2016).

2.3.2 Institutional racism

Institutional racism may be defined as "*the collective failure of an organization to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. This can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantages people in ethnic minority groups*" (MacPherson, 1999).

The presence of institutional racism within the NHS has been acknowledged, and training of front-line staff in race equality was advocated to enhance the cultural diversity capability of services (Chakraborty et al., 2018; Fernando, 2017). While the programme achieved some key objectives, particularly enhancing the cultural sensitivity of services, institutional racism and racial inequalities appeared to have been relegated to the less important priorities in mental health policy. The key policy drivers to address institutional racism in mental health practice were most likely compromised by the disagreements that ensued on whether

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institutional racism existed or not. Wilson (2010) agrees with this observation and argues that the Delivering Race Equality agenda, without taking a consensus of all stake holders, dampened the wider ambitions of the agenda. In follow up reviews of the policy initiative within mental health services, the diluted race equality agenda contributed to the continuing problems faced by BAME communities in mental health services.

The 'Count Me In' Census (2010) showed several disparities. Admission rates to mental health services remained higher than average among some minority ethnic groups, especially black or white and black mixed service users whose admission rates were two or more times higher than the national average. Black African and Caribbean people were more likely to be detained under compulsory powers than were other races (Office of National Statistics, 2018; Baker, 2018). The rates of being secluded within mental health services were found to be higher in black African and Caribbean service users than for the generality of other races. This minority community was also more likely to be subjected to Community Treatment Orders (CTO) than other races by 22-106%.

Karlsen (2007) illustrated the connections between racial discrimination and poor health and concluded that people from black African and Caribbean communities experienced poor treatment and inequalities in accessing mental health services due to their perceived negative attitudes towards the services, and vice versa. Other predisposing, or rather interlocking, factors to mental ill health for BAME people were the risky conditions and life situations that they can find themselves in. These include exclusion from mainstream education; social deprivation as a result of unemployment; prevalence of crime and drug cultures; and over-representation of the men in prisons. This trend has also been confirmed in other indices of economic and social well-being (White, 2006; Ford & Airhihenbuwa, 2018). People of black African and Caribbean background living in the UK have lower reported rates of common mental illness than other ethnic groups (Mental Health Foundation, 2014). They are more likely to be diagnosed with more severe illnesses and are 3-5 times more likely than any other group to be diagnosed and admitted to hospital for schizophrenic type of illnesses (Bard et al., 2021). Black African and Caribbean people were more likely to be prescribed higher doses of medication regardless of their views on the causes of schizophrenia being due to non-biological factors (McCabe & Priebe, 2004).

In all the studies that attempt to disentangle and explore the reasons behind the disparities in mental health outcomes between different ethnic groups, 50% of these have positively identified 'race-based' explanations, as well as negative stereotyping, to be complicit (Singh et al., 2013). These experiences are underpinned by experiences of racism, stigma, discrimination, and the myth that black African and Caribbean people with mental health

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problems are criminals, cannot work and are violent (McKenzie & Bhui, 2007). It has been well established that there is a link between the experience of racism and mental distress. There are studies that have shown how people experience racism as interpersonal violence, institutional racism or socio-economic disadvantage each of which have detrimental effects on health (Karlsen & Nazroo, 2014).

Coid et al. (2008) demonstrated that social experience of racism is a causative factor in mental health problems, and that in mental health services racism results in inadequate and inappropriate care provision. The complex interaction of racism and mental health and its effects on BAME communities is further influenced by the changing social perceptions of those communities (Rethink, 2007).

2.3.3 Cultural dimensions

It has been noted that there is a wholly inappropriate tendency within mental health services - and in society - to see all black African and Caribbean people as homogenous groups with shared cultural beliefs and practices (Fernando, 2017). In fact, there are vast differences in national and regional origins, religious beliefs, racial and ethnic subdivisions, language, migratory patterns, experiences of colonialism and the extent of 'Britishness' in their identity which influence the wide range of cultural beliefs and practices within the communities (Maguire et al., 2016).

Culture plays an important role in how people understand mental health. A large proportion of black African and Caribbean groups are shown to understand mental health problems outside of the medical model and prefer terms such as 'depression' or 'behavioural problems' to 'mental illness' (Grey et al., 2013). They observed that mental health problems are viewed in the social context as associated with stigma and denial of mental illness, while linked to ideas such as the belief in supernatural power, witchcraft or religious punishment. Chakraborty et al. (2013) reported similar outcomes from their study. In many cultures there is a stigma attached to being mentally ill, and mental health problems are not openly disclosed or discussed within the family or community (Scambler, 2019; Tuffour & Simpson, 2019). Therefore, this suggests the need to improve cultural competency in mental health services; improvements such as proactive interventions to reduce experiences of stigma and racism, the provision of culturally appropriate food, increasing the ethnic diversity of staff, the provision of gender-specific services and staff, accommodating faith-related or religious needs, and better provision for language interpretation and translation services.

2.3.4 Language factors

There is a vast range of languages used by people from BAME groups, and language (written and spoken) has been identified as a barrier for service use and appropriate service delivery

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(Bowl, 2007). Greenwood et al. (2000) showed that among the service users and carers interviewed about their experiences of those services, the need for translators and interpreters was identified and the need to translate the language of psychiatry in a way that people from BAME groups can understand and relate to was emphasized. Also, some assessment tools used in the research of BAME populations have been critically reviewed for applicability, given that the subjects' culture and interpretation of life was not adequately understood (Parker & Philp, 2004).

The lack of effective comprehension of psychiatric terms and of a person's emotions can lead to misdiagnosis and hence to inappropriate treatment (Mzimkulu & Simbayi, 2006; Olugubile et al., 2009).The language barrier goes beyond that of specific language, and highlights the comparison of Eurocentric psychiatric models of mental ill health with the culturally specific understanding of experiences and emotions.

2.3.5 Religious issues

Religiosity is a multidimensional concept that encapsulates a range of beliefs, attitudes and behaviours that influence mental ill health and wellbeing (Kang & Moran, 2020; Kang, 2021). Religion can influence positive mental health by operating as a stress coping resource. This means that individuals from a black African and Caribbean background may turn to prayer in order to cope with stressful situations. It may involve individuals engaging in prayer in times of stress to seek guidance or intervention from God in dealing with stressful predicaments (Raffay et al., 2016). Among black communities, the church is considered to be more than just a religious institution as it offers social, cultural, civic, educational and political resources to its congregants (Shafiq et al., 2020). Therefore, religion is an important resource for resilience.

In Africa, the subject of mental health is still largely considered as a taboo subject and most Africans perceive mental disturbances as a result of an external attack on the person by an evil spirit (Ventevogel et al., 2013; Kang & Moran, 2020). Therefore, victims are thought to be under a bad spell, or bewitched, and only the traditional healer or a priest can deal with those problems. Many religions in Africa tend to cast out those who develop mental health problems, and victims are often ostracised, including their families.

It is important to accept that religion, faith and spirituality play a key role in the way people perceive, understand and interpret their mental and emotional lives (Olugubile et al., 2009). There are some commonalities and differences in various religious and cultural practices where a person with a strong religious identity may understand mental health issues in a different way from someone with a Eurocentric medical understanding (Grey et al., 2013; Bhui et al., 2014). These variations can render problematic the contact of such people with mental health services as their needs may not be met by available services. Faith and spirituality have

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also been identified as major components of the healing and recovery process after an episode of mental-ill health. Hussain and Cochrane (2003) asserted that people's religious and spiritual needs need to be taken into consideration when planning treatment and care. This confirms that prayer and religion may be relied on as a main coping strategy (Deacon et al., 2013).

2.3.6 Experiences of refugees and asylum seekers

Refugees and asylum seekers may experience exclusion and marginalisation in various sectors of society, including healthcare, housing, education, employment, welfare and support, and these can directly contribute to mental distress (Aspenall & Watters, 2010). These factors may cause or exacerbate pre-existing mental health problems. Mental health services offered to refugees and asylum seekers have been deemed culturally inappropriate in most cases (Tempany, 2009). There is a lack of therapeutic and psychological services available for them, and access to secondary mental health services is viewed as problematically rigid (MIND, 2009). A survey of failed asylum seekers showed that 50% reported worsening health statuses from the point of entry into the UK (Institute of Race Relations, 2014).

Migrants may encounter health threats in their host countries (Department of Health, 2011). The circumstances of migration may be traumatic physically and psychologically, for example as in the case of migrants coming from war-torn countries (Haynes & Sales, 2009; Steel et al., 2009). Economic motives for migration may lead to racialised patterns of living in the host country and result in poor mental health (Department of Health, 2019). An emergent pattern was elicited showing that people of the same origin move to the same area to work in the same employment, characterised by low-paid work in poor areas of inner cities (World Health Organisation, 2012). Such conditions are thought to lead to health outcomes that affect not just the migrants but their children and subsequent generations. Therefore, while there is a high probability of migrants enhancing their wealth by migrating, they may remain deprived within the host countries, as the literature above suggests. This means that the individuals' full productive life may be characterised by poor pay, housing disadvantage and unemployment. The health impact of racism is therefore on two levels as victims of racism are prone to stress, injury and death (Department of Health, 2019). Hence, the direct effects of racial discrimination which result from poor access to housing and labour markets, ordinarily lead to poorer health outcomes. All these factors make migrants highly susceptible to the direct health impact of poverty, which later translates to their mental health. Therefore, it is essential for mental health services to reach out to these communities and offer both psychological and practical support.

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2.3.7 Experiences of children and adolescents

In relation to young people and family services, 20% of children and adolescents are understood to have mental health problems, but there is no clear evidence to show how much of this proportion is constituted by young people from black African and Caribbean backgrounds. However, one 2016 report on the youth justice system in England and Wales found that over 40% of the children involved are from BAME backgrounds, and more than one-third have a diagnosed mental health problem (Taylor, 2016). Therefore, young people from BAME populations are disproportionately over-represented within the youth justice system, social services and looked-after provision, exclusion from school, and educational underachievement. The expectation was that common practices and processes would be detected across other institutions which would help to explain the discrepancies in psychiatric morbidity between black African and Caribbean people and the native whites (Malek, 2011). In the education system, for example, IQ testing disadvantaged many black children who were classified as 'educationally subnormal'.

Nazroo (2007) complemented the perspectives above by adopting a theoretical position in exploring ethnic inequalities in mental and physical health services. He rejected the emphasis on historical, genetic and cultural factors, which had been well received with earlier psychiatric epidemiological work, in favour of a more structured approach. He focused on the finer aspects of disadvantages faced by black African and Caribbean people in society, which included the experience of racism, ethnic identity and relevance of group affiliation and culture in the context of the nature of ethnicity.

2.3.8 Suicide

Young black African and Caribbean mental health service users were found to be three times more likely than their white counterparts to commit suicide in the year preceding their first contact with mental health services (Bhui & McKenzie, 2008; Forte et al., 2018). In these review studies it was observed that black African and Caribbean individuals were likely to commit suicide within a year of encountering mental health services. Furthermore, it was observed that, upon review of the suicide incidences, most of these cases were more likely to be considered preventable (Bhui et al., 2018). Therefore, this indicated a vacuum where mental health services had failed to exploit opportunities to engage meaningfully with young black African and Caribbean service users and thus mitigate suicide risks.

After reviewing the vulnerability of black African and Caribbean individuals to psychiatric morbidity, literature suggested that these individuals are more susceptible to disadvantages that negatively impact on mental health. This prompted me to review the historic conceptualisation of psychiatric morbidity and its prevalence among these individuals.

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Furthermore, I wanted to gain an understanding of the theoretical formulations of psychiatric morbidity using both psychosocial and biological perspectives.

2.4 Historical conceptualisations about BAME populations and mental health

Historically, race was used to make biological distinctions between groups and to assume white supremacy (Hawkins, 2010). This historical state of affairs manifested in 'Eugenics', a science which was used for improving a race or population by controlled breeding in order to increase the occurrence of what was discriminatorily claimed to be desirable heritable characteristics (Templeton, 2005; Kaplan, 2015; Nisbett et al., 2012). This means white supremacy is a direct construct of mankind. An extreme form of eugenics was witnessed in Nazi Germany where it culminated in the mass extermination of those populations that were perceived as racially inferior (Hawkins, 2010). The notions of controlled breeding extended to include those with mental and physical disabilities, who were incarcerated, sterilised and, in some cases, killed with the endorsement of the Nazi government. As a result, the social policies that emanated from the eugenic principles impacted unfairly and negatively on the 'racially inferior' who also had psychiatric morbidity. Literature suggests that the influence of social policies developed by the Nazi government became more significant and permeated into the wider Europe and North America where medically supported initiatives were formulated in close alliance with the eugenic principles (Meyer, 1988). One could argue that his brought about sexual segregation and sterilisation of the disabled population groups.

Mackintosh (2011) described that there was a long and strongly held medical opinion which operated on the basis that the brains of black people are inferior to those of white people. Therefore, mental illness and the inferiority of race has always been closely linked and has led to the perpetuation of pejorative theories and oppressive practices towards certain racial groups (Kaplan, 2015). This means that the medical profession has been blamed and criticised for not adopting a neutral position when determining the relationship between psychiatric morbidity and individuals from perceived inferior ethnic backgrounds.

In social sciences, race has been viewed in the context of 'race relations', which involves the relationship between a dominant and a minority group (Equality Act, 2010). Ethnicity, therefore, emerged as the socio-cultural difference between the groups. Ethnicity encompasses the collective identity of the subjective elements of the group. Thus, ethnicity views the ways of life of different ethnic groups to be dependent on a combination of their inherited culture and their relations with other cultures. Some empirical studies point out that ethnic identifiers are multiple, complex and contingent, and disagree with the notion of singular

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or primary identities, such as having a psychiatric diagnosis and being black (Creanza et al., 2017; Fernando, 2017).

Minority ethnic groups and health discussions largely centre on cultural differences as a way of explaining the different experiences of groups within a community (Creanza et al., 2017). These include differences in language, values, norms and beliefs. The debate and analysis focus on the individual and their culture, and is concerned with the role of prejudice and discrimination in determining differences in health behaviour and service usage (Bhopal, 2018). The notion of prejudice implies a psychological concept that is related to a set of personal attitudes.

Transcultural or cross-cultural psychiatry is concerned with how different ethnic minorities are treated by mental health workers who have been trained and socialised in the mainstream dominant cultural ways (Tseng, 2003; Equality Act, 2010). This, therefore, provides a platform for initiatives to challenge and change prejudices through race awareness training. The remit is on challenging stereotypical and negative views about minority ethnic groups held by powerful individuals such as health care professionals. While cross-cultural psychiatry has been focusing on various manifestations of mental disorders among diverse societies, it has widened its scope to incorporate social and cultural aspects of mental illness into a clinical framework (Kraepelin, 1995). Therefore, transcultural psychiatry is more focused on the illness experience than the biological causal mechanisms as viewed from the health care practitioner's perspective. However, the impact of inequality in rates of psychiatric diagnoses, service contact and variable professional responses to BAME groups is still not fully known.

2.5 Prevalence and vulnerability of BAME individuals in mental health services

Although there is a sharp contrast in the research findings, an overview of the majority of studies carried out indicate consistency in the evidence of over-representation of African and Caribbean groups in in-patient environments (Tolmac & Hodes, 2004). A follow-up study by Tolmac and Hodes (2016), demonstrated that young black people are still over-represented in mental health services, especially if they immigrated to the UK or had refugee status.

The Mental Health Foundation (2014) reported that the rates of admission to acute inpatient care units were lower than average for the white populations as well as for some Asian backgrounds. However, Halvorsrud et al. (2018) observed rates of admission to be higher than average for other minority ethnic groups, especially black African and Caribbean and the mixed white/black. The rates ranged from 2-6 times higher than for the other groups, and the

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length of hospital stay was significantly longer for black African and Caribbean service users than for other populations.

In contrast, some studies have indicated that British-born blacks were more over-represented than black migrants (Nazroo & Karlsen, 2007; 2016). This contrast can be explained by some confounding variables which include a change in data collection methodology influenced by a change in migration patterns (Office for National Statistics, 2020). Also, hospital admission records have been criticised for inaccuracy and for being incomplete, as a result of which rates of contact for specific ethnic groups, particularly among Black ethnic groups, are likely to be under-estimated. My observation is that this remains evident in present day mental health services where ethnic background monitoring forms are inadequately completed or not completed altogether. Other observations relate to clinical staff making these records based on their own perceptions, without asking the patient to describe their own ethnicities. As a result, this skews the data recorded about incidences and prevalence of mental disorders among the minority ethnic populations.

However, measuring incidence and prevalence of mental disorders by hospital admissions can be misleading in that admissions are predicted by demand and supply management policies (Bhui et al., 2018) and community-based incidences and prevalence are therefore not measured across the potential service users. Further, it is indicated in other studies that white natives have better access to psychological therapies, and hence may not necessarily require admission to the in-patient services (Beck & Naz, 2019). This suggests that such incidences will not be recorded against those of black African and Caribbean populations. The current study assumes that hospital admission offers an exposure to the totality of mental health services, thereby providing a broad spectrum for exploring and interpreting experiences of service usage.

There is continuing disproportionate representation of black African and Caribbean service users, especially men, with mental health problems at the 'extreme end' of services (NHS Digital, 2020). Turnbull (2020) identified that the most egregious inequalities in mental health care are characterised by the overrepresentation of black men at the sharp end of the services, including being arrested, receiving care while in prison, and being secluded within secure treatment facilities. The evidence from the review study above indicates that the experience of mental health services by black African and Caribbean communities continues to be imbalanced. The results showed the main theme of the outcomes to be about racism and the perception of black men as dangerous. This observation was linked to heavy police involvement and excessive response to reported distressed behaviour portrayed by black African and Caribbean individuals (Gage et al., 2016). The interpretation, therefore, links these

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observations to the narrative of institutional racism, or an institutional misunderstanding of black people in mental health crisis by professionals who are not necessarily trained in mental health care.

There is evidence to show that black African and Caribbean mental health service users experience poor or harsh treatment from both primary care and mental health services (Keating, 2009). 'Circles of fear' remains a common phenomenon that is experienced by black African and Caribbean mental health service users, as well as their communities, in relation to accessing mainstream mental health services. Once services are accessed, the treatment is more likely to be harsher and more coercive than that received by white service users (Keating, 2007). Above all, the black African and Caribbean service users' presentation to secondary mental health services is often characterised by a lower level of involvement or uptake of primary care services or psychosocial interventions (Robinson & Keating, 2011). Mental health professionals interviewed in this study, including consultant psychiatrists, described the pattern of mental health service usage by black African and Caribbean service users to be unfair and that individual service users were actively disadvantaged. The disadvantages included being more likely to be admitted under compulsory powers, being sectioned, or being given deplorable diagnoses such as schizophrenia, which attracted stigma instead of therapy.

Access to adequate mental health services by service users of this ethnic background was observed to be very poor (Keating, 2007). While it can be argued that services are readily available for anyone to access, individuals from black African and Caribbean communities perceived the services to be inaccessible, inappropriate and with an absence of meaningful response to their needs.

2.6 Theoretical construction of psychiatric morbidity in black African and Caribbean people

2.6.1 Psychosocial formulations

Mental health professionals have developed psychotherapy which tends to distance itself from the biologically and diagnostically oriented psychiatric practice. These therapeutic approaches are based on the works of Sigmund Freud in Europe, and Carl Rogers from an American perspective, and are commonly constructed around western values and assumptions. Bhugra et al. (2011) argued that though these approaches claim to be trans-historically and culturally valid, they remain implicit in most of the epidemiological studies. More recently, Singh et al. (2013) demonstrated that, in practice, these approaches are blamed for castigating BAME individuals for being inappropriate or non-receptive to psychotherapy.

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There are disparities that continue to exist between ethnic minority groups and White people in mental health service usage, and service satisfaction and outcome (Beck & Naz, 2019). These have been viewed as largely negative and aversive. They also observed that black African and Caribbean communities experience more disproportionate disadvantages and discrimination within the mental health services because different groups of people do not start from a level 'playing field'. They added that society categorises people in accordance with a range of social strata such as colour of skin, gender, age, sexual orientation or disability. Therefore, any encounter of human beings is immediately cast to social division where individuals automatically categorise other human beings as male, female, black or white, older or younger, richer or poorer (Equality Act, 2010).

It has been observed that mental illness represents a multi-factorial causality which extends beyond just racism (Bhugra et al., 2011). Regarding genetics, there is a deliberate tendency by social scientists to denigrate genetic explanations because of their prior associations with eugenic concepts. In support of this position, Saini (2019) argued that genetic variation occurs between individuals and not races. She dismissed as arbitrary the assumptions that some racial groups are more genetically susceptible to certain psychophysiological disorders. These arguments are further acknowledged and buttressed in the next subheading (Biological perspectives).

Mainstream mental health practice has been criticised for adopting the 'Eurocentricity' model of mental health service delivery which was a major obstacle to effective and inclusively responsive services (Deacon, 2013; Bard et al., 2021). In line with 'Eurocentricity', the bio-medical model of practice is commonly used based on the 'expert relationship' where the professional determines and charts the path of treatment with little consideration for the service user's or carers' views. This model of practice perpetuates a power imbalance between the professional and the service user. New Horizon (2010) reported that the bio-medical model does not work and advocated for the 'psychosocial model' as being more effective. The effectiveness of these models was reviewed in the context of the generality of all service users but was found to have had more significant effects on service users from a black African and Caribbean background as well as other minority communities (Turnbull, 2020). There is an inherent problem at commissioning level within the NHS as it is largely inclined towards the bio-medical model. In the research carried out by the Mental Health Foundation (2014), service users reported that accessing help was shaped by the experience of being quickly pushed into the system, and compromising with that very system in order to get the help that one needed. The black service users described the service as lacking flexibility, so much so that it sounded more like it was a taboo to express one's cultural,

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religious or spiritual needs lest these could be misconstrued as psychosis and thus attract coercive treatment procedures.

2.6.2 Biological perspectives

Drapetomania was defined as a disease which made slaves run away from their masters. An American Psychiatrist - Cartwright - expressed that the art of trying to escape from bondage service was a disease of the mind which warranted treatment like any other psychiatric diagnosis (Ranger, 1989). The invention of racist categories was observed to be bound with the institutions of slavery and social control (Saini, 2019). This implies that cannabis psychosis and schizophrenia are the contemporary examples of psychiatry and social control of black people. Cannabis psychosis has been singularly attached to black African and Caribbean people as a predisposing factor (Gage et al., 2016). However, earlier works by Kirkbride et al. (2018) indicated that there was no evidence that incidence of psychotic illness corresponded to a rise in cannabis use. The Royal College of Psychiatrists defined psychosis as an exaggeration of ordinary expression where 'ordinary' was dictated by the dominant groups in the society; that is, dependent on numerical superiority, power and status. In the UK, therefore, 'ordinary' implied that being 'normal' was emulating and behaving like the people with a white skin. This observation speaks to the tenets of Critical Race Theory (Delgado & Stefancic, 2017) and the concept of 'Othering', discussed earlier.

There are some further racist assumptions underlying the theoretical tradition of Kraepelin, the German psychiatrist who was responsible for the development of the category and classification of schizophrenia. Kraepelin's theory on schizophrenia blames its occurrence on a tainted gene that causes disruptive and dangerous conduct. According to Bhui et al. (2018), these observations fit in well with racist stereotypes held about black people. It was observed that Western psychiatry was also heavily influenced by German eugenic medicine which underpinned the Nazi programme of racial hygiene and the degeneracy theory of disability and dangerousness. From these theories, western psychiatry also derived presuppositions on the possibility of inheritability of schizophrenia (Bhui & Bhugra, 2001). Therefore, assumptions about genetic inferiority and race are deeply ingrained in psychiatric theory, albeit there is strong contestation by modern scientific researchers such as Angela Saini in her book '*Superior: Return of race sciences*' (2019).

The ability of western psychiatric knowledge to adequately respond to cross-cultural diversity is closely linked to racist constructs (Chakraborty et al., 2013). It is further argued that even when psychiatric knowledge is deemed either implicit or explicit, it remains a product of its time and place. Therefore, the dominance of works by earlier psychiatrists such as Kraepelin and Bleuler continue to permeate and guide present day practice based on Anglo-American

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psychiatrists. This is further evidenced in the adoption and usage of several versions of the American Diagnostic Statistical Manual (DSM) and the European International Classification of Disease (ICD). These sets of diagnostic predictions were developed from earlier notions derived from Germanic psychiatry (First, 2009).

Thus far, there has been little work done to further our understanding of the biological causality hypothesis in psychiatric diagnosis (Kingdom, 2020). This means that the misguided historic assumptions made about black people and psychiatric diagnoses continue to hold ground in the mental health caring field.

2.7 Interface with mental health services

Having discussed cultural differences and vulnerability to mental distress based on ethnicity, another dimension emerges. In trying to determine over-representation of black African and Caribbean service users in mental health services, it is worth reviewing the attitudes of professionals in psychiatric practice and how they respond to black African and Caribbean people. In line with the aim of this current study, the review process evaluates the relationship from point of contact with services and the subsequent treatment received from those services through to aftercare.

It has been observed that black African and Caribbean people are much more likely than white people to contact mental health services via the police, courts and prison systems (Melton et al., 2017). The majority of black African and Caribbean people who tend to be predominantly incarcerated by law enforcement agencies are male and young (Taylor & Gunn, 1999; Melton et al., 2017). The implication is that young black men are more likely to encounter forensic mental health services than their white counterparts. It appears that this observation was made across all migrant and British-born second generations. Black men and women were found to be referred and detained 29 times more frequently than their white equivalent (Chakraborty et al., 2018).

According to Melton et al. (2017), black African and Caribbean defendants that were deemed mentally unstable were less likely than white defendants to get bail, and more likely to be committed to court orders involving compulsory psychiatric treatment. The evidence showed staged discrimination in processes of both the criminal justice system and the psychiatric systems (Binswanger et al., 2012). Also, when reviewing coercive psychiatric treatment, a definitive trend seemed to emerge showing that black African and Caribbean service users were under-represented in outpatient and self-referral services, and were less likely to be referred to services by their general practitioners than other groups.

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2.7.1 Referral pathways – primary care services involvement

The Institute of Race Relations (2014) identified that, in general, Black, Asian and Minority Ethnic (BAME) populations experience and report ill health earlier than native white British people. Another observation was that black African and Caribbean service users are significantly less likely than non-black service users to have a GP involved in their care pathway leading to their first psychotic breakdown (Birchwood & Singh, 2013; Bhugra et al., 2014).

There is a linking narrative in that rates of referral from GPs and community mental health teams to secondary mental health services are lower than average among black African and Caribbean services users, as well as for those from a white/black mixed background (NHS Digital, 2019). Literature has shown that psychiatric epidemiology gives insights into the differences in the sources of referrals and rates of admissions to psychiatric hospitals (Sutterland et al., 2013). However, little insight has been provided as to why black people encounter mental health services through the criminal justice system, police or courts. Previous studies have identified that black people's characteristics and culture make them more susceptible to being identified as deviant to social norms and order by lay persons (Singh et al., 2013). The implication is that black people were observed to express their mental distress in an idiosyncratic fashion and that the manifestation of psychiatric morbidity predisposed black African and Caribbean people to being arrested because they presented in a particularly disturbed or violent way.

Frederick et al. (2018) reported a relatively low registration with primary care services among black African and Caribbean people who subsequently get admitted to hospital. They also observed lower rates of treatment for depression when compared with other ethnic minority groups. Some argued that the environment where the behaviour takes place has some inherent significance (Karlsen & Nazroo, 2015). For instance, if a greater part of young black African and Caribbean people's social life takes place in a public arena, then deviant conduct is more likely to be detected and dealt with by police and psychiatrists (McDaniel et al., 2020; Rose et al., 2015). Contrary to this observation, their white counterparts have more of an indoor culture. Therefore, this lessens their chances of being found on the wrong side of the social norms, values and the law.

However, emphasis on cultural differences has been criticised for making stereotypical generalisations about behaviour which may be faulty (Karlsen & Nazroo, 2015). The state agents, like the police, will incline towards identifying the problem as being inherent in a person's own culture, thus perceiving it as pathological (Singh et al., 2013). Therefore, the assumption here seems to be that black African and Caribbean people should adopt the

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whites' way of life in order to avoid being perceived as deviant and mentally ill. Also, the view that generalisations will suffice when cultural differences occur shows that there are risks of apportioning blame to specific cultures (Deacon, 2013). However, victim-blaming may also carry with it another focus on the part played by lay persons and their reactions towards other cultures or ethnic differences. Therefore, it is not only the conduct of the black African and Caribbean people that is the issue, but also the nature of reaction by others. The greater the cultural variation, the more likely is the tendency to label a person with mental ill health (Karlsen & Nazroo, 2015). The implication is that members of a minority ethnic group are more likely to be labelled as mentally ill than those belonging to the dominant white indigenous group.

Black African and Caribbean patients were found to be the least served minority ethnic populations by mental health services (Commission for Healthcare Audit and Inspection, 2007). They were often found at the harsher end of the services with their rates of admission to hospital being three times higher than average. Their access routes to mental health services were closely reviewed, and it was observed that rates of referral from general practitioners were lower than average, and rates of referrals from the criminal justice system were higher than average.

2.7.2 Compulsory admission to mental health services

The Care Quality Commission (2014) observed that detention rates under the Mental Health Act during the period 2012-2013 were 2.2 times higher than average for black African service users, 4.2 times higher for black Caribbean service users, and 6.6 times higher for black other ethnic groups. Black African and Caribbean service users recorded higher than average rates of access or admission to hospital than other groups (Health and Social Care Centre of Information, 2013).

The Care Quality Commission (2011) recorded that the difference between ethnic groups in relation to rates of admission, rates of detention under the Mental Health Act, and rates of seclusion in secure mental health facilities remained the same throughout the period of the 'Count Me in Census' held between 2005-2010. It was also observed on the census day that 23% of inpatients on mental health wards, or outpatients on Community Treatment Orders, were from BAME groups, particularly those from a black African and Caribbean origin.

There was a generally greater involvement of the police in referrals, and the average rates of detention of black African and Caribbean people under the Mental Health Act 1983 (as amended 2007) were estimated to be around 30% higher than the average (NHS Digital, 2020). The rates of detention in medium- and high-secure units were also observed to be higher than average where the use of control and restraint, as well as aversive treatment

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procedures, was prevalent (Duffy & Kelly, 2017; McDaniel et al., 2020). The Healthcare Commission - 'Count Me In' (2005) concurred with most studies and confirmed that Black African and Caribbean people are much less likely to be referred by their GPs but are twice as likely to be referred to mental health services via police and the courts. The Commission for Healthcare Audit Inspection (2007) asserted that although many explanations have been given for the existence of these inequalities, the evidence was not conclusive.

2.7.3 Police / Courts involvement

Black African and Caribbean populations have higher than average rates of being detained under Section 37/41 of the Mental Health Act: despite these populations constituting 2.8% of the service user population, and 3.1% of the general population in England, they represent 16.2% of service users subject to Compulsory Treatment Orders (Centre for Mental Health, 2013). Black African and Caribbean service users are twice as likely than non-blacks to have Criminal Justice Agency involvement in their pathways to care during a first episode of psychosis (Singh et al., 2013; Applebaum, 2019), yet there is an under-representation of the imprisoned black African and Caribbean as well as other minority ethnic populations amongst those who access potentially beneficial prison-based mental health services or psychological therapy programmes (Race Disparity Audit, 2017).

There have been several deaths of black African and Caribbean men with mental health problems under police detention on Section 136 of the Mental Health Act. In most cases, such deaths have been linked to harsh treatment, including physical restraint whilst under police detention. Case studies carried out by the Inquest (Inquest, 2013, NHS Digital, 2020) concluded that a disproportionate number of people with mental health problems who die in or following coercive police detention are from the BAME populations.

Research has shown that 90% of prisoners suffer from one form or more of mental health problems (Hoffman et al., 2016; McDaniel et al., 2020). Since BAME populations make up 25% of the UK prison population in comparison to 11% of whites, psychiatric morbidity among black African and Caribbean prisoners becomes a more significant phenomenon than is shown within the general population (Ministry of Justice, 2011; Frederick et al., 2018).

Previously, a study confirmed that lay people were responsible for initiating police action rather than the police themselves (Qassem et al., 2015). This is explained by the native British people's predisposition to interpret black African and Caribbean people's behaviour as indicative of insanity and danger. Black African and Caribbean people were also found to be less frequently referred to services by their relatives than by strangers and passers-by (Chakraborty et al., 2018). Therefore, the conduct of black African and Caribbean people is viewed more negatively by the native white than that of other lay white people. Keating (2009)

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referred to a process called 'transmitted discrimination' whereby attitudes to black people's behaviour are viewed in context with the number of police referrals. The strained relationship between police and young black men resulted in intensive policing strategies in inner city housing estates where many black African and Caribbean people usually reside (Bennewith et al., 2010; Ministry of Justice, 2011). This therefore has a contributory effect on all the raised levels of police detention for all forms of deviance as well as mental disorders. Other related agencies, such as courts and psychiatric services, operate policies which have been found to be influential in how police react when detaining black people suspected to be having mental health problems (NHS Digital, 2020).

A study conducted on behalf of the National Association for the Care and Resettlement of Offenders (NACRO) found that legal decision-makers tended to err on the side of caution with black defenders considered to be mentally vulnerable (Ministry of Justice, 2011). This shows that the pathways that black African and Caribbean people follow to access mental health services can be viewed as a larger part of a social control apparatus used to regulate and monitor lives of black people. Further to the fact that black African and Caribbean people are over-represented in all parts of the criminal justice system, conclusions have been made that both 'criminalisation' and 'medicalisation' of black people are interconnected processes (Cummins, 2018): it was identified that higher rates of admission to psychiatric services through the criminal justice system suggested a close coalescence of the criminalisation and medicalisation of black people. The focus here was to advocate for a more broad-based definition of psychiatry that would embrace other essential modalities used to determine vulnerability to mental health problems (Office of National Statistics, 2021). Therefore, the psychiatric system would be seen to adopt an extended network of scientific expertise and professional practice which necessitates a review, assessment and management of black people while considering their welfare in several other related state institutions and psycho-social circumstances. These could include education, employment, socialisation circles, health care, courts and prisons, as well as how black people fare in housing and other amenities.

2.7.4 Application of the Mental Health Act

Recent studies have shown that Black African and Caribbean people are more likely to be detained under the Mental Health Act 1983, and across most cases there are similar patterns of inequalities based on race and ethnicity (NHS England, 2019).

The Mental Health Task Force Project - a research study that was supported by the National Health Service Executive - reported that African-Caribbean males were over-represented among those formally detained in acute inpatient units and were more likely to be taken by

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police to a place of safety under Section 136 of the Mental Health Act 1983. The research also found that black African-Caribbean people were more likely to be sectioned than their white counterparts. Of black African-Caribbean women,18% were also likely to be compulsorily detained, compared to a mere 2% of their white counterparts (CQC, 2018; NHS Digital, 2020).

The police were described as inconsistent in their use of the Mental Health Act whereby many black African and Caribbean people were detained under Section 136 (Cummins, 2018). The expected outcome was, in most cases, a compulsory admission to an acute mental health setting. These results indicate that most black African and Caribbean individuals were compulsorily admitted to psychiatric hospitals under a section of the Mental Health Act 1983, which was most likely preceded by the use of compulsory powers under Section 136, or emergency admission under Section 4 (NHS Digital, 2020; CQC, 2018). However, other researchers have disputed this observation, arguing that ethnic status did not determine whether police were involved at the point of referral for people with a first episode of psychosis (Karlsen & Nazroo, 2014; Cummins, 2018); they instead pointed out that the factors associated with compulsory admissions were people living alone, the absence of a GP involvement, and a lack of immediate family members, relatives or friends to negotiate access to an appropriate care package.

Further, men in general are considered less able to identify their own experiences of mental ill health and lack the awareness of available sources of help: as such, they are unlikely to seek professional help until it is too late (White, 2006). Other researchers suggested that the reasons for their not seeking help may be due to fear of the possible consequences, such as loss of status, control, independence and autonomy (Keating & Robertson, 2004). They continued by asserting that a range of perceived problems in accessing mental health services has been identified as even wider and more complicated for the BAME populations., because of their profoundly held negative perceptions of mental health services and that they would be discriminated against, as evidenced in the broader societal indices of success (Bhopal, 2018; Fernando, 2017). Therefore, the authors above seem to agree that, in order to successfully evaluate accessing mental health services by black African and Caribbean populations, there is a need to critically understand the connections of culture, ethnicity, racism and mental illness.

2.8 Mental health service provision and management

There is a concerning underrepresentation of ethnically diverse people, particularly in senior leadership within UK NHS organisations and institutions (NHS England, 2019). It is equally concerning to begin contemplating how the mental health needs of black African and

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Caribbean people can be understood and accommodated by an undiversified NHS management structure that does not reflect a diversity of the people it serves (Priest et al., 2015). The history of nursing and nurse education was facilitated by the colonial system which placed white people in privileged positions of dominance over non-whites (Kline, 2014). Despite the egalitarian promise in a democracy that all should be treated equally and should be free to rise according to their merits (Race Equality, 2010; NHS England – WRES, 2019), 'Othering' practices continue to create inequality by presenting bias and structural barriers associated with institutional racism. Despite cultural diversity, 'Othering' still makes it harder for ethnically diverse and racialised individuals and their descendants to rise through NHS promotional ranks (Priest et al., 2015). This imbalance is captured by the hegemonic carriers of power and ideology - within which ideas about difference and diversity are created and fortified against efforts to dismantle them. These meta-discourses of 'Otherness' shape attitudes, beliefs and actions as well as uphold the systems of privilege or disadvantage that have historically characterised the society (Priest et al., 2015; NHS Digital, 2020). Despite the rhetoric of multiculturalism, whiteness still shapes the national imagery of who does, and who does not, belong to privileged groups (Kmietowicz et al., 2019).

To date, there is ever more increasing pressure on mental health service managers to provide responsive services that are accommodating and inclusive (Department of Health, 2019). The experience of disparities in mental health services has been a trend going back in history (Barnett et al., 2019). A snapshot of the recent past decades proves the existence of these imbalanced trends amongst BAME populations, and especially the black African and Caribbean individuals. Priest et al. (2015) identified that 20-30% of all compulsory admissions were constituted by black African and Caribbean people. More so, the rate was found to be even higher for younger black African and Caribbean people. A four-year study to monitor detention or compulsory admission rates showed that black African and Caribbean service users were 17 times more likely to experience compulsory admissions from the community compared to their white counterparts. Furthermore, this group was 25 times more frequently admitted via the criminal justice system than were the comparison group (Sashidharan, 2002).

Follow-up studies in the 1990s found that black African and Caribbean people were over-represented in psychiatric hospital admissions (Bhui et al., 2003); it was also observed that this group was more likely to be admitted compulsorily and to be placed in locked wards, with the likelihood of having been involved in a conflict with the police (White et al., 2016). They concluded that black African and Caribbean people are generally treated in a more coercive manner within psychiatric services. Another observation was that these individuals were over-represented in locked wards and secure units, and were more likely to receive physical treatments such as Electroconvulsive Therapy (ECT), tranquilisations and depot medications,

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and were subject to control and restraint more than their white counterparts (Barnett et al., 2019).

Cummins (2019) confirmed these observations, that black patients were more likely to receive major tranquilisers and intramuscular injections, and that they were more likely to be reviewed by junior medical staff than were their white counterparts. More recent results show that black service users are often observed to receive higher dosages of medication and are more likely to be prescribed depot medication (Halvorsrud et al., 2018). Black African and Caribbean people were more likely to be misunderstood and misdiagnosed, as well as to be prescribed more ECT and pharmacological interventions rather than psychosocial interventions or talking therapies (Naz et al., 2019).

It was also shown that Black and South Asian people tended to stay longer in hospital and were less likely to have their psychological needs addressed (Bhui et al., 2018). Therefore, their rights and healthcare needs were less likely to be taken seriously than those of their fellow white patients. They seemed more likely to be put under supervision, as well as be subject to physical restraint and chemical tranquilisation, overrepresented in secure units and have pharmacological therapy as their first line of treatment. Further, Rose et al. (2017) confirmed that there is enough evidence to suggest that black African and Caribbean people with mental health problems were more likely to receive medication as the primary form of treatment than they were to receive psychotherapy.

In the Lammy Review, Shepherd (2017) found that black Caribbean patients were more likely to be compulsorily detained in psychiatric hospitals without a formal diagnosis. This highlighted that all black service users may be perceived by the professional staff as being uncooperative and are more likely to be transferred to secure units regardless of there being any tangible evidence of violence. In contrast, these experiences were unlikely to happen to their counterpart white patients (White, 2016). Another study found that black African and Caribbean service users were more likely to be formally detained or committed to locked secure wards than were their white counterparts (Turnbull, 2020).

Also, black service users were more often than whites recorded as being violent, as observed by Rogers and Pilgrim (2014), who believed this triggered a spiral of expectations that resembled the authoritarian penal regime; the implication being that mental health professionals treated black service users more coercively than they did their white counterparts. Resultantly, black service users were expected to react to a discriminatory regime in a more aggressive manner. Therefore, as a stop gap measure, mental health professionals behave more coercively towards incidents involving black service users and this results in a vicious circle. Morgan et al. (2004) pointed out that, despite the progressive

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evidence of continued over-representation of black service users in psychiatric services, or being under compulsory detention and coercive treatment regimes, this has driven a shift in policy initiatives or strategy towards developing culturally inclusive services for the UK's diverse population.

A shift to incorporate service users' and carers' views of the care received has shown more evidence that black service users experience their contact with services as unsatisfactory, and characterised by racism (Rose e al., 2015).

2.8.1 Experiencing stereotypical psychiatric diagnosis

In the UK, the incidence rate of schizophrenia has been recorded as being 12-13 times higher for black African and Caribbean people than for the general population (Pilgrim & Rogers, 2014). Black African and Caribbean people were found to experience hallucinatory delusions at a rate that was 2.5 times higher than for white people. However, when most cases of hallucinatory experiences were measured against the diagnostic criteria, they did not warrant a diagnosis of psychosis (Qassem et al., 2015). The implication, therefore, is that there are cultural differences in the reporting of hallucinations which are predominantly unaccounted for when diagnosing psychotic disorders.

The apparent over-representation of black African and Caribbean people diagnosed with schizophrenia against other minority ethnic populations can be viewed in terms of the existent cultural variations (Singh et al., 2013). The under-representation of other ethnic minority populations admitted with schizophrenia may be explained by their tendency to avoid contact with mental health services because of their fear of stigma attached to mental illness (Turnbull, 2020). Also, this avoidance of contact with services could potentially be influenced by the perception of available services to be inappropriate (Udah & Singh, 2019). Therefore, mental health service provision may be inadequately designed to understand or address varying cultural meanings of symptomatology. There is, however, a current drive to have all mental health services incorporate cultural sensitivity ethos in care design and provision (Bhopal, 2018). Karlsen and Nazroo (2014) identified that BAME individuals experience diverse forms of distress derived from racism in the same manner which affects their mental health. Therefore, this creates a gap in data to explain why there is this discrepancy in service usage between ethnic minority groups.

Another explanation depicts vulnerability to distress emanating from social deprivation and unfavourable environmental conditions, such as poverty, unemployment, racial harassment and discrimination, and overcrowded housing (Office of National Statistics, 2021). Again, there is a striking imbalance in the representation of black African and Caribbean people in mental health services compared with other ethnic minority populations (Halvorsrud et al., 2018).

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Research studies have not been conclusive enough in determining service usage by BAME populations due to poor data collection (Race Disparity Audit Report (2017). There is a discrepancy among ethnic minority people's service usage, and inaccurate recording of ethnicity in health records can have several consequences including an introduction of bias in research results, the over-coding of "Other" groups, and underestimation. These biases in the data can potentially skew results when ethnicity is ascribed by staff rather than being self-reported.

In one study, black African and Caribbean people described various factors affecting their mental health, and these included problems of coping with adolescence and the education system, which resultantly nullified their adult life expectations (Pilgrim & Rogers, 2014). Therefore, growing up in a hostile environment with few positive role models of black people would have brought confusion of identity and a failure to acclimatise within the white British culture (Fernando, 2017). According to Memon et al. (2016), simple social stress hypotheses, with predominate causality variables of poverty and racism, cannot sufficiently account for the data available on psychiatric morbidity. As such, the notion of external stressors cannot unilaterally deduce the aggregate data on over-representation among black African and Caribbean service users (Qassem et al., 2015). In conclusion, community studies and those that focused on hospital admissions were criticised for their lack of methodological robustness, which casts doubts on the validity of their conclusions. This criticism included the unreliability and lack of conceptual validity of the diagnoses of schizophrenia. Ethnicity data gathering processes in public sectors were deemed to be inaccurate and problematic, which meant data about ethnic groups were subject to a large margin of error (Fernando, 2010). In subsequent works, (Fernando, 2017), it is argued that previous studies tended to be suffused with cultural stereotypes and therefore it is difficult to make sound conclusive and accurate estimates about rates of psychiatric morbidity among BAME populations.

2.8.2 Psychiatric misdiagnosis

Literature suggests that admission rates for schizophrenia and other psychotic disorders do not accurately reflect the incidence of these disorders in the generality of communities (Turnbull, 2020). Others have identified that biases in diagnostic criteria, like the Diagnostic Statistical Manual (DSM) and International Classification of Disease (ICD), are to blame (McManus et al., 2016). They explained that psychiatrists adopt an ethnocentric view that may result in misattribution of labels such as 'schizophrenia'. Therefore, there is an imposition of Western concepts of diagnosing while the varying cultural differences of non-western people are disregarded. Labels such as 'schizophrenia' and 'cannabis psychosis' have been often advanced whenever black people presented to services with disturbed behaviour (Baker, 2018; Gage et al., 2016). The discrepancies involved in psychiatric diagnostic work have been

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further compounded by the observation that more black service users than white have their diagnoses reviewed over long periods of time (Grey et al., 2013; Gage, 2019).

The assumption that high rates of schizophrenia are prevalent among black African and Caribbean people can be blamed on the misdiagnosis hypothesis which does not challenge these fundamental assumptions (McManus et al., 2016). Nazroo et al. (2007) carried out a study to look at service users with religious delusions, and identified that those reported to have acute psychotic reactions were likely to be misdiagnosed as having schizophrenia. Therefore, this observation does not challenge the validity of either the diagnostic categories or the scientific status of psychiatric knowledge and practices. Further studies have looked at transcultural psychiatry and found that white psychiatrists predominantly adopted simplistic views of culture by making inferences and assimilating these into their practice when caring for black service users (Bhui et al., 2013).

Qassem et al. (2015) argued that over-representation of black African and Caribbean people in mental health services could be explained not only by the misdiagnosis hypothesis. Their view was that other concurrent explanatory factors need to be accounted for, which include institutional racism, and the conceptual inadequacy of psychiatric knowledge. The main thrust of this argument was to highlight an account that psychiatry is unjust and unscientific not only to black African and Caribbean people but also to the wider client group, inclusive of native white populations. There was also an assertion that racialised psychiatric constructs reflect and reinforce wider racism (Turnbull, 2020). The implication is that police referrals to mental health services may be perceived as reflective of 'transmitted racism' when black individuals are seen by authorities in the same light as that portrayed by lay judgements and stereotypes held by native white people about black individuals being violent and a threat. The fact that police and psychiatrists' practices are embedded in the same societal context as the general public means that the science of psychiatry is affected by the environmental and social forces where it operates (Halvorsrud et al., 2018). Evidence has shown that there are both past and contemporary examples that illustrate how race and culture are inextricably bound in the construction of disease (Fernando, 2017).

2.8.3 Use of coercive treatment procedures

The Sainsbury Centre for Mental Health carried out a two-year research study '*Breaking the Circles of Fear'*, which was inspired by '*The Bennett Inquiry'* and reviewed several untoward incidences involving the death of black African and Caribbean men when under the care of forensic mental health services (Department of Health, 2002). The deaths were believed to have occurred during physical restraint of the patients by staff. The Sainsbury Centre for Mental Health (2002) found that there are circles of fear that prevent black African and

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Caribbean people from engaging with services. Other studies explored the experiences of black African and Caribbean people within mental health services and revealed several discrepancies that have continued to be evident in contemporary practice (Rose et al., 2015). Mainstream services were experienced as inhumane, unhelpful and inappropriate.

Black African and Caribbean people with mental health problems were previously thought to have at least four forces that underpin their experiences: how black people are treated in society; how people with mental health problems are treated in society; the power of institutions to control and coerce people with mental health problems; and the perceptions of mental health services by black African and Caribbean people, and vice versa (Rose et al., 2017). According to Bhui et al. (2018), the historical and contemporary position that black African and Caribbean people assume in society affects how they are treated in mental health services. The interaction of these experiences is closely linked to what Trivedi (2002) coined a 'spiral of oppression'. Therefore, black African and Caribbean people do not trust mental health services, and those who work within these services fear them, which results in lack of engagement on both sides.

The negative perceptions of mental health services create reluctance to seek help among black African and Caribbean people (Memon et al., 2016), and because services are not sure of how to engage with them, these individuals are at risk of further deterioration in their mental health. Therefore, there tends to be an increased likelihood of coercive interventions being used and this reinforces the already existent negative discourses and continued reluctance to engage because patients believe they are not treated with respect and their voices are not heard. The available services are perceived as not accessible, unwelcoming, irrelevant or not well-integrated within the community. A qualitative study to evaluate service usage by black African and Caribbean populations in Birmingham (Rabiee & Smith, 2013) illustrated further the views and experiences of these communities at the hands of mental health services. The study found that service users, overall, have negative perceptions of mainstream mental health services. The survey found that black service users were most disadvantaged in in-patient settings: they reported higher levels of dissatisfaction with their care and were more likely to have harsher treatments, such as 'control and restraint', meted out to them (Mental Health Act Commission, 2015).

2.9 Summary

In summary, the overall observation about modes of referral, diagnosis, compulsory admission and psychiatric management indicates that black African and Caribbean people are more likely to be subjected to draconian services than are white people.

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Literature has shown that black people are over-represented in in-patient mental health settings and are disproportionately coerced within those services. In order to better understand this phenomenon, it is essential to draw on three explanations from the literature: that black people are mentally ill more often than whites, black people may be mentally ill more often but are misdiagnosed, and that psychiatric theory and practice are part of the wider framework of racism dating back to the era of slavery.

High rates of schizophrenia have been cited as an explanatory factor for the high incidence rate of compulsory detention for psychotic disorders. Therefore, the argument is that black people are diagnosed as having schizophrenia more often than white people, hence may receive more aggressive treatment in services. However, counter arguments have been made about some methodological inadequacies in ethnicity monitoring data, as well as uncertainties over the diagnoses and aetiology of schizophrenia. This is especially so among black African and Caribbean people, whose lives are usually intertwined by less-understood psychosocial, cultural issues, race and ethnicity belongingness. This implies that using this as a justification to explain the various discrepancies is not totally convincing because of the convoluted nature of psychosocial circumstances that surround black people who use NHS mental health services.

Literature has shown that a multiplicity of possibilities, including potential biological differences in regard to genetics; neurochemistry; pre- and peri-natal trauma; virology; and immunology, as well as the effects of living in poverty-stricken areas with high unemployment and poor housing, which can be positively associated with high levels of psychiatric morbidity amongst black people. As far as schizophrenia is concerned, there is no definitive causality of its occurrence; therefore, this invalidates the combination of race and genetics criteria in diagnosing disease and its prognosis. It can be concluded, therefore, that the imbalanced association of black people and schizophrenia is incorrect and a misperception. While most of these studies have concurred on the evidence of over-representation being instigated by a prevalence of schizophrenia in black people, there is no clear linkage to conceptual and empirical validity, which compromises the rigour of the scientific evidence.

It is worth noting that different 'schools of thought' have tried to disentangle the root causes of these disparities. Some have sought biological explanations. Sharpley et al. (2001), Morgan et al. (2004), and McKenzie (2006) have looked more for the social explanations for these disparities, while others such as Fernando (2017), and Bhui et al. (2018) attempted to explore 'racism' as a causal factor.

Literature has shown that black people continue to experience wide-ranging disparities when accessing mental health services, especially when this is a first-time experience. Coppock and

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Hopton (2000), Fernando (2017), Saini (2019), and Bracken and Thomas (2005) argued that there is enough evidence to show that mental illness is not merely a biological issue, but is also intertwined with socio-economic and political factors. However, none of these hypotheses conclusively explains why disparities in accessing mental health services continue to exist among black African and Caribbean communities. Furthermore, mental illness itself is seen as dehumanising and alienating, and is generally viewed with anxiety and fear which in turn leads to rejection and exclusion (Fernando, 2017). Also, a report by the Social Exclusion Unit (2004) concluded that people with mental health problems are among the most disadvantaged and socially excluded groups in society.

There are still stereotypical views about black people, racism, cultural ignorance, stigma and anxiety associated with mental illness (Keating et al., 2002). These views often undermine the way in which mental health services assess and respond to the needs of BAME communities. These authors successfully demonstrated that young black men end up with an extremely radicalised profile of their mental health. Placing labels on people with words such as 'big, black, bad, dangerous and mad', potentially leads to misconceptions that black African and Caribbean populations are less deserving of treatment that aids recovery. This is evidence, therefore, to suggest that more punitive and restrictive forms of treatment are administered to these groups. Keating (2007) identified that black African and Caribbean people experience challenges at two levels: their lives in general are characterised by having to be continually aware that, in everything they do, they are being measured against how they fit the norm. In mental health, they must deal with misconceptions about black people as portrayed by populist views from the media and other sources, and naturally these views become embedded in mental health practice.

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Chapter 3 – Methodology (Part 1)

3.1 Chapter overview

The aim of this study was to explore black African and Caribbean service users' subjective experience of accessing NHS mental health services for the first time. The chapter discusses theoretical concepts and how these link to the practical methods employed in this study. It begins by presenting sociological frameworks that are considered and extensively discussed in order to determine the most appropriate theoretical perspective from which the study could be undertaken. Further, methodological discussions on quantitative and qualitative research are presented with a demonstrable trail of arguments that led to the identification of a qualitative inductive approach as the most appropriate method to explore the subjective experiences of the participants in this study.

The chapter develops by identifying 'Interpretive Phenomenology' as a chosen research paradigm, which assumes that social reality is not singular or objective but rather is determined by human experiences within given social contexts (Reiners, 2012). This approach was favourable because of its specific qualities that were best suited to achieve the goals of the current study. Arguments and counterarguments are presented to justify the suitability of the theoretical underpinnings of this approach pitted against other approaches encapsulated within the qualitative research paradigm.

Given that the study would explore various contentious psychosocial, socio-economic and cultural issues that were central to the overall experience of accessing mental health services by black African and Caribbean people, 'Conflict Theory' was chosen. This approach provided a more robust basis to adequately explore varying participants' experiences within the realm of health inequalities. Conflict theory was propounded by Karl Marx and claims that society is in perpetual conflict due to competition for limited resources (Dahrendorf, 2007). It holds that social order is maintained by domination and power, rather than consensus and conformity (Chappelow, 2019). The 'Literature Review' chapter has shown that access to mental health services by the current study target population continues to be marred by discrepancies characterised by inequality, aversive treatment, racism, denigration and other discriminatory practices (Grey, 2013). It was observed that sociological inquiry can broaden an understanding of how a range of social processes impact on the health of individuals and social groups. These social processes include social inequalities, professional relationships, change and self-identity, knowledge, power, consumption and risk (Crinson, 2008).

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Therefore the remit of sociological research is to unpack what gives society a sense of stability and order, how social change and development come about, the nature of the relationship between the individual and the society in which they live, and to what extent the society into which people are born shapes their beliefs, behaviour, life and health outcomes.

3.2 Theoretical perspectives

As a theory-based academic discipline, sociology endeavours to go beyond a simplistic description of the phenomena being investigated (Rogers & Pilgrim, 2005). This means that the sociological discipline rejects both the naturalistic and individualistic explanations of the social phenomena, and upholds that understanding of the social phenomena arises because of individuals being socialised when growing up in particular cultures or social structures. The observations I make above show the compatibility of a sociology-based theoretical framework and the interpretative phenomenological design that shaped this study. The aim was to explore the subjective experiences of the participants from their own psychosocial and cultural perspectives. I will now discuss the reasons behind adopting 'Conflict Theory' as a framework for this study. The other sociological approaches that I considered, such as the 'Functionalist Perspective' and 'Symbolic Interactionism', will also be vigorously discussed.

3.2.1 Conflict theory

As pointed out earlier, conflict theory derives from the ideas of Karl Marx, and views society as a competition for the distribution of resources, power and inequality (Chappelow, 2019). This perspective of social science claims that stratification is dysfunctional and harmful in society because it benefits the rich and powerful at the expense of the poor, hence perpetuating inequality. When studying a social phenomenon or institution, as, indeed, was the focus of this study, sociologists focus on the distribution of resources, power and inequality with the aim of determining those who do or do not benefit from this arrangement (Marx, 1993).

In an endeavour to explore the varying experiences of accessing mental health services by people of a black African and Caribbean background, 'Conflict Theory' offered me a perspective which focused on the social origins of disease, healthcare provision, and experience and outcomes of healthcare as they are influenced by the operation of a capitalist economic system. The aim of the study was to have an in-depth understanding of the participants' experiences. This would not have been adequately achieved without exploring the psycho-social, economic and political forces that underpin inequality in accessing mental health services for the study population. Therefore, income and wealth were major determinants of people's standards of living, including access to education opportunities,

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access to health care, availability and affordability of dietary requirements, and having recreational opportunities (Friedli, 2009).

Marxist conflict perspective emerged to subsume issues related to race and ethnicity, and viewed these to be secondary to class struggle. However, other conflict theorists, such as Gumplowicz, Du Bois and Crenshaw, viewed racial and ethnic conflict as more central (Hancock, 2006). Du Bois asserted that intersectionality paradigms of race, class and nationality might explain certain aspects of Black political economy (Du Bois, 2007). Therefore, his view is that race, class and nationality are not determinants of personal identity categories but are social hierarchies that map access to status, poverty and power. However, these stand points could only be true in as far as over-representation of black African and Caribbean service users in undesirable circumstances is concerned. Black African and Caribbean people who excel in the parameters aforementioned can also enjoy the benefits of being at the top of the hierarchical order regardless of their race, class or nationality through processes underpinned by upward social mobility.

The feminist theory of intersectionality suggests that different biological, social and cultural categories such as race, ethnicity and gender interact and intersect to form a system of oppression (Collins, 2002; Du Bois, 2007). These theorists appear to believe that civilisation is realised through conflict between cultures and ethnic groups and that large complex human societies evolved from war and conquest.

In terms of mental health, Keating (2007) identified that there are different forces that underpin the experience of mental health services by people of a black African and Caribbean background. Some of these forces identified include how black people are treated in society, how people with mental health problems are treated in society, the power of institutions to control and coerce people with mental health problems, and the perceptions of black people of mental health services and vice versa. The implication of these observations is that black people's experiences in their society have an impact on their mental and emotional well-being and these experiences in turn influence how they perceive and experience mental health services. Therefore, the historical and contemporary positioning of these individuals within a society shapes how they are treated within mental health services, and that these varying experiences interact to produce a spiral of feeling oppressed.

Modern conflict theorists believe that social structures are created because of differing and conflicting interests which result in differentials of power between the societal elite and the generality of a given population (Mills, 2002). A similar philosophy was coined by Domhoff (2011), who studied the politics of the powerful elite in USA's governmental departments and

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large corporations and successfully demonstrated the perpetuation of power imbalance in those entities.

Contrary to the functionalist perspective, conflict theory is better at explaining social change but weaker at explaining social stability derived from societal history (Dahrendorf, 2007). However, it has been argued that conflict theory only recognises two distinct classes of 'winners' and 'losers', which is not an absolute truth since societies also allocate resources through compromising and negotiating (Giddens et al., 2000). They also rejected the theoretical notion which presumes that everything is designed to benefit the elite and that the working class do not realise their subordinate status. They went on to identify another limitation of conflict theory, that it presumes working-class subjects do not rebel against the norms and values set down by the ruling class. There has been more criticism levelled at conflict theory for adopting a determinist stance and failing to explain how individual subjects are affected by any given social structure (Weingart, 1969). Conflict theory was also criticised for its inability to explain social stability and incremental change (Giddens et al., 2000).

It seems that while functionalism emphasises stability, conflict theorists emphasise change where society is in constant conflict over resources, resulting in abrupt revolutionary social change rather than incremental change. Therefore, conflict theory provides a sociological framework by which social change can be explained, hence adding a dimension that the functionalist perspective does not address. However, in as much as conflict theory is criticised for neglecting social stability, it has been argued that, in fact, the conflict perspective also developed a theory to explain social stability (Weingart, 1969; Collins, 2002). The explanation of this argument is that inequalities in power and imbalanced reward systems are inherent in social structures, therefore societal elements that benefit from a given social structure will strive to see this form of social stability maintained. This implies that social stability can exist within parameters of inequality, which includes privileged access to education, health care, housing, jobs and other resources, which are all pertinent to the participants in this current study.

3.2.2 Functionalist perspective

Another sociological perspective that was considered is 'Functionalist Theory', which views society as a complex system whose parts work together in harmony to produce social solidarity and stability and thus maintain a state of balance and social equilibrium (Turner, 2017). The functionalist perspective is largely based on the works of Herbert Spencer, Emile Durkheim, Talcott Parsons, and Robert Merton (Krieger, 2001). It appears that this theory places attention on the interconnectedness of a society and how each element within a given society influences and is also influenced by other elements. The focus is on how the effects

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of the social parts of the society determine it to be either 'functional' or 'dysfunctional'. This means the functional state of the society comes about when the societal elements contribute towards social stability, but vice versa would result in a dysfunctional society.

In health care, functionalism is concerned with the theme of 'sick role' and its association with illness behaviour. Parsons (1951) described health as an individual's state of optimum capacity to effectively perform the roles and tasks for which they have been socialised. Therefore, the state of wellbeing and being healthy is vital to the stability of society where sickness is regarded as a form of deviance. According to Giddens et al. (2000), illness is identified as a complex socially constructed phenomenon rather than a purely physical condition.

However, the functionalist perspective has been criticised for failing to explain the origins of societal conflict, times of instability, and social change (Giddens et al., 2000). Other critics have rejected the theory's presumption that society and its institutions are designed to benefit everyone without critically evaluating the negative aspects of those institutions. More importantly, functionalism is criticised for not allowing macro-analyses of contentious race-related issues (Collins, 2002): it was considered to view race just as another constituent element within the larger society. As such, this approach was inadequate for exploring inequalities as experienced by people of a black African and Caribbean background in mental health services. The approach appears to maintain an emphasis on social consensus and pays little attention to micro-analyses such as identify formation, as happens in symbolic interactionism.

3.2.3 Symbolic interactionism perspective

Another sociological perspective considered for this study was 'symbolic interactionism' which reflects on the micro-sociological perspective that focuses on social psychological dynamics of individuals interacting in small groups (Giddens et al., 2000). Symbolic interactionism is largely based on the works of George Herbert Mead and Erving Goffman. In their view, they appear to place emphasis on human behaviour being influenced by definitions and meanings that are created and maintained through symbolic interaction with others. Symbolic interactionism suggests that identity or sense of self is shaped by social interaction, and self-concept is developed by observing how others interact with us and label us (Collins, 2002). Therefore, when individuals in each society observe how others view them, they see a reflection of themselves.

The implications to health are that symbolic interactionism rejects medicine as an objective science and views it as a social practice (Giddens et al., 2000). This implies that symbolic interactionists focus on specific meanings and causes that people attribute to illness. A doctor-

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patient relationship can result in the patient's dissatisfaction because of the doctor's inclination towards using pre-existing frameworks to categorise disease (Rogers & Pilgrim, 2005). In mental health practice, the rigidity of these pre-existing frameworks does not allow room for exploration of individuals' subjective experiences of mental distress.

Robert Park, another key sociologist, coined the 'Race Relations Cycle' which had four stages, namely contact, conflict, accommodation and assimilation (Giddens et al., 2000). His view was that interactionism is linked to a social process that entails the initial individual contact followed by competition or conflict. Conflict then results in some form of a hierarchical arrangement where the competition victors assume dominant positions, while the losers assume subordinate statuses. By assuming these societal statuses, assimilation into the new acquired statuses prevails. While there is a strong reference to cultural, racial and ethnic variations, I observed that this perspective bears similarities with conflict theory.

3.3 Positivism versus Interpretivism methodology

3.3.1 Positivism

Positivism and interpretivism are the two main approaches employed in sociological research, and while positivists rely on scientific quantitative methods of research, interpretivists use humanistic qualitative methods (Healy & Perry, 2000). Therefore, positivists work with quantitative methods such as social surveys, structured questionnaires, and official statistics which are believed to produce reliable and representative data about a given study population. The approach holds that society shapes the individual and that people's actions can be explained through the social norms that they have been socialised to. In research the aim is to expose the laws that govern human behaviour and use quantitative methods which allow the researcher to remain detached from the research subjects. According to Healy and Perry (2000), positivists are more interested in getting an overview of society by drawing comparisons, correlations, and plotting trends and patterns of human behaviour rather than the individual experiences of participants. Therefore I observed that this approach was not compatible with the aim and objectives of the current study and chose to pay more attention to the interpretivists approach.

3.3.2 Interpretivism

The interpretivists approach was considered because it claims that individuals are intricate and complex because different people understand and experience the same objective reality differently (Thompson, 2015). This approach presented compatibility qualities to my study, in that the aim of the study was to gain an in-depth insight into the experiences of the research

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participants and an understanding of their behaviour. It seems, therefore, that - unlike the positivists approach - interpretivists prefer qualitative methods of research such as interviews, focus groups, and participant observation studies, which allow for close interaction with the participants. Interpretivists argue that in order to understand human action we need to achieve 'Verstehen', which is an empathetic level of understanding (Healy & Perry, 2000). Therefore, there is the need to see the world through the eyes of the actors doing the acting and, by so doing, to sacrifice reliability and representativeness for greater validity achievable by qualitative research methodology.

3.4 Qualitative research methodology

A qualitative approach to research was chosen for this study because I wanted to explore the participants' subjective experiences of accessing mental health services for the first time. As inferred in the 'Introduction' chapter, there is a limited qualitative research database of studies that investigated subjective experiences of accessing mental health services for this study population. While other research studies have tried to explore service user experiences, these were quantitative in nature and used closed questionnaires and numerical rating scales to measure experience, satisfaction and outcomes from services. Some of these studies have used mixed method approaches where the qualitative component of research involved a selected number of participants partaking in short interviews. However, I observed that short interviews do not allow for the full exploration or in-depth insight of participants' experiences which this study aimed to achieve. Moreover, in order to understand subjective experiences, short interviews or satisfaction surveys would leave a significant number of variables and an array of experiential modalities unexplored.

According to Kvale (2009), quantitative methods of research have little place when exploring participants' subjective experiences. Crossley (2000) argues that simple reductionist measurements do not capture complex human experience and are unable to provide in-depth insight into the way in which individuals experience and give meaning to phenomena. The implication of this position is critical to the current study because the participants had a significant personal component attached to their experiences and these were perceived to be intimate, private and very personal. This means that a qualitative approach to research was more suitable for engaging participants at a level where they could open up on their previous intricate and distressing experiences. A quantitative approach would have brought challenges in so far as this dimension of data acquisition was concerned.

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Gaining deeper insight into subjective experiences meant placing the participant at the centre, and taking an exploratory inductive approach. This allowed the voice of the participant to be heard, thereby enabling an understanding to be constructed from the participant's subjective accounts. Adopting this strategy meant that normative assumptions about the phenomena investigated were mostly unhelpful The emphasis was on avoiding strict boundaries such that participants could express themselves freely. Contrary to this, quantitative research tends to move too quickly to impose hypotheses and structures which are not grounded in the participants being investigated.

3.4.1 Qualitative design

Having adopted a qualitative design for this study, it was now time to choose from the many qualitative research methodologies available. In doing so, the qualitative methodologies that would best address the research aim and objectives were considered. The focus was to gain an insight into the subjective experiences of first-time contact with mental health services by people of a black African and Caribbean background. Therefore, the qualitative method had to allow exploration of and a focus on the participants themselves *and* the subjective accounts of their experiences. The aim was to choose a method that would aid understanding and help to explain the on-going problematic access to mental health services experienced by this study population. The researcher believed that this in-depth understanding could potentially influence the wider response strategy of mental health services. The methodology had to enable exploration of the participants' thoughts, beliefs, feelings and attitudes on encountering NHS mental health services for the first time and inductively determine the influences attributable to contexts of social, cultural, economic, political and psychological factors. Below are brief discussions of some of the alternative qualitative approaches considered for this study, and the reasons why 'Interpretative Phenomenological Approach' was chosen by the researcher. Following careful consideration of these alternative approaches, IPA was adopted on pragmatic grounds, and in the interest of first gaining in-depth experiential accounts of the participants. Therefore, these alternative methods could potentially be used to further elaborate emerging theories, stories and the ways these are discoursed for black service users within mental health services. Alternative methods considered include; 'Grounded Theory', 'Discourse Analysis' and 'Focus Groups'.

3.4.2 Grounded theory

Grounded Theory developed first from the ideas of Glaser and Strauss in the 1960s. According to Charmaz and Belgrave (2007), Grounded Theory is based on the symbolic interactionist perspective. This approach appealed to the current study in that it attempts to explain the social and contextual influences on the participants' experiences of accessing mental health services for the first time. This, therefore, allows a theory to be constructed around the service

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users' experiences and to make comments about realistic issues with the world. This approach demonstrated clear strengths in researching basic social processes (Reigner, 2019) and was potentially suitable for this study. However, for the aforementioned reasons, I moved on to consider the suitability of 'Discourse Analysis' as a qualitative research method.

3.4.3 Discourse analysis

Discourse Analysis is a qualitative research approach that focuses on analysis of written, vocal or sign language, or other semiotic methods (Wodak & Meyer, 2009). The emphasis of this approach is in the lifeworld and meaning-making using language (Luo, 2019). The method involves the analytical processes of deconstructing and critiquing language as well as the social context of language usage (Cheek, 2004). Therefore, interpretations are based on both the details of the material itself and on contextual knowledge.

Having grasped the essence of 'Discourse Analysis' and its potential applicability to the current study, this approach was discussed further. The approach was appealing in that it would allow for further exploration of social and contextual factors that influence how participants construct meaning from their experiences of accessing mental health services for the first time. However, there is a distinction in that discourse analysis takes a broader perspective in looking at language used during a social event, while 'Conversation Analysis' focuses on specific conversational activities in a sequential context (Wooffitt, 2005).

Discourse analysis can be criticised for taking on a relativist view in which the people and the world around them are believed to be socially constructed through language (Keller, 2011). However, this approach was again potentially useful for this study and could help expand understanding of the participants' experiences through conversational stories about accessing mental health services for the first time, and the influence that this had on their subjective experiences. With this realisation of the potential usefulness of 'Discourse Analysis', I proceeded to consider 'Focus Groups'.

3.4.4 Focus groups

Focus groups were considered as a data gathering method that could be used to complement the development of semi-structured interview questions for this study. The use of focus groups has increasingly become a chosen method of inquiry in social research, and they are valuable for triangulation of qualitative methodology (Gilgun, 2014). Focus group methodology gives advice on group formation, running the groups, and analysing results (Liamputtong, 2011). I observed that, just as in interviews, the researcher leads and facilitates a time-limited interaction of a small group of participants with the aim of soliciting general views and opinions about a topic of discussion. The method is based on distinct stages such as forming, storming, norming, performing and mourning (Morgan, 1997). Focus groups organised for ethnic

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minority groups help to foster values such as trust, solidarity and reciprocity that are shared among group members and provide an enabling environment for the expression of difficult taboo experiences within a group context (Wilkinson, 1998). This means that the method has the qualities to empower participants to take part in cordially organised groups for the purposes of sharing personal experiences.

In relation to the field of health and medicine, researchers find focus groups helpful in that they do not discriminate against participants who cannot read or write, while encouraging contribution from participants who may otherwise be reluctant to be interviewed on an individual basis (Kitzinger, 1995). However, for the participants in this current study, understanding of the English language was a prerequisite to participate because semi-structured interviews were used.

Social scientists who have attempted to explain ethnic group solidarity have tended to use either the primordial or the circumstantial approach (Darlington & Scott, 2003). The first accounts for strong ethnic attachments based on participants' ineffable affective significance. As in 'symbolic interactionism' discussed earlier, affective significance largely surrounds images of the group's distinctive past, thus giving a historical dimension to the concept of primordialism. The second approach views ethnic group solidarity as resulting from certain social circumstances, both internal and external, under which the members of the group exist. Therefore, participants in a focus group are likely to expose unconscious solidarity that is influenced by shared historical, physical and socio-economic circumstances. The implication is that participants feel more empowered to share their experiences within an environment characterised by solidarity and camaraderie.

As in most research activities, ethical issues need to be considered in relation to the confidentiality of what is discussed during focus groups. While the dynamics of groups can present challenges to the researcher, such as when some participants choose not to talk, there are opportunities for the group members to agree and counter each other's opinions and this results in detailed presentation of opinions (Gibbs, 1997). With this approach, it is important to ensure that every participant contributes because group members may initially be reluctant to participate due to feeling uncomfortable or shy. Eventually, I decided to explore more phenomenological approaches which focus on the individual participants, with the aim of first gaining an in-depth understanding of their experiential accounts, their own perspectives and what those experiences meant for them.

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3.5 Phenomenological approach

Phenomenology is a large body of philosophical work from which numerous phenomenological methodologies have been derived. Groenewald (2004) described phenomenology as a way to seek meanings from appearances, and arrives at essences through intuition and reflection on conscious acts of experience that lead to ideas, concepts, judgements and understandings. Therefore, phenomenologists ask questions such as, 'What is it like for you…?' or 'How do you feel when…?'. As such, this study adopted a retrospective approach in an endeavour to understand the first-time experience of encountering mental health services by the study participants.

In line with the aim of study, phenomenology is a means of research inquiry that identifies the essence of human experiences relating to a phenomenon as described by the participants (Creswell, 2009). It is a philosophical study of structures of subjective experiences and consciousness. It was founded by Edmund Husserl at the beginning of the 20th century and later developed by Martin Heidegger and others (McConnell-Henry & Chapman, 2009).

Husserl's conception of phenomenology is primarily concerned with the systematic reflection on the study of the structures of consciousness and the phenomena that appear in the acts of consciousness (Creswell, 2009). Husserl envisioned phenomenology as a method of philosophical inquiry that rejects the rationalist bias in favour of a method of reflective attentiveness that discloses the individual's lived experience (Racher & Robinson, 2002). The approach entails the suspension of judgement of the phenomena while relying on the intuitive grasp of knowledge that is free from presuppositions and intellectualising (LeVasseur, 2003). Therefore, phenomenology assumes spontaneity and candour in participant responses.

Martin Heidegger modified Husserl's conception of phenomenology, arguing that consciousness is peripheral to one's existence; Husserl differed by asserting that humans are constituted by states of consciousness (Smith, 2003). Heidegger offered a way to conceptualise experience that could accommodate aspects of one's existence that are peripheral to sentient awareness and interested in subconscious or unconscious states (Polit & Hungler, 1999).

There are two main and distinct schools of thought in phenomenology: Husserl propounded 'descriptive phenomenology', and Heidegger inspired 'interpretative phenomenology' (Wertz, 2005). Phenomenological research starts off with concrete descriptions of lived experiences, which are often first-person accounts that are set down in everyday language and are devoid of intellectual generalisations (Creswell, 2009). This, therefore, constitutes the descriptive phenomenological approach, from which the researcher can proceed to reflect and analyse

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descriptions to produce a synthesised account representing the themes of a phenomenon. Interpretive phenomenological approach involves going beyond the surface expressions or explicit meanings to unearth the implicit dimensions by 'reading between the lines' (Ashworth, 2006).

My initial thoughts were to consider Husserl's descriptive phenomenological works, as being the founder of phenomenological philosophy (Giorgi & Giorgi, 2003). However, the concept of bracketing assumptions and stepping outside of one's own subjectivity in order to have an objective view of the phenomena was challenged by other phenomenologists, more prominently by Heidegger (Horrigan-Kelly, 2016). I made the decision that this concept of 'bracketing' was unachievable and was set against the intended research process including my own black African ethnic background, as well as my historical and current experiences as a black African living in a predominantly white community. Outside of this study, the researcher has inside knowledge of mental health services because he worked as a mental health professional for many years. Further reflections regarding this observation on reflexivity are discussed later in this chapter.

Besides gaining an insight into the subjective experiences of the participants of accessing mental health services, the researcher also wanted to understand the impact of varying contextual factors on the participants' experiences. This, therefore, prompted a focus on interpretative phenomenological approach as propounded by Martin Heidegger (1962). This approach is based on the ontological perspective which holds that we understand the phenomena by being bound in it, rather than by taking a step back to have a subjective view and by so doing, lay claim to making 'pure' descriptions (Horrigan-Kelly, 2016). Van Manen (1990) critically evaluated Heidegger and Gadamer's works and observed that pre-understandings acquired through the individual's historical context, cultural, socioeconomic and psychosocial factors are important attributes to understanding participants' experiences. This means that acknowledging the researcher's subjectivity allows for an exploration of a multitude of factors that underpin participants' experiences (Creswell, 2013). Given these observations, I became inclined to focus more on Heidegger's 'Interpretive Phenomenology' rather than Husserl's 'Descriptive Phenomenology'.

3.5.1 Interpretive phenomenology - theoretical underpinnings

Phenomenology is a philosophy that researchers use to understand experiential meanings of participants in a study (Smith, 2007). It provides a platform for researchers to focus on fresh, complex and rich descriptions of experiences as vividly lived by the participants in a given study (Horrigan-Kelly, 2016). The aim is to gather concreteness of participants' lifeworld

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experiences while being responsive to both the phenomenon and the subjective interconnectedness between the researcher and the researched (Wertz, 2005).

I observed that phenomenological research starts off with concrete descriptions of lived experiences which are often first-person accounts that are set down in everyday language and devoid of intellectual generalisations (Creswell, 2013). This constitutes the descriptive phenomenological approach, from which the researcher can proceed to reflect and analyse descriptions to produce a synthesised account representing the themes of the essence of the phenomenon. This means that interpretive phenomenology involves going beyond the surface expressions or explicit meanings to unearth the implicit dimensions by 'reading between the lines'.

Husserl inspired descriptive phenomenology, whilst an interpretative phenomenological approach emerged from the work of hermeneutics, chiefly by Heidegger, Gadamer and Ricoeur, who argued that, as researchers, we are embedded in the world of language and social relationships, and the inescapable historicity of all understanding (Grondin & Plant, 2014). These views about qualities of interpretative phenomenology are consistent with what this study set out to explore, that is to understand the impact of social, economic, cultural, political and historical contexts on subjective experiences of the participants. Heidegger believed descriptive phenomenology was part of interpretation and that, as human beings, we experience a phenomenon as something that has already been interpreted (Creswell, 2013; Smith, 2007). I will now discuss the two key disciplines of interpretive phenomenology, which are 'Verstehen' and 'Hermeneutics'.

3.5.2 Verstehen

Verstehen, a German term used to refer to the literal context of understanding, implies the interpretive and participatory examination of social phenomena and is predominantly based on the works of a German sociologist, Maximilian Weber (Ashworth, 2006). It is the systematic interpretative process in which an outside observer attempts to acclimatise with an alien culture in order to understand the subjects within it (Giddens, 2000). Verstehen refers to the understanding of the meaning of an action based on the actor's point of view. Therefore, interpretive sociology is the study of society that concentrates on the attributes people make about their social world. This implies that reality is constructed by people themselves in their daily lives (Macionis & Gerber, 2008, as cited in Al Farabi, 2008).

While the approach was opposed to sociological positivism and economic determinism, Weber observed a potential for the amalgamation of these approaches (Macionis & Gerber, 2006). However, there is a contrast in that interpretative sociology deals with the meaning attached to behaviour, while positivist sociology focuses on action (Giddens, 2000). Interpretive

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sociology holds that reality is constructed by people or subjects in a given society, while positivist sociology revolves around the notion that there is an objective reality out there to be grasped. In addition, interpretive sociology uses qualitative data, while positivist sociology tends to rely on quantitative data (Creswell, 2013).

Some of the criticisms levelled against the social scientific concept of Verstehen included those by Wilkie-Stibbs (2013), who argued that it is simply impossible for a person born of one culture to ever completely understand another culture. She further stated that it is arrogant and conceited to attempt to interpret the significance of one's culture through terms of another perceived superior culture. However, Heidegger (1999) countered that the concept of Verstehen does not claim total understanding of a way of life and, further, that any given individual participant brought up in their distinct societal culture may never have a full understanding of their own culture. He advocated for a grasp of cross-cultural understanding as valuable in the quest of interpretive understanding, and argued that ignoring factors such as the cultural domains of participants limits our understanding to just that which is observable. Other critics also argue that, in social research, investigators should not just focus on observing participants and what they do, but should also share in their world of meaning and come to appreciate why they act as they do (Macionis & Gerber, 2011).

Therefore, understanding of the overall participants' experiences meant uncovering the perceptions and attitudes to specific aspects of mental health services by service users of a black African and Caribbean background. In this study, the researcher attempts to uncover the underlying psychosocial, economic and political contexts impacting on the participants' experiences, and thereafter avoids claiming totality of understanding in his concluding remarks by proffering tentative opinions about the meaning of their experiences.

3.5.3 Hermeneutics

Hermeneutics developed as a systematic theory of interpretation after the realisation that the literal meaning of a text can conceal a deeper non-literal meaning that can only be uncovered through systematic interpretive work (Idczak, 2007). As a mental health professional, the researcher was strategically positioned, and had a good grasp of the language that participants used to describe their experiences in mental health services. According to modern hermeneutics, the pivotal connection is between language and interpretation, and claims that interpretation involves a deeper, existential level of self-understanding. Heidegger was mainly interested in the notion of 'being' and not in the nature of his engagement with specific hermeneutic issues (Inwood, 1999).

In the development of early modern hermeneutics, Vico is reported to have argued that thinking is always rooted in each cultural context, which is historically developed and based

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on ordinary language (Mootz & Taylor, 2011). He further stated that hermeneutics offers a model of truth and objectivity that differs from what natural sciences obtain. This development is observed as evolving from the stages of myths and poetry to the later stages of theoretical abstraction. The implications for this study are, therefore, that in order to understand oneself, the focus should be around the genealogy of one's own intellectual horizon. Hence understanding and self-understanding cannot be separated within a given context of practice and understanding. There is the need to keep in mind the historical context in which data is produced, and the mind by which data is produced (Laverty, 2003). The researcher's self-understanding and acknowledgement of this awareness is discussed briefly in this chapter under subheadings - 'researcher subjectivity', 'reflexivity' and 'bracketing'. These discussions are further elaborated in the 'Conclusion' chapter, under 'Limitations'.

According to Fleming et al. (2003), Gadamer argues that human beings are considered as 'being' through language and believes the world is opened to us through language. Therefore, his assertion holds that we can never really understand ourselves unless we understand ourselves as situated in a linguistically mediated historical culture. He views language as our second culture and points out that historical works do not primarily present themselves to us as neutral and value-free objects of scientific investigation (Macionis & Gerber, 2011). Therefore, history is part of the horizon in which we live and through which our worldviews are conceptualised. In as far as the researcher is concerned, there was need to reflect on my historical subjectivity to enable judgements to be made on how my concepts were developed. Such acknowledgements helped to improve the validity of this study, as will be shown later in this chapter.

Macionis and Gerber (2006) stated that Gadamer believes human beings are shaped by these historical values before they can attempt to approach them with any objectivising gaze. He argued that we can never know a historical work in its originality as we cannot access its original context of production, or what the author intended to portray. This means that history and tradition are not passive, but are productive and in a state of constant development (Wolff, 2017). Gadamer further observed that history is passed down to generations through the complex and ever-changing fabric of interpretations, which gets more complex as generations evolve, and culminates in the truth of self-understanding (Mootz & Taylor, 2011). His view, therefore, nullifies the earlier hermeneuticians' attempt to locate the scientific value of humanities through objective reconstruction, as discussed earlier.

3.5.4 Theoretical discussions

Habermas criticised Gadamer's view on hermeneutics as placing too much emphasis on the authority of tradition and restricting the platform for any critical judgement and reflection

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(Habermas, 1967; 1981). He argues that the way individuals are conditioned by history should not only be subject to analysis but also to evaluation against a set of quasi-transcendental principles of validity (Bohman, 2007). Habermas believes hermeneutics must be completed by a critical theory of society (Scambler, 2001). Gadamer's work was further criticised by Habermas for incorrectly asserting that hermeneutics was a universal concept. However, they both agreed that it was impossible to methodically standardise the validity assessment for hermeneutics. Habermas proceeded to suggest that quasi-transcendental principles of communicative reason could serve the purpose of emancipation and social liberation in social sciences (Bleicher, 2017).

Consideration of the above discussions enabled a more liberal research process of data gathering and analysis, as opposed to positivists' structured approach which the researcher avoided. Due regard was given to the subjectivity of the participants, which was essential for this type of research. Another implication of the arguments above was to allow for newer ways of acquiring data through hermeneutics and assessing validity of data without very strict parameters: it means there is no one way of acquiring or observing a truth.

Another student of Heidegger, Apel, criticised Gadamer for missing Heidegger's later conception that an ontological level of understanding must be completed by appealing to the trans-historical dimension of validity. Apel agrees with Heidegger, who found world-disclosive understanding to be a necessary condition for truth (Wolff, 2017). Gadamer countered the criticisms saying that he had never set out to disagree with every appeal to validity, objectivity and method of understanding. He claimed his work was misread and taken out of context as he tried to investigate the conditions of understanding (Bleicher, 2017).

From these arguments, Ricoeur emerged to propose a third way in hermeneutics, which was an alternative to both an epistemological orientation in hermeneutics and to Gadamer's ontological questioning of the distinction between facticity and validity in interpretation (Mootz & Taylor, 2011). I will now discuss the ontological position of the study in order to illuminate the researcher's relationship with the reality of this study.

3.5.5 Ontological assumptions

Qualitative researchers make certain philosophical assumptions which consist of a stance or position towards the nature of the reality (Edirisingha, 2012). Ontological assumptions are relativist in nature and support the belief by Heidegger (1999) that there is no absolute truth but that all truth is constructed by humans and situated within an historical moment and social or cultural context (Wolff, 2017). Ontology relates to the issue of 'nature of reality' and its characteristics, which means that multiple meanings exist for perhaps the same data (Erlingsson & Brysiewicz, 2013).

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Therefore, it is essential for qualitative researchers to acknowledge and accept the idea of multiple realities in their endeavours to study a given population. This implies that different researchers embrace different realities, just as do the participants being researched and the readers of the research study. As such, it was essential to acknowledge in this current study that each participant understood reality from a personal perspective, which reflects diversity and variation of lived experiences. My focus was to report these varying realities using multiple quotes based on what participants said, in their own words, and presenting different perspectives from the individual participants.

Heidegger (1999) argued that the task of philosophy is to show how the subject can rationally establish the norms of epistemic certainty whereby a given representation is judged to be true or false. He maintained his belief that hermeneutics is ontology and adopts a stance to nullify the Cartesian trajectory of modern philosophical reason which claims 'certainty' from hermeneutical approaches. His view is divorced from that of Gadamer (Bleicher, 2017) in that he believes hermeneutics is not about understanding linguistics, nor is it about mastering methodological bases for the human sciences, but that it is about the hermeneutics of facticity (Fleming et al., 2003). According to Heidegger, understanding is a characteristic of a human being and not something we consciously do or fail to do (Bleicher, 2017). He believes our understanding of the world presupposes a kind of pragmatic know-how by which we orientate ourselves to the world, without necessarily and initially applying some theoretical concepts.

Therefore, an interpretation of the participants' responses becomes the disclosure of meaning and assertion. This approach is further elaborated later in this chapter under 'Hermeneutic Circle', which informed the analysis procedure. As a qualitative researcher, I had to acknowledge and declare my position as being part of the study. It is a position that could also be viewed as being a research instrument that contributed and influenced the way data were obtained and interpreted. As such, there was need to acknowledge and reflect on researcher subjectivity in this current study.

3.5.6 Researcher subjectivity

I observed that in phenomenological studies, there is need to realise and accept that researcher subjectivity is inevitable (Tufford & Newman, 2010). It is the intersubjective connectedness between the researcher and the participants, and Giorgi (2008) contended that elimination of subjectivity is not the solution in achieving objectivity, as claimed by other phenomenologists. The implication of his argument is that nothing can be accomplished without acknowledging researcher subjectivity and how it impacts on the research process. Other phenomenologists concur with Giorgi's view that researchers need to adopt an open attitude and attempt to see the world afresh and in a different way (Tufford & Newman, 2010;

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Ratner, 2002; Le Compte, 1987). This means that subjectivity bias should be acknowledged as part of the research process in order to establish rigour and validity of the study.

However, there is an on-going debate with other phenomenologists who propose that there is need to engage a reductionist approach with the aim of minimising the researcher subjectivity to the research process (Finlay, 2008). This proposal guided the researcher to avoid bringing his own experiences to the foreground by reflexively exploring and declaring his own embodied subjectivity. Others proposed the need for a reductionist approach to create a non-influential researcher who is as neutral as possible when engaging a research process (Tufford & Newman, 2010); the implication being that researchers should aim to 'bracket' their previous understandings, past knowledge and assumptions about the phenomenon so that they purely focus on the emerging phenomenon.

However, hermeneutic researchers reject the idea of a reductionist approach or 'bracketing' and argue that it is not possible to set aside researchers' past experiences and pre-understandings (Giorgi, 2008). Instead, they recommend that researchers, through reflexivity, need to declare an awareness of their pre-existing beliefs, own subjectivity, vested interests and assumptions which allows a review of emerging data in the light of new evidence (Halling et al., 2006). For the current study, therefore, this critical self-awareness constituted an important step in the research process. It meant that any pre-conceived biases and presuppositions I held needed to be declared in order to separate them from participants' accounts. Further personal reflection on managing researcher subjectivity are discussed later in this chapter under 'Reflexivity', 'Bracketing', and, in the 'Conclusion' chapter, under 'Limitations'.

3.5.7 Hermeneutic Circle

The 'Hermeneutic Circle' is an approach that was adopted for analysing the participants' transcripts in this study. It is essentially the hermeneutical process of understanding text, and the approach claims that understanding of the whole text is achieved by making reference to the individual parts of the texts and the researcher's own understanding of each individual part by reference to the entirety of the transcript text (Shklar, 2004; Mantzavinos, 2016). Therefore, neither the whole text nor any individual parts of the transcripts can be understood without reference to one another. Hence, this process gave birth to the term 'hermeneutic circle' (Shklar, 2004). Interpretation of text in this circular fashion implied that the meaning of the text must be found within its cultural, historical and literal context.

According to Schleiermacher (1998), understanding does not simply involve reading text but also the knowledge of the historical context of the text. Therefore, the interpretation of text holds an influential role in the process of understanding the text. He goes on to state that

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understanding of other cultures cannot be taken for granted but that a researcher ought to maintain an openness towards participants' subjective facts that may seem rational, true and coherent because these can conceal some data that is deeply unfamiliar. There are some fundamental implications for the current study in that the researcher had to be able to systematically scrutinise his own hermeneutic prejudices. These included having insider knowledge of the provision and management of mental health services as he worked for the NHS as a Community Psychiatric Nurse. Reflexivity and reflections about the researcher's subjectivity and hermeneutic prejudices are briefly discussed in 'Methodology (Part 2)' under 'Reflexivity', and further elaborated in the 'Limitations' section of the 'Conclusion' chapter.

Heidegger's aim in devising the concept of the hermeneutic circle was to enable a vision of the whole text as the reality that is situated in the detailed experience of everyday existence by an individual (Gadamer, 1994). This implies that understanding evolved based on pre-existing structures that allowed for the initial interpretation of phenomena to occur and develop through the iterative processes, which led to new understanding.

Postmodernists criticised the hermeneutic circle as problematic for claiming that we only know the world we live in through the words used to describe it (Richardson & Fowers, 1997). The implication of this neo-pragmatic argument is that meaning-making involves open-ended communication systems, and that no single concept has an ultimate and unequivocal meaning. Therefore, a research activity should not result in a predetermined truth but embrace the possibility of deriving multiple realities and truths.

Shklar (2004) criticised the hermeneutic concept in that it metaphorically refers to a centre, but it is unclear whether the interpreter positions themself in the centre or that the centre represents some organising and illuminating principle of understanding. He further argued that the hermeneutic concept only makes sense when and if there is a known and closed whole. However, the researcher observed that there is no rule of thumb on when to enter or exit the hermeneutic circle. Nevertheless, the hermeneutic circle was criticised for not acknowledging the interpreter as having varied and multiple - and sometimes conflicting - cultural attachments to the subject of interpretation (Shklar, 2004). This view is compounded by Spinoza (1994), who argued that in order to understand the most dense and difficult sections of any text, one must be attuned to the historical context as well as the mind by which the data was produced. Therefore, it follows that understanding parts of the text hinges on our understanding of the larger whole, which can only be understood based on the parts. This means, the main theme of the hermeneutical circle is the movement back and forth between parts and whole of the text.

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Grondin (1997) described that Chladenius attempted to distinguish hermeneutics from logic by explaining how different variations in our perception of phenomena and problems may cause difficulties in our understanding of research participants' texts and statements . He stresses that what is important is the didactic and cognitively oriented approach to data interpretation, while raising an awareness of potential obscurities to understanding. He warns that the researcher needs to take into account the tacit and pre-reflective assumptions characterising the point of view from which complex texts and statements in the data are derived. A consideration of these factors in hermeneutics reveals similarities with the epistemological approach in pursuit of the truth or objective understanding of the subject matter.

However, Heidegger (2000) countered these several criticisms levelled against his concept by saying that the hermeneutical interpretation is unfairly criticised for lack of rigour in parameters that it is not intended to address. He further argued that the concept is not simply rooted within formal logic but makes presuppositions, which implies it does not make and take a premise for granted. In the current study, the application process of the hermeneutic circle concept is integral to the interpretive 'Analysis' chapter.

3.6 Methodology (Part 2) - Procedures

3.6.1 Research design – procedures overview

This is a qualitative study set within the naturalistic research paradigm, which promotes subjectivity associated with the social world and perceptions of that social world. This design is guided by Martin Heidegger's 'Interpretive Phenomenology'. In this second part of the Methodology chapter, the researcher starts by giving a brief description of the research setting then goes on to explain the study sample. The study sample comprised of 15 participants who were mental health services users from a black African and Caribbean background, and who were actively under the care of community-based mental health teams. Convenience sampling was used to recruit the study participants in accordance with the inclusion and exclusion criteria of the study. The sample size of 15 was based on the initial plan to use thematic analysis data; all data collected was still used in a compatible manner with the later adopted IPA process of analysing data.

Semi-structured interviews were used for data collection with the aid of an interview schedule developed from the specialist professional opinions of a local NHS Black and Minority Ethnic network group. Additionally, the interview schedule was shaped by opinions arising from a

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pressure group workshop consultation with BAME mental health service users. Thereafter, the audio-recorded interviews were transcribed verbatim by the researcher.

Data was analysed using the hermeneutic circle as it is effective and fits in with interpretive phenomenological work. The approach allows for data to be continually reviewed and analysed between extracts from the transcripts and the whole of the text (Idczak, 2007). Computer software-aided analysis was deliberately avoided because it is set against the tenets of interpretive phenomenological analysis. Using computer software for analysis would have introduced another layer of analysis devoid of consideration for the varying individual participant experiences.

3.6.2 Setting

The study involved a total of 10 Community Mental Health Teams across a setting in the south east of England. According to the Office of National Statistics – Census (2011), the research setting recorded an estimated total population of just over one million – 1,184,400 – across its 10 District Councils; about 48.8% were male and 51.2% female. Of this total, 11.2% were from BAME groups. For the purpose of this study, an age range of 18 to 65 years was initially considered as the sampling target and, according to the above census, 53% of the total population fell into this category. However, following Health Research Authority ethics review and recommendations, the upper limit of 65 years was adjusted to ensure equitable chances for potential participation across all adults.

Each Community Mental Health Team comprised multi-professionals, namely Psychiatrists, Psychologists, Community Mental Health Nurses, Social Workers, Occupational Therapists, and others. The teams looked after a caseload of service users from different localities within respective districts, and provided community-based care to mental health service users in their homes. For the purpose of this study, service users needed to have had an in-patient spell on an acute psychiatric admission ward or psychiatric intensive care unit before being discharged to a CMHT.

In the CMHTs, most patients are allocated to care coordinators who are responsible for the overall care of individually allocated service users. The care coordinator could be any one of the professionals identified above. The teams offer a multi-professional approach to providing care after a comprehensive needs' assessment. The service users receive help in their own homes, and this is usually done by supportive visits; sometimes, patients come to the team bases for treatment and support, or sometimes for clinical review by their responsible medical officers. Treatment is provided in the form of pharmacological or psycho-social interventions, or a combination of the two depending on the identified needs.

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3.6.3 Sample

The study sample comprised 15 participants. These participants were service users actively under the care of community-based mental health teams. Care coordinators across the research setting assisted in the recruitment of the sample guided by the inclusion and exclusion criteria. Therefore, care coordinators assumed the role of gatekeeper for the recruitment of potential participants to this study. The sample size of 15 was compatible with the requirements of a qualitative study, and convenience sampling ensured that only those service users likely to inform this inquiry were considered (Boddy, 2016).

On reflection, however, interpretive phenomenological studies use much smaller sample sizes (Wagstaff et al., 2014) than the 15 participants recruited here. Recruiting larger sample sizes for interpretive phenomenological inquiry could run the risk of data overload (Holland & Peterson, 2014). Initially, I intended to use thematic coding and analysis strategies, hence the larger sample; however, as will be explained in the 'Analysis' chapter, six participants' transcripts were used to develop a thematic framework, and inferences were made from the remainder of the participants' transcripts, as suggested by Smith et al. (2009). It would have been unethical to just discard all the other participants' data that had been volunteered in good faith.

3.6.4 Inclusion and Exclusion criteria

Recruitment of participants was regardless of gender, marital status, sexuality, socio-economic status or migrant status. Participants belonged to the ethnic category background of black African and Caribbean. This variation of the sampling strategy was commended by Patton (2015) as allowing the researcher to obtain the broadest range of information and perspectives from the subjects of the study.

Participants were aged 18 years and over after the researcher adjusted the upper limit of 65 years, as recommended by the Health Research Authority - Ethics Committee. Either male or female mental health service users were considered for potential participation in this study. Participants were selected on the basis that they had undergone an in-patient spell in an acute psychiatric admission ward or psychiatric intensive care unit within the two years preceding the research commencement. Participants had to be active service users under the care of Community Mental Health Teams and be relatively stable in their mental state. First-time admissions only were considered for this study. All participants who lacked mental capacity as stipulated by the Mental Capacity Act (2005) were excluded. All service users who had been directly under my care were excluded due to the potential introduction of bias in the research activity. Participants who could not understand the English language were excluded because using interpreters would have been costly. Participants who did not provide a written

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consent to participate in the study, and those who were likely to relapse into an acute phase of mental ill health during the study, were also excluded. The care coordinators who assumed gatekeeping roles had the responsibility of excluding such potential participants.

3.6.5 Sample recruitment

Convenience sampling procedures as discussed by Lavrakas (2008) were used to recruit potential study participants who were already actively involved with mental health services. The aim was to recruit participants who had been involved in most or all of the mental health services tier system in order to gain an insight into the experiences at respective levels. The chronology of these tiers started with the service users' family/ carer input, GP/ primary care services, secondary mental health services including community-based mental health teams, and hospitalisation in psychiatric facilities. However, recruitment of only the participants who remained actively involved with mental health services suggests that opportunities to gain insights from the experiences of those who had disengaged from services, or those who never accessed them, were potentially missed. Further discussions and justification for this recruitment strategy can be found under the 'Limitations' section of the 'Conclusion' chapter.

Convenience sampling procedures discussed by Lavrakas (2008) were used to recruit a sample of study participants who presented with physical characteristics of black African and Caribbean individuals. The process was guided by the inclusion/exclusion criteria. This method of sampling was chosen because it was readily accessible, efficient and cost effective. While, in general research, convenience sampling can be criticised for sampling errors and a lack of representativeness of results (Given & Lisa, 2008), this study was concerned with a specific group of participants, hence the applicability of its outcomes was only expected to be pertinent to that specific population group.

Potential participants were identified by their care coordinators across the research setting. Those identified and deemed relatively stable in their mental state each received a research information pack and a letter of invitation to participate in the study. A minimum of two weeks was facilitated to allow participants to read, understand and retain information about the study before deciding on whether to take part. The potential participants were invited to sign the consent form prior to the interviews as an expression of willingness to participate in the study.

Care coordinators were strategically positioned to identify potential participants amongst their caseloads, and they adhered to the inclusion/exclusion criteria of the study: identification of potential participants was done solely by the direct care team. If they expressed interest in participating in the study, potential participants' permission was sought for their contact details to be passed on to the researcher through an encrypted email. The decision to enrol care coordinators as gatekeepers in the sample recruitment was contentious because this could

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potentially have introduced sampling bias and errors that compromised the samples' representativeness. Further discussions about this observation can be found in the 'Limitations' section of the 'Conclusion' chapter.

3.6.6 Table 1 - Demographic distribution of the sample participants

Female Participants	Male Participants
- 8/15 were female participants	- 7/15 were male participants
- 4 female participants were of a black African background	- 5 male participants were of a black Caribbean background
- 4 female participants were of a black Caribbean background	- 2 male participants were of a black African background

3.6.7 Demographic characteristics of the sample participants

This section provides brief contextual information about the participants of the current study. Each participant had their name anonymised and replaced with a code number in order to protect their confidentiality. The first six participants' transcripts were selected for use in the data analysis process, with the remaining transcripts being used to make inferences and to highlight recurrent observations. This approach was necessary to enable the process to be compliant with the IPA guidelines of data analysis. Also, IPA usually requires a homogenous sample but my choice to include both black African and black Caribbean participants in the study sample was deliberate and not misguided by the misconception of race as a unifying concept. The aim was to understand the black participants' experiences using the same lens with which they were perceived within NHS mental health services – black 'African-Caribbean'. Black African and black Caribbean ethnicity is often erroneously recorded as if it is the same. The assumption I had was that these ethnically diverse participants' experiences would be similar, though I was intrinsically mindful of the dichotomous ethnic and cultural variations between the two groups. Further reflections on this are discussed in the 'Limitations' section of the 'Conclusion' chapter.

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Participant 238867 is a black Caribbean female in her late 40s. She had been going through a lot of stressful life events after losing her job and her rented house in an affluent area, due to being wrongly accused of an offence and charged in court, and was committed to a psychiatric hospital order with suspected psychotic disorder. She had no family and lost many friends as a result of being accused in court.

Participant 271332 is a black African male in his mid-40s. He was dealing with numerous psychosocial issues with added pressure from his asylum-seeker immigration status. He was still grieving for his wife's sudden death and was having to manage alone to look after his terminally ill young son. He had no form of income and had on-going housing problems. He also did not have any family in the UK and was struggling to make friends locally. He was admitted informally to a psychiatric hospital with severe depression.

Participant 300528 is a black Caribbean male in his mid-30s who had given up his job to concentrate on a personal business venture with the support of a financial loan from family. He became stressed as his business failed to take off, and started isolating himself while practicing spiritual rituals. He acknowledged that he was not functioning well mentally but was against seeking any professional help. His family became very concerned and contacted services. He was assessed at home, detained under the MHA, and was hospitalised for suspected psychotic disorder.

Participant 190643 is a black African female in her early 20s. She was a third-year university student going through stressful life events at both personal and familial levels. Her family unit was breaking up, and she took on the responsibility of looking after her teenage brother. She had to work extra part-time hours to raise money for self-sustenance and to support her brother, and this was compromising her studies. She was relying on her church for prayer support, but she had an acute mental breakdown that prompted police intervention. She was detained under Section 136 and later admitted to a psychiatric hospital for suspected psychotic breakdown.

Participant 161218 is a black Caribbean female in her mid-50s who lived alone with no regular family contact. She had been off work for a long time due to a shoulder injury and inadvertently became addicted to painkillers. Her GP referred her to the local CMHT, but she did not engage. She was not getting any support from family or friends and, in the end took too many painkillers and became physically ill. She was admitted to a general hospital and spent a week in a coma before she was assessed psychiatrically and detained under the MHA, and admitted to a psychiatric hospital for suspected depression with suicidal intent.

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Participant 161219 is a black Caribbean male in his early 50s who lived with his partner and a stepdaughter. He was unemployed and was detained by police under Section 136 after being found grieving near a graveyard church on Mothering Sunday, which happened to be the anniversary of his mother's death. He was taken into police custody and later transferred to a psychiatric hospital under Section 136 as he was suspected of having a psychotic episode.

3.7 Data collection

The participants who consented to partake in the study were invited to be interviewed once by the researcher at their local community mental health centres, where private interview rooms were pre-booked through the respective team administrators. Interviews lasted about 60 minutes for each participant and were audio-recorded as well as transcribed with participants' written consent. The flexibility with time allocated for interviews allowed ample time for the participants to engage with the interview questions. The questions were kept open, exploratory and orientated to process and meaning as recommended by Smith et al. (2009). It was my responsibility to maintain dignity and privacy for the participants, and I also ensured that participants were comfortable during interviews. Participants were also assured of the strict privacy and confidentiality under which the interview material would be kept.

The opinions of a service user pressure group outside of the research setting were used to develop the topic guide for the semi-structured interviews. The service user pressure group had similarities to the sample for this study based on the members' ethnic backgrounds, except that these were experienced mental health service users. Contributions from this group helped me to rearrange the sequence of the interview schedule questions. More general questions were used to start the interviews and progressed on to more specific questions. In addition, and through a pilot study, specialist professional input was sought from a local staff BAME Networking Group to help validate and refine the interview schedule. Their observations and opinions helped to improve the interview schedule regarding its specificity and sensitivity qualities before I could use it in the actual interviews. Adjusting the interview schedule included eliminating any leading questions or prior theoretical constructs about accessing mental health services by this population group, and placing more attention on the meaning-making experiences emerging from the dialogue. The focus was on it being flexible enough both to allow participants to reflect on their experiences and to produce meaning-making narratives derived from lived experiences, using the same interview schedule throughout.

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Items in the interview topic guide explored participants' experiences in relation to accessing primary care services before admission, care pathways used to navigate the mental health services, determining involvement and experience of community-based mental health teams, assessing the experience of statutory powers involved in the process of hospital admission, in-patient experience, determining socio-economic status of the participants, cultural attributes and attitudes towards services, choice and involvement in care planning as well as involvement of family and carers, and exploring the relationship dynamics between participants and health care professionals. Using the semi-structured interview format allowed me to incorporate topics that would guide the interviewees to respond to questions that were pertinent to the study aim and objectives. A copy of the interview schedule is appended under 'Appendix 1' of the Appendices section.

3.7.1 Semi-structured interviews

Semi-structured interviews are guided, concentrated, focused and open-ended communication events that are co-created by the interviewer and the interviewee. The questions, probes and prompts are written in the form of a flexible interview guide (Creswell et al., 2007; Gray, 2009; Corbin & Morse, 2003).

I considered other ways of data collection, although semi-structured interviews stood out as being more compatible with the current study. I observed that semi-structured interviews are in-depth interviews where the interviewees respond to pre-set open-ended questions. They are popularly used by health care professional to carry out research where they need to interview individuals or a group of participants (Corbin & Strauss, 2008). Semi-structured interviews are conducted once only and can last from 30 minutes to just over an hour (Dicicco-Bloom & Crabtree, 2006). They are based on an interview guide which is a schematic presentation of questions that supports the purpose of exploring many respondents more systematically and comprehensively while keeping the interviews focused. A prepared interview schedule was used as a guide on the sequence of questioning.

3.7.2 Unstructured interviews

Unstructured interviews developed from the initial works of pioneers of ethnographic studies (Gray, 2009). They involve the collection of data from known key informants by using observation and a record of field notes. Sometimes the researchers involve themselves with the research participants as a way of getting to understand their way of living, or any aspect of their life activity or behaviour. Unstructured interviews are an informal conversational interview based on an unplanned set of questions that are generated instantaneously during the interview (Gray, 2009). They may seem like controlled conversations which are skewed towards the interests of the researcher or interviewer, but they have the strength of gathering

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in-depth information about the participants and usually do not use a set of pre-planned questions.

I made an informed decision not to use unstructured interviews, based on a few observations. Unstructured interviews are time-consuming and can compromise the achievement of time-limited goals in a research activity (Thorpe & Holt, 2007). The implication of this observation is that, while it was essential to acquire in-depth responses from the participants, time was a limiting factor; I therefore had to settle for other methods that would achieve the same goals but in a time-limited event. Unstructured interviews are not standardised and usually involve different questions being asked of different participants, making it almost impossible to replicate a study (Sandelowski, 2010). This meant the rigour and validity of the current study could be compromised because of difficulties in demonstrating an audit trail of the research methods.

Semi-structured interviews were selected for data collection because they align with a general principle of phenomenological research in that they foster minimum structure and maximum depth (Plummer, 2017). In contrast to other methods, semi-structured interviews are most appropriate for gathering deep information about an individual experience (Gray, 2009). The key to success with a phenomenological approach is to establish a good rapport with interviewees, which is critical to gaining depth of information, especially when investigating issues where the participants have a strong personal stake (Creswell, 2009). In a one-to-one sitting, interviewees felt more at liberty to express their individual experiences without fear of being judged by others. The open-ended questions used in the semi-structured interviews allowed interviewees to express themselves in their own words, which helped to produce qualitative data that gave insights into the meanings that participants attached to their experiences. Semi-structured interviews are, therefore, well suited for the exploration of attitudes, values, beliefs and motives and offer flexibility and opportunity for immediate feedback, while clarity can be sought either way between the researcher and the interviewee. Active listening skills were used effectively to help settle the participants into the detail and essence of their varying experiences.

3.7.3 Justification for semi-structured interviews

An interview occurs when the interviewer and respondent cooperate in a conversation to "give voice" to knowledge that would otherwise not exist (Fielding & Thomas, 2001). Respondents express their unique thoughts and experiences which are recorded as data that the researcher analyses, interprets and synthesises in relation to a body of sociological knowledge (Silverman, 2013). For this analysis to be successful, the initial collaboration between the interviewer and respondent should result in "thick" descriptive data (Geertz, 1973). Thick, rich

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interview data are highly descriptive, and the respondent's language is precise, vivid and colourful. Concrete details conjure visual imagery, hence the researcher can picture the scenario of a narrative.

Open-ended questions were used for the semi-structured interviews to elicit rich narratives from selected respondents who had personal knowledge and experience of accessing mental health services (Silverman, 1998). The nature of questions posed to respondents provided adequate opportunity for them to reflect on and narrate their experiences. Silverman (2013) states that good questions in qualitative interviews should be open-ended, neutral, and sensitive and clear to the interviewee. The researcher started with simple and more general questions that the interviewees found easy to respond to, and progressed to more difficult and sensitive questions. Caution was taken to avoid 'leading questions' or 'double edged/barrelled questions' as stated in Silverman (1998).

Good interviewers are described as those who assume that interviewees are the experts when it comes to telling a story about their life experiences (Eyles & Perry, 1993). In this study, the researcher observed that it was valuable that participants gave accounts of their own lives by speaking from first-hand experience, and that those responses were likely to be rich with detail and meaning-making. Establishing good rapport and a trusting relationship between the researcher and the interviewees was paramount to successful interviews; this involved asking questions skilfully, then actively listening while ensuring that a conducive environment was facilitated for the respondents to talk freely and without inhibition.

However, some argue that long-winded responses do not necessarily result in 'thick' descriptive data (Silverman, 2007). The researcher was more concerned about the quality of responses during interviews and in ensuring that participants remained focused as they incorporated elements about deep personal experiences. The participants were encouraged to be descriptive and to narrate their experiences as this would convey more than just opinions and information. These personal narrations were based on first-hand experience devoid of abstracts, summaries or generalisations and represented an emotional significance.

Plummer (2017) described narratives as powerful in communicating emotional and unconscious levels of thought since they resonate with larger stories or myths that we understand in common through shared culture and shared humanity. Therefore, through narrative, respondents could convey their cultural views, attitudes, perceptions and self-understanding as well as express emotions, beliefs and principles that shaped their experiences of first-time engagement with mental health services. The questioning strategy discouraged participants from giving opinions but to express more about how they felt about their experiences and to speak freely with the 'inner' voice, as opposed to the 'public' voice.

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The 'inner' voice reveals true feelings and experiences - even trivial accounts were considered as these can have a bearing on the true meaning of their experiences (Silverman, 2016). The 'public' voice tends to tell the "official" story and often uses intellectual tones and guards against revealing sensitive information. There is usually a hesitation to discuss the particularities of a story which resultantly conveys a singular impression free of contradictory information (Plummer, 2017).

3.8 Ethical considerations

It is essential when undertaking research that an awareness of the ethical principles of the study be demonstrated and adhered to (Speid, 2010). Beauchamp and Childress (1989) devised four ethical principles, namely autonomy, non-maleficence, beneficence and justice. The implications of these principles for the current study are that the participants had the right to self-determination in consenting to take part. As the researcher, I had the responsibility of explaining the nature of their participation and declaring any potential benefits or disadvantages of taking part to the participants. I therefore acknowledged the participants' capacities and perspectives and their ultimate right to make choices about whether take part in the study, which would involve them in talking about their intimate life experiences.

To start with, I successfully registered the study with the University of Hertfordshire Research Board and proceeded to obtain a favourable opinion from the Health Research Authority after the study proposal was reviewed by the Research Ethics Committee. I finally applied for approval from the NHS Research and Development Department, which was responsible for providing access to the research field. Guidelines from these main stakeholders were adhered to throughout the research process. Also, the General Practitioner and Responsible Medical Officer of each participant were informed, with permission from the participants, about their patients' potential participation in the study.

Obtaining informed consent from the participants was done by sending invitation letters, through the participants' care coordinators, spelling out the purpose of the study and including a detailed information sheet about the study. A minimum of two weeks was facilitated to allow participants to freely make their choices. The voluntary nature of participating in the study was emphasised. All consent was accepted in written form as recommended by Ahmed (2014). The consent form and information pack used are included in the Appendices.

Reassurance was given to participants about the private and confidential nature of the research and their participation. Participants were assured of anonymity attaching to any of the research findings, and audio-recorded or transcribed material. Participants' names and

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personal identifiable information was anonymised, and these personal details were replaced by codes that only the researcher could identify and link to the respective participant. Audio records and subsequent transcriptions were kept in a locked cabinet where only the researcher would have access. All word-processed transcriptions were stored on an encrypted NHS computer. Giving assurance of confidentiality makes participants more comfortable in sharing and explaining their personal views (Cobb & Forbes, 2002).

3.8.1 Invitation and Consent

Participants were initially introduced to the study by their care coordinators, who gave them invitation letters together with the study information sheets. This was done following routine consultations between service users and their care coordinators. Only those who expressed an interest in participating were given the study information sheets. Ample time was allowed for potential participants to read and understand what was asked of them, and to discuss the study with their family or friends if they so wished. The researcher accessed contact details of potential participants to arrange times and venues for the interviews. Follow-up on non-responders, and reminders for the interviews, were managed by telephoning the participants with their previous permission. The researcher reminded participants of what the study was about and administered consent forms just before commencement of the interviews. Participants were invited to sign the consent forms as an expression of their willingness to participate.

Although the targeted sample may be classified as a vulnerable group, the inclusion/ exclusion criteria for recruitment of the sample were such that those who lacked mental capacity (Mental Capacity Act, 2005) were excluded from the study. The researcher observed that ascertaining the voluntary nature of consent given by mentally unstable participants would have been a challenge. In order to minimise data loss, participants were asked to consent to any information already collected about them during the study to be used if they lost capacity to consent. The issue of diminishing mental capacity during study participation was also addressed in the information sheet.

3.8.2 Data security

Personal identifiable information was stored on an NHS encrypted and password-protected computer to which only the researcher had access. A back-up file was stored on a password-protected NHS memory stick which could only be used on an encrypted NHS computer. Interviews were audio-recorded, and all the materials and instruments used were securely kept in the researcher's locked cabinet within a locked office.

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3.8.3 Confidentiality and record keeping

The Nursing and Midwifery Council - Code of Professional Conduct (2019) stipulates the essential responsibility for protecting all information about individual circumstances. Interviews were audio-recorded, and all the materials and instruments used were securely kept for safeguarding participants' personal information.

3.8.4 Research governance

Pseudonymisation is a principle concerned with concealing the identities of research participants in all documents and research material resulting from a study (Dativa, 2018). Anonymity and privacy were respected throughout the study. Identities and research records were kept private and confidential. Confidentiality guidelines assert that access to data provided by participants be restricted and only accessed on a need-to-know basis (Data Protection Act, 2018).

Caldicott Principles (1998) also provide guidance on how personal identifiable data should always be protected. All documents and research materials containing participants' personal identifiable information, such as names, dates of birth, addresses, telephone numbers, post codes and NHS numbers, were secured.

3.8.5 Data Protection Act (2018)

Guidelines of the Data Protection Act (2018) were adhered to throughout the research, and this entailed retention and disposal of the research materials and participants' identifiable information. Hard copies containing participants' personal identifiable information were kept under lock and key with a commitment to destroy these after five years following the commencement of the study.

3.9 Ensuring rigour of the methodological procedures

Given the potential risk of phenomenological studies derailing because of methodological challenges, the researcher equipped himself with different approaches that could be used to enhance rigour in qualitative studies. The underpinning philosophy of the phenomenological approach is that it rejects rationalists' bias in favour of intuitive attentiveness that discloses the individual lived experience (Creswell, 2009). Therefore, the essence is devoid of judgement of the phenomena and pays attention to a reflective grasp of knowledge without presuppositions and intellectualising.

This constructivist methodology is often criticised when assessed for reliability and validity against positivist trajectories (Farmer et al., 2006). The researcher acquired the relevant

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knowledge and skills involved in the processes of demonstrating methodological rigour which helped to enhance the integrity of the study outcomes. Denzin and Lincoln (2011) argued that qualitative research is distinct and separate from quantitative inquiry. While quantitative research focuses on causal relationships described in terms of observation statements, verifications and prediction, qualitative research thrives in the exploration of human behaviour and the search for understanding through people's actions.

3.9.1 Framework for rigour in qualitative phenomenological research

Lincoln and Guba (2011) described a framework for assessing rigour in research studies and this incorporated four factors, namely truth value, applicability, consistency and neutrality. They devised an alternative criterion to specifically deal with issues of rigour in qualitative research and which includes credibility, fittingness or transferability, auditability or dependability, and confirmability (Sandelowski, 2010). I will now discuss some of the standards that had a direct bearing on the current study.

3.9.2 Truth value

The truth value is probably the most important criterion used to assess rigour in qualitative research (Sandelowski, 2010). It is primarily concerned with the researcher's inquiry to establish confidence in the truth of the findings for the participants, and the context in which the study was carried out.

In this study, the aim of the researcher was to establish confidence in the truth of the findings based on an interpretive phenomenological design, the convenient sample and the context in which the research was undertaken. According to Lincoln and Guba (2011), assessment of a given inquiry's 'truth value' is based on the extent to which it establishes how things really are and really work. This view fits in well with the chosen theoretical concept of phenomenological research, which aims to discover the individual experiences as they are lived and perceived by the participants of the current study. I held on to the belief that the truth value is subject-oriented and not predetermined by the researcher; therefore the truth lies in the participants' expressions. This understanding is corroborated by the ontological position. However, Lincoln and Guba (2011) replaced 'truth value' in favour of 'credibility' and asserted that the internal validity of a study is based on the assumption that there is a single tangible reality to be measured and the researcher's role is to reveal this reality as adequately as possible. However, this assumption appears to gravitate towards the epistemological stance which holds that there is a single truth. Therefore, this approach was juxtaposed to my ontological position which embraced the possibility of emerging multiple realities as participants narrated their individual experiences.

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3.9.3 Applicability

According to Lincoln and Guba (2011), applicability in research refers to the degree to which findings can be applied to other settings or contexts. It entails generalisability of study outcomes to wider populations.

For this study, therefore, the essence was in recruiting a convenient sample that fits the inclusion and exclusion criteria. It was anticipated that this sample recruitment procedure could help to yield results that could be generalised to wider but specific populations of black African and Caribbean people who access mental health services elsewhere, outside of the research setting. However, in reference to 'fittingness and transferability', Barbour (2001) argues that we should not expect qualitative research to be measured against qualities that it was not designed for. Phenomenological work is not about gaining generalisability because each case, its variables and results, is unique for individual participants. Sandelowski (2010) also argued that generalisability is not always relevant to qualitative research inquiries. The strength of qualitative research is that it is conducted in naturalistic settings with minimal controlling variables; therefore, each situation is defined as unique with its design, methodology and participants being determined by a researcher. This implies that results of such studies are not always compatible with generalisations.

3.9.4 Credibility

Miles and Huberman (2002) proposed that credibility in qualitative research can be achieved by following specific steps. These include identifying and describing the study area, explaining the researcher's interest in the subject matter to be investigated, identifying his potential study participants and how they would be recruited on the basis of inclusion/ exclusion criteria, describing the research setting and methods of data collection, including the duration, and a justified proposal of the methods of data analysis. Credibility in qualitative research requires adequate submersion into the research setting by the researcher for recurrent patterns to be identified. These steps have already been discussed earlier in the chapter; however, submersion into the research setting was not necessary, given that this was a single case study where participants were interviewed only once. Submersion came about when the researcher started analysing the data from the interview transcripts and immersed himself with the data.

3.9.5 Auditability

Unlike quantitative studies, qualitative investigation focuses on the uniqueness of the human experience that is not necessarily accessible to the senses, which this study intended to achieve (Creswell, 2009). In response to the unsuitability of reliability as a measure of

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consistency, Morse et al. (2008) proposed the concept of auditability to be used as the criterion of rigour instead.

Lincoln and Guba (2011) asserted that findings of a study are said to be auditable when an independent researcher can clearly follow the audit trail used by the primary investigator during the study. In some cases, the independent researcher can reach similar conclusions by utilising the primary researcher's perspective, data and situation. This means that by spelling out the various methods and strategies used in sampling, data collection, data analysis and reporting, the auditability of the current study was increased. The implication is that there is a chance that the same results can be replicated by a different researcher using the same research materials and methods.

3.9.6 Reflexivity

There is need to recognise the constructed nature of qualitative analysis and its coherence to the research question through narrative analysis and reflexivity (Finlay & Gough, 2008). Reflexive qualitative research emerged within social constructionist, postmodern and discourse analytic work which promotes subjectivity and authenticates research as more real, insightful and objective.

Reflexivity in qualitative research is the awareness of the researcher's contribution to the construction of meanings throughout the research process. It involves the acknowledgement of the multiple influences that the researcher has on the research processes, and how the research processes affect the researcher (Gilgun, 2010). In carrying out the semi-structured interviews, the researcher observed the need to be reflective on his conduct throughout the processes involved. This involved examining himself as a researcher in relation to the research process itself and observing any assumptions or pre-conceptions that could potentially affect his decisions about choice of questions used in the interviews. Similarly, the researcher needed to observe the research relationship between himself as a researcher and the participants, and how the relationship dynamics could affect the quality of responses that the interviews generated. These observations are discussed further in the 'Limitations' section of the 'Conclusion' chapter, including reflections from my field journal.

3.9.7 Bracketing

In order to locate myself in the research process, I thought it prudent to briefly describe the concept of 'bracketing', which some researchers recommend for phenomenological work. Bracketing is a method used in qualitative research to mitigate the potentially deleterious effects of preconceptions that may taint the research process (Tufford & Newman, 2010). I observed that unacknowledged preconceptions held about a research project can potentially compromise the rigor and quality of the outcomes. From its inception, bracketing has been a

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contentious concept with tensions and misunderstandings arising on how it could be utilised, by whom and at what stage in the research process (Starks & Trinidad, 2007). However, the researcher is seen as the instrument for analysis and reflection across all phases of a qualitative research project.

The researcher's subjective endeavour entailed the inevitable transmission of assumptions, values, interests, emotions and theories - collectively referred to as preconceptions - within and across the research project (Beech, 1999). These preconceptions can potentially skew how data are gathered and interpreted, and the results presented. Therefore, bracketing can facilitate the researcher in reaching deeper levels of reflection across all stages of qualitative research, from selecting a topic and population, to designing the interview, collecting and interpreting data, and to acuity in reporting findings. The process of bracketing is evolving and amorphous, and as such has given rise to several tensions following Husserl's introduction of the phenomenological reduction (Paley, 2008).

Beech (1999) asserted that researchers need to be explicit about the process of bracketing so that others can observe and understand the rules of the game. Alternatively, should a researcher elect to follow a more Heideggerian position and reject the concept of the reduction (Scharff, 2018), it is important to maintain transparency around this decision as well, to articulate the researcher's reasons for following this course of action, and to describe the researcher's chosen methods. For Husserl (Gearing, 2004), the essence of phenomenology constituted a way to see the world anew and as it really is, rather than as it is philosophically constructed. Tapping this essence of experience and looking beyond preconceptions became known by various interchangeable terms: phenomenological reduction, epoche, or bracketing (Caelli, 2000; Gearing, 2004).

Heidegger, a later phenomenologist, rejected the concept of phenomenological reduction (Scharff 2018). Rather, he argued that fully comprehending the lived experience was an interpretative process, and that bracketing out preconceptions was neither possible nor desirable (Scharff, 2018). Instead, he adopted the position of being in the world, where contextual interpretation and meaning were sought and valued (Ashworth, 1999; LeVasseur, 2003; Gearing, 2004). His concept epitomises engagement as a means of knowing and stresses the importance of researcher subjectivity, given the close relationship between the researcher and the participant who both function as decision makers in all aspects of the research process (Heidegger, 1962). In contrast to Husserl's descriptive phenomenology, Heidegger's interpretive phenomenology eliminates 'bracketing' and posits that impartiality is not possible as researchers become immersed in the experiences reported by participants (Gearing, 2004). The rationale above prompted me to align with Heidegger's conception of

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interpretative phenomenology, rather than Husserl's descriptive phenomenology. Furthermore, my aim was to comprehend lived experiences of the participants within their given 'worlds' by adopting a critical realist approach.

In my detailed reflexivity account (see 'Conclusion' chapter), I discuss this concept of subjectivity because it was instrumental in embracing and surfacing the frames of reference that I brought to the inquiry, such as my preconceptions, the influence of my gender, race, ethnicity or cultural beliefs, and socioeconomic status.

3.9.8 Triangulation

Triangulation is another powerful strategy used to enhance credibility of research. Farmer et al (2006) added that consistency across data sets increases confidence in the results. The approach uses convergence of multiple perspectives for mutual confirmation of data and, by so doing, minimises distortion from a single data source or from a biased researcher (Speziale et al., 2011).

For the purpose of this study, triangulation was achieved by developing an interview schedule that was informed by BAME specialist professional opinions and those from peer support groups of black African and Caribbean mental health services users. While objectivity in quantitative studies is achieved and maintained using well-established boundaries between researcher and the researched, qualitative inquiry underscores the value of findings acquired by eliminating these boundaries (Heidegger, 1999). I observed that interpretative phenomenologists advocate minimising subjective from objective reality by reducing the distance between the researcher and the research subjects.

In qualitative research, therefore, the emphasis is on engagement with rather than detachment from what is sought to be known in a quest for the truth. Qualitative researchers accept that there are complexities involved with this lack of boundary, but that the advantages of this approach outweigh the disadvantages (Dickson-Swift et al., 2006). As for the current study, it was about acknowledging these potential complexities and managing them, as the aim was to reduce the boundary between the researcher and the participants. Lincoln and Guba (2011) proposed that confirmability should be the standard by which neutrality is judged in qualitative studies. Qualitative researchers seek the truth by interacting with, as opposed to disengaging from, that which is being investigated. Mays and Pope (2000) stated that comprehensiveness of data is achieved by a process of 'crystallisation'. The approach was valuable in aiding an element of corroboration and reassurance to the study outcomes.

Barbour (2001) warned of some challenges in performing triangulation because data collected by different methods emerges in different forms, and this defies direct comparison. Moran-

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Ellis et al. (2006) argued that there is always a possibility that methods used in triangulation may have similar flaws which then multiply and hide the error.

3.9.9 Member checking

Member checking is a technique used to continually test the researcher's data, analytic categories, interpretations and conclusions in conjunction with the respondents. It considers if data collected accurately reflects the participants' account of their experiences (Morse, 2008).

For the current study, this approach helped to ensure and confirm that the researcher accurately collected and interpreted data about participants' viewpoints. The process helped in ensuring accuracy and authenticity while decreasing the chances of misrepresentation of data. The researcher carried out member checking during data collection and transcription stages of the research process for all the participants. This was achieved by validating the responses that the participants gave during interviews.

In relation to this study, Mactavish et al. (2000) provided a key reference for aspects of interviewing people with less power and those with learning difficulties. The general focus was on using simple open-ended questions that were focused and specific. Cross-checking the responses is essential for such interviewees. Similarly, paraphrased questions with visual aids enable comprehension of the questions being asked and therefore increases the chances of getting accurate responses that require minimal checking. However, through convenience sampling the study succeeded in recruiting participants who were relatively stable in their mental health and, as such, were competent enough to participate in the interviews. The nature of questions on the interview schedule and the hierarchical arrangement was such that participants eased themselves into the interview.

While this approach enhances the credibility of studies, it comes with challenges. Ethical aspects of this approach will need to be considered to ensure that participants are not exposed to summarised data that may potentially affect their well-being (Morse, 2008). Also, respondents may have the tendency to internalise the data they receive during member checking and resultantly alter their subsequent responses (Seidman, 2006; Smith & McGannon, 2018). The key aspect in this approach is to not repeat the interview in any aspect of the wider project. Morse (2008) asserted that collusion may occur when some researchers disregard their own interpretation and accept those of respondents at face value. Atkinson (1997) described this as 'romanticising' the accounts of the participants.

3.9.10 Peer examination

Peer examination occurs when the researcher shares and discusses the research processes and results with colleagues who are impartial to the study but who have expertise in the

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research area and its corresponding methodology (Lincoln & Guba, 2011). This approach is based on the same principles as in member-checking and it involves discussing the study insights and problems in the form of a de-brief.

Peer examination and interface with my university supervision team helped keep the data gathering and analysis processes honest, and thereby increased the credibility of the study findings through validation by research experts and professional colleagues. The professionals were active members of the local BAME network group, with some actively involved in various other research activities. Colleagues who were independent to this study were better positioned to observe for any disconfirming or negative cases in my data analysis and presentation. The ability of these colleagues to identify deviant cases helped to demonstrate rigour and served to confirm the truths and eliminate bias. However, Barbour (2001) warned that 'peer review' should be used with caution because of the varied interests in qualitative researchers and the complexities inherent in qualitative data. An in-depth understanding of the study, beyond just the transcripts, is required otherwise a different researcher will come up with different coding categories. Armstrong et al. (1997) observed that researchers' original interpretations of data have been known to change after peer reviews.

3.10 The phenomenological process and application

After collection of data, the researcher started looking more at how a phenomenological approach could be effectively applied to this qualitative study. In further reading, it became clearer that there were some criteria by which the philosophy could be intertwined with a qualitative study design while improving its rigour. This involved using a framework to ask and answer the following probing questions: What philosophical assumptions are being implicitly acknowledged? When researchers bring their own beliefs to a qualitative research, what alternative paradigms are they likely to use? When a framework is selected as a lens for the study, what interpretative or theoretical frameworks are they likely to use? When designing or conducting qualitative research, how are assumptions, paradigms, and interpretive/ theoretical frameworks used?

I intuitively observed that phenomenology and its associated qualitative approaches can be applied to single case studies on purposive samples to achieve robustness in illustrating discrepancies and system failures, which this study aimed to do. I also observed that phenomenology fosters an effective process which exposes the presence of factors and their effects on individual cases. However, I had to adopt a tentative stance in suggesting their

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impact and extent in relation to the population from which the participants were drawn. The general principle of phenomenology is that of minimum structure and maximum depth; therefore, it was essential to avoid undue influence of the researcher while keeping a focus on the research issues. In this study, establishment of good rapport and empathy with the participants was critical in gaining in-depth information, especially considering that the participants had a strong personal stake in the issues that were being investigated.

3.10.1 Analysis process

It was understandable that phenomenological research presents a challenge to researchers because it generates a large collection of interview notes, digital audio recordings, jottings / field notes and other records, all which need to be analysed. The analysis process itself tends to be laborious as data generated does not automatically fall into pre-defined categories. The use of semi-structured interviews helped present data in a fairly organised manner once the data had been transcribed verbatim. Inductive data was analysed using the 'hermeneutic circle' as this approach is most appropriate for analysing interpretive phenomenological work. The approach allows for data to be continually reviewed and analysed between extracts from the transcripts and the whole of the text (Idczak, 2007).

3.10.2 Reporting

I observed that phenomenological research aims to report detailed comments about varying individual situations that do not lend themselves to direct generalisations, as is sometimes the case with surveys. Development of theory is derived from these detailed comments which can apply to the population from where the sample was drawn. The key in interpreting phenomenological findings is transparency, and this makes valid the findings and theory resulting from these findings. The process had to be clear for any reader to work through from the findings to the theories and see how the researcher has arrived at these interpretations.

3.10.3 Summary of findings

As explained in my Analysis section above, findings are arranged according to superordinate, subordinate and low-level themes, and these formed the headings and subheadings used in my Results chapter to represent key issues that were reported by the participants. The researcher remains 'faithful' to the participants and demonstrates an awareness of the inevitable biases being brought to the process of editing findings. This was achieved by reflexively acknowledging and declaring my own presumptions as a black African mental health nurse working for the NHS. Participants' subjective accounts, supported by direct quotes, had to come first, before any of my attempts to interpret the data. Plummer (1983) warns of an ethical issue of 'treachery' when information provided by participants in good faith is misrepresented, distorted or deleted for compatibility with the researcher's wishes. The

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findings of a phenomenological study can be reported robustly with an inclusion of direct quotes, sound bites and even more extensive quotes from participants in order to illustrate points. Connell (1985) suggests that sometimes it is beneficial to use vignettes of individual cases or participants, if this does not compromise confidentiality.

3.10.4 Discussion of findings

I considered how I could delve more into the study by making interpretations and linkages in the emerging data. This involved relating the findings of previous research in order to personalise experiences, and even relating those experiences to my own reflections in practice and then developing tentative recommendations for practice. Speculation and theorising in relation to some of the study findings is incorporated at this stage. However, interpretations and theories developed could not be passed off as more concrete than they really appeared in the data.

3.10.5 Implications of findings

This section involved making conclusions and recommendations at the end of the study. Again, the fundamental issue was to avoid finality and surety as this is indefensible in phenomenological research. This provided an opportunity to be more creative with ideas developed from the arguments and discussions. The focus here was the adoption of a suppositional stance with the arguments raised, and avoiding firm conclusions.

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Chapter 4 - Data analysis

4.1 Chapter outline

Essentially, this chapter is an extension of the Methodology chapter but draws special attention to the data analysis process and spells out the methods and techniques used in the process. In this chapter, there is a detailed description of how data collected from the 15 participants during semi-structured interviews was analysed. While particular focus is given to the analytic process of the data gathered, using guidelines from Smith et al. (1999) and Smith and Osborn (2003), it is arguable that the analysis process goes beyond the focus on just the data gathered, but also includes activities such as the transcription of interviews, and tidying up of the transcripts. This, therefore, becomes the starting point of my analytic work.

After the iterative process of reading and re-reading of transcripts to achieve familiarity with the participants' accounts, the researcher goes on to demonstrate the depiction of clusters of interesting issues arising from participants' accounts as taken from their individual transcripts. In order to facilitate the idiosyncratic analysis of each individual transcript, the layout of the transcript was adjusted to conform to the IPA guidelines and process.

The development of emergent themes that capture meaning in participants' accounts is explained before identifying convergence and divergence across the emergent themes from different participants. The researcher goes on to develop a master table of themes abstracted from individual participant themes, and clusters these according to relevance and meaning. Clustered themes are then used to develop a master table of themes containing superordinate themes, subordinate themes and low-level themes. The master table with aggregated themes is further developed to provide a framework with which results of the interpretative work are reported.

An audit trail of these activities is aided by tables and extracts from individual transcripts demonstrating the line-by-line coding as stipulated in the IPA process guidelines (Smith, 1999). In addition, to enhance rigour and quality of the analysis process and the study, some reflective considerations were made. Together with declaring the study's ontological and epistemological positions, there was need to work out my own pre-understandings or pre-conceptions about the phenomena under study and how these were managed to avoid obfuscating the generation of original data that truly reflected the participants' experiences. These concepts are briefly discussed in the 'Methodology' chapter and further elaborated in the 'Conclusion' chapter: they all demonstrate how data 'contamination' was minimised while validity and credibility of results was increased.

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4.2 Analysis process

After transcribing all the interviews and gathering the transcripts, it was now the mammoth task of reading through every individual transcript to get an initial impression of what the participants were saying. This was done while keeping an open mind, and avoiding making judgements or conclusions on the initial thoughts gleaned from reading through the individual transcripts.

4.2.1 Familiarising with transcripts

Reading and re-reading transcripts was done in order to familiarise myself with participants' accounts. This was achieved by the iterative process of reading each transcript repeatedly to become immersed in the interview transcript. That was followed by some initial reflections about what the participants were saying, and these descriptive clusters were entered in the left hermeneutic column.

4.2.2 Hermeneutic circle

The researcher analysed data using the hermeneutic circle as it is most appropriate for analysing interpretative phenomenological work (Idczak, 2007). The approach allows for data to be continually reviewed and analysed between extracts from the transcripts and the whole of the text. The hermeneutic cycle in interpretative phenomenology facilitates a process of understanding of how participants make meaning of their experiences (Welch, 1998). The hermeneutic circle is discussed in-depth in the previous 'Methodology' chapter.

4.2.3 Analytic framework

Smith et al. (1999) laid out some illustrative guidelines on the use of the Interpretive Phenomenological Analysis approach to analysing data from interviews, and these have proven to be valuable in the first order of analysis process: managing, coding and organising data. However, these guidelines have been criticised for being merely a thematic and simplistic approach, which does not fully engage in the IPA's interpretative modality (Larkin et al., 2006). To deal with this challenge, I drew upon the IPA's theoretical underpinnings, as discussed earlier in the 'Methodology' chapter, and integrated these with the IPA guidelines to embolden and enable the analytic process to go beyond the first order (descriptive) to the second order (interpretative) to comply with the IPA's theoretical stance.

4.2.4 Declaration of preconceptions

There is a clear link between IPA and the interpretative phenomenological philosophy elaborated by Heidegger, who posits that we are embedded in the world: a theory that it is impossible to step back from the world and set aside or 'bracket' what we already know by being in the world in order to view the phenomena from a purely objective position (Larkin et

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al., 2006). Such prior knowledge, also referred to as pre-understandings, pre-conceptions or pre-structures, need to be worked out and declared so that the researcher is not viewed as merely confirming their own truth when analysing data. Again, the IPA guidelines do not explain how pre-understandings should be worked out.

Therefore, I could not suddenly delete everything that I knew about the experience of mental health services by people of a black African and Caribbean background. Instead, I give a reflexive account of my prior knowledge of the research aspect: I am a community mental health nurse with a black African ethnic background and hold a significant bearing on the three elements of pre-understanding, namely professional, personal and socio-cultural. A more in-depth analysis and reflections on preconceptions has been included in the 'Limitations' section of the 'Conclusion' chapter.

4.3 First Order – Descriptive analysis

After adjusting the transcripts by removing any irrelevant material, I formatted all the transcript pages to be in landscape layout, leaving wide enough margins on either side to jot down notes. According to Smith et al. (1999), IPA guidelines recommend beginning the analysis process by reading each individual transcript a number of times and making notes of *"anything that strikes you as interesting or significant about what the respondent is saying"*, in the left hand margin of the transcript (Smith et al., 1999: p220). The diary I kept during the data gathering process using semi-structured interviews became useful at this stage as it served to highlight key themes that I needed to pay particular attention to during the analysis process. Therefore, I gave precedence to the participant's account and noted anything they said that gave an insight into their experience of accessing mental health services for the first time.

Below is an example of a transcript extract from one of the participants, demonstrating how I deduced and documented my initial thoughts in the left-hand margin. The process of abstracting themes was done in a circular fashion, a concept that was gleaned from the hermeneutic circle (Idczak, 2007). The approach allows for data to be continually reviewed and analysed between extracts from the transcripts and the whole of the text. See extracts below.

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4.3.1 Transcript extracts from Participant 300528

INTERVIEWER: So you are feeling that the staff can have their decisions made already that we are going to do this.

INTERVIEWEE: I believe some of them feel very much a pre-consider motion of what it was I was going through and I did everything I could to say that it is something I am choosing to do it is something that I know what is my life for and I know the process and the dynamics where my life currently is I understand this does not seem why would you want to put yourself through such discomfort, but it's knowing that at the end that discomfort is the thing that you are supposed to do for life and I think a lot of professionals I spoke to they couldn't understand why someone could himself through that

[margin notes: Early. Diagnosis. Spiritual process. Sacrifice – discomfort then reward. Self awareness]

INTERVIEWER: that was my next question I was going to ask you, how much do you think the staff understood your spiritual world, or issues to do with spirituality or was there any link there?

INTERVIEWEE: Ye, I don't think there was, you know they always did their best to try and understand elements of what it was but I mean, I can't blame them, I do understand it's not just specifically the staff, there is also how the world is and there is a bit misconception on spirituality when it goes to certain level, people just see someone that will cause the problem.

[margin notes: Staff operate within frameworks. Staff attempted to accommodate and understand his perspective. World. Pre-conceived frameworks. Misunderstood. Influence of preconceptions]

INTERVIEWER: How do you see your physical may be sort of elements about your background, the physical appearance, how do you feel that could have impacted the way that you have accessed mental health services? Have been on section? And

INTERVIEWEE: Em, I am not sure, I didn't face any direct racism or anything like that, I am very wary, I am 6ft 3", so I think naturally, there is a certain level of judgement that occurs, I do my best regardless to shift someone maybe to realise that I am not potentially what you will pursue to be from my physical appearance, so I wouldn't say that there was within staff that I can put any direct racism or anything I can pick, say that happened because of my skin colour, or image, I think it was more misunderstanding of my spirituality than just lack of understanding to what I was doing, to cause people to act that way.

[margin notes: Didn't experience in racism. Conscious about stigma based on physical appearance and bodily features. Staff misunderstood spirituality. Racism not evident. Lack of knowledge about spirituality among staff. Predisposed by physical appearance]

INTERVIEWEE: Correct, ye, and I told them, if that's the case then surely you don't need doctors then, because the pill will be doing the work for you, so, that was quite confusing, at the end of me having these conversations and then a few days later they forced me, I was actually pinned down by a few people and injected, so they injected, not sure what exactly what it was, that like I was very ill by the injection they gave me and also I can see some of the staff and some of the patients were distressed over that , so I showed the fact that I am dedicated to what it is that I am doing, I wasn't willing to take the medication, I don't feel there was a problem so at that point I decided and I knew that I was protected regardless and that I would take the medication orally, so I took the medication orally twice and I had a reaction to it, the doctor just said to me that the doctor has given correct and I had that reaction, I explained to them may be because it was likely to be because I haven't had medication in my system for over a decade, I don't have any medication, I don't take any aspirin, and also the fact that I have been away from animal products, kept away from bad meats, for a long period of time, so my body is going to be more sensitive than someone else, even after explaining that after the reaction, they forced me to try a different one, so I tried a different one and I had another reaction, after that I explained to them I wouldn't take any other medication unless it was explained to me and the doctor, after two reactions I had he forced me to try a third medication, so at that point I started to feel like a bit of a lab rat, it felt like rather than looking at what occurred since I have been in hospital look at reasons why I came into hospital whether they have improved or not, they just made up their minds in a way things to improve the way they see it, I didn't see that as an improvement , but the only for me to be normal like them would be for me to have medication and forced to take medication, so I was injected and then with three types of medication I tried which I had reactions to, at that point I said I had heart palpitations, sweating, quite a negative experience, I refused to take medication again, because how it feels like, rather than you looking at, what was the purpose of being in hospital than improvement have been made because I am not on medication was the problem, now is not about what's happening but is about the fact that I am not following the rule book that they put in place and because of that is a problem, so I didn't take medication for the following week, where at that point I believe they were worried because I put together all the things that happened since I have been in hospital and I was very willing to go to the papers. It has felt that xxxxxx because they can see having these reactions while I was on medications I was a lot more embarrassed so

[margin notes left: Resisted taking medication. Questioned the Dr's professional knowledge. Adverse reaction to injection. Other staff and fellow patients sympathised. His body was not used to medication. Agreed to take oral meds. Adverse reaction to oral meds. Felt he was being experimented on. No change for better in mental state. Perceived as a troublesome patient.]

[margin notes right: Physically Restrained. Forced medication. Personal opinion ignored. Compromised to take oral meds. Naivity to meds. Drug sensitivity. Confusion. Experimentation – guinea pig. No therapeutic benefits for being in hospital. Complaint about quality of care.]

As themes emerged from my initial analytic work, I had to modify and change throughout the analysis process any pre-understandings I had about the phenomena, just as deliberated by the hermeneutic circle. This resulted in new modified understandings that were liable to change yet again in light of further new understandings. For example, I had a preconception

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that most patients from a black African and Caribbean background experience racism in mental health services. I modified this standpoint when considering what a few participants had stated about *not* experiencing racism in mental health services. Other abstractions that transpired from this particular theme include experience of indirect racism, or a manifestation of stigma and discrimination. The last paragraph of the transcript extract above shows the abstraction of this theme which modified my presumption about racism in mental health services.

Another pre-understanding I had was about the presumed satisfaction of participants from being allocated key workers who resembled their own ethnic origin. This preconception transcended and was modified during the hermeneutical analysis process. The transcript extracts below from Participant 238867 shows how my assumption was modified after giving precedence to the participant's account. Participant 238867 refers to how assumptions were made that she would be adequately served if a key worker/ care coordinator was allocated from clinicians of a black African and Caribbean background. It emerged that the participant preferred a key worker who understood and was knowledgeable about her needs rather than someone allocated based on their matching skin colour or ethnicity.

> "*…I do different things and I want to sit down, like with my faith for instance, I want to talk to somebody regardless of who they are. Somebody who understands, somebody who may not be a Christian, may not be Muslim, so my care coordinator doesn't necessarily have to be black because I don't think that makes a difference…*"

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4.3.2 Transcript extract from Participant 238867

Felt let down
Doesn't want to engage any more.

Independence
Self-reliance.

INTERVIEWEE: So they say but I can't be bothered, I don't have that feeling for them, I just want to be independent now. Even though I am voluntary, I just want to be off the whole thing, it just really let me down badly, if the court behaves badly I expect the mental health to actually have a different outlook and say we had women and men who been assaulted, let's look into that, because that's the main part of the complaint, it is the assault and the fact that they didn't even look into that, really let me down. If I went in there and said, oh well, I have this issue and that issue, you know and I expected them to look into the assault and they did well I don't expect them , I can't expect them to look into that when my main issue could have been 'I don't like the colour blue', you know, but if I go in there with my main issue being, 'I was assaulted and this is what's happened the ex-boyfriend and all that stuff and what happened to me when I was living in that area, I expected them to say well actually she has been saying this for over two years, and I think my background, my heritage, my skin colour makes the reason why, my biggest thing is they don't want to spend any money. I am not saying I am an outright racist but I think there is a big ignorance there were no matter what's said they do treat people differently and also. I always said you don't have to get me black care co-ordinators, even though the nurses like me. With care co-ordinators, I don't think they necessarily have to be black, because my life style outside is not necessarily, you know, similar to certain people. It's not because I have become white, no, otherwise I will want white nurses all the time. No it's just I do different things and I want to sit down like my faith for instance, I want to talk to somebody regardless of who they are. Somebody who understands, somebody who may not be Christian, may be not muslin, so my care co-ordinator doesn't necessarily have to be black, because I don't think that makes a big difference unless you are coming from an area where you know. For me, the hospital I think, the nurses need to be reflective of who you are, so they understand.

Deprived opportunity.
Segregation

Lack of understanding by staff.

Wanted a care coordinator that understands regardless of race, colour, religion

INTERVIEWER: Ok, receiving what you need, that's what is more important than being white or black

INTERVIEWEE: Ye, that's what I think.

Thank you very much.

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Several other preunderstandings were encountered and adjusted as the analysis process progressed. Smith (2007) suggested that some pre-understandings do not always come to light until one finally gets immersed in the analysis work.

4.3.3 Hermeneutics of empathy / Left hand hermeneutics

Once the iterative process of reading the transcripts several times and adjusting my preconceptions was done, I kept an open mind on and gave priority to the participants' subjective accounts. Ricoeur (1970, p.32) referred to this process as *"hermeneutics of empathy"* or meaning collection (see Methodology chapter). Therefore, the notes I made in the left-hand margin gave an overview representation of experiences described by the participants. This was a result of 'fusion of horizons' between the researcher and the participant to bring out the phenomenon. Wertz (2005) states that the aim is to gather concreteness of participants' lifeworld experiences while being responsive to both the phenomenon and the subjective interconnectedness between the researcher and the researched. As is the remit of IPA, my aim was to go beyond participants' descriptions of experiences and delve more into the explanatory trajectory (Willig, 2001).

According to Larkin et al. (2006, p.113), in IPA the researcher is said to play a greater role in interpreting participants' experiential accounts further to produce a theoretical framework which is based on but may transcend and exceed the participants' own terminology and

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conceptualisations. IPA guidelines, as laid out by Smith et al. (1999) and Smith and Osborn (2003; 2015; 2015), do not explicitly distinguish the 'descriptive' and 'interpretive' stages of the analysis process. Perhaps this contributes to the way the two entities overlap sometimes and thereby preclude the demarcation line in the analysis process. I found it valuable to use the 'left- and right-hand hermeneutics' (see extracts above) to at least give a chronological order of my analysis activities.

4.4 Second Order – Interpretative analysis

Interpretative phenomenological analysis starts off with concrete descriptions of lived experiences which are often first-person accounts that are set down in everyday language and are devoid of intellectual generalisations. This, therefore, constitutes the descriptive phenomenological approach from which the researcher can proceed to reflect and analyse descriptions and produce a synthesised account representing the themes of the essence of the phenomenon. Interpretive phenomenology involves going beyond the surface expressions or explicit meanings to unearth the implicit dimensions by 'reading between the lines' (Ashworth, 2006).

4.4.1 Right hand hermeneutics

After going through all transcripts and jotting down my initial thoughts on the left side of the transcript, it was now time to embark on a more inductive process of interpretative analysis. The process involved writing key words or theme titles in the right-hand margin of the transcript that related to the initial thoughts I had written in the left-hand margin. According to Smith and Osborn (2003, p.66), these themes should be at a slightly higher level of abstraction, which may invoke psychological terminology. The skill involves identifying expressions that are high level enough to allow theoretical connections within and across cases yet remain grounded in the specific phenomenon that participants expressed. Further advancements have been proffered on how this interpretative analytic phase can be worked (Smith, 2004; Larkin et al., 2006) but I observed that such techniques are only applicable to the analysis of specific texts and the specific researcher's goals. Therefore, interpretation is not based on universal guidelines but is personal to the researcher and the interpretative resources at their disposal. In addition, however, I also recognised that IPA is not only a descriptive exercise but that it goes beyond the surface to extrapolate inductive data. My experience was that these higher-level theme abstractions could change in light of more fitting higher-level themes.

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4.4.2 Hermeneutics of suspicion

Upon reflecting on the theoretical underpinnings of IPA, 'hermeneutics of suspicion' (Ricoeur, 1970, p.32) was advanced as one of the most important interpretative resources. It can be used to gain an insight that a participant may not be aware of or may be unwilling to acknowledge (Smith, 2004; Larkin et al., 2006). Given that participants in this study were asked to reflect upon their experience of first contact with mental health services – a potentially distressing experience – they were rather cagey about their initial pathway experiences. Employing hermeneutics of suspicion in IPA required grounding in the participants' original accounts, located in the left-hand margin, and the actual expressions they made in the transcript text. This involved reading 'between the lines' of the participants' accounts to expose the hidden meaning within these texts.

For example, in the transcript extract below (lines 10-14), Participant 300632 said she had forgotten all that happened at the time she was eventually admitted to a psychiatric hospital. She described a very confused state of affairs in addition to concerns about her physical health and a pending surgical shoulder operation. After reading 'between the lines' using the hermeneutics of suspicion, it appeared that the participant was trying to deliberately suppress her recollections of events as they were too upsetting to her. I later used psychological terminology to describe the participant's experience and reaction as that of 'motivated forgetfulness', and that it was a form of coping mechanism. In further analysis using the hermeneutics of suspicion on other participants, I abstracted a few more themes such as pride (in not seeking help), self-efficacy, independence, resilience and others.

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4.4.3 Transcript extract from Participant 300632

Left margin handwritten notes:
- ...gaining self awareness.
- ...d a quick recovery
- ...: offered voluntary ...mission
- ...ld not remember 1st days of being ...itted.
- ...s worried that ...cannot for that ...d of time during ...mission.
- ...had mounting stress other physical health ...ons.
- ...et and BP remained ...despite taking ...lication for it.
- ...n time off work.

Transcript (center):

to stay there for 28 days I knew that from day one, from when I came back to myself, I remember the doctor saying to me your recovery has been very quick (ok, ok), my recovery was very quick. I didn't have any arguments with anybody I didn't, you can ask them

INTERVIEWER: But you appealed against the Section?

INTERVIEWEE: ye, my brother appealed against it on my behalf, because at the end of the day nobody asked me if I wanted to go into hospital?

INTERVIEWER: you were not given the option?

INTERVIEWEE: No, that's the thing, probably the way I felt I would have said yes. Or maybe, I was, the thing is my daughter said I was in hospital for four days and I don't remember a thing, (and you don't remember those four days?) no, it is frightening four days in your life you can't account for and I don't really want to account for it, but and the thing I get more upset about, is that I did so well with my operation, I went into the operation on my own, I took a cab, my brother was supposed to take me to the hospital, I didn't want my boyfriend to take me, my brother was supposed to take me in the morning. There were a lot of things building up to my operation, my BP was high, they couldn't get my BP down. My BP was up to 200. I had to have medicine while I was in hospital. I was going to the doctors to check my BP and it was not going down and I was getting upset, because they were not going to operate on me. They cancelled it the first time because my BP was too high and the second time, I had to be going up and down to the hospital. They signed me off work, ye, yea they phoned me at work and they said that, I went to the doctors and the doctor upset me because they gave me a letter to give to the doctor, because it was like, ok your BP is high and we need you to go to casualty, what were they going to do

Right margin handwritten notes:
- Quick Recovery process
- Not offer Admissions options not discussed.
- Vague memory of initial stages of admission.
- Frightened by loss of memory.
- Stress - from other health concerns - physical operation.
- Physical condition not responding to treatment or improving.
- Emergency situation with high BP.
- Stressed and upset for being moved around departments in hospital.

The extract above shows how the initial description from the left-hand margin of the transcript is further analysed and given a more abstract and psychological code 'coping mechanism'. One could say I have used the hermeneutics of suspicion because I have probed below the surface to uncover a deeper meaning that the participant may not have been able to see. Therefore, the participant may not know that her experience may be interpreted as a coping mechanism. As such, the interpretation exercise went beyond the participant's words and to a first order description.

Another example is Participant 300528 (transcript extract below). He was not keen to access help from mental health services and decided to change his lifestyle and intensify his spiritual practices in the hope that a physically fit body would translate into a healthy state of mind (lines 12-16). Using hermeneutics of suspicion, I observed that the participant believed that meditation, a strict, healthy diet and physical activity could cleanse any problem that he might have had with his mental health. He was, in fact, self-helping and I abstracted this to be a self-directed coping strategy.

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4.4.4 Transcript extract from Participant 300528

Tape 300528

Thank you very much for agreeing to take part

INTERVIEWER: Would you like to tell me a bit about yourself at the time you got admitted to the psychiatric hospital?

INTERVIEWEE: Yes, sure, so March 2015 I started an IT project and I left my job and I was fully focussed on this part-time work and going into create a business myself and running that fulltime, so I was looking at ways to make myself as strong as possible, put it that way, try to stay as healthy as possible, and I started looking to self-help type things and I was also just generally healthy, always looking into my health and fitness. So I went from eating a meal, I used to eat lots of junk food to be honest and I was really trying to find my place within the world I was. I've done music and sport when I was working in a recruitment job but I didn't feel like I found what I was supposed to do, so when I was writing social music I felt like, this makes sense for me at the moment, but if I am going to do this I need to do it seriously, so I cut down the amount of alcohol I was drinking, and I cut out all meals at that point and went vegetarian, and I am now vegan, so my journey after coming more involved in health I try to understand more ways to improve myself, let me to realise until that point I very much led a spiritual life, but not of the core spiritual principles, while I was learning spirituality I felt like, there was definitely an air of spirituality there and that fitted the way I was. So, saying that, I have always been very ambitious as a person and a type of person who follows my emotions so I go with what makes sense at the time, that very much landed me in the place that I was in, my project went from strength to strength and my spirituality and understanding while I was in recruiting became more and more evident and I was very much at home and everything was ok, (ye, everything was shaping up), that's right ye, I used to get a lot of anxiety, a lot of depression, I felt like, all that started to move away, so what happened was my business was going in one direction and it was certain amount of money from the project has been created and there was potential to become to an end, at the end I had to make a decision because with my spiritual life in terms of the level of meditation, fasting and the health side was a matter to make a decision whether to put that on the back burner and kind of really focus on the money side, or focus my mind on spiritual work and

Left-margin handwritten notes:
Left his job to start IT project
Wanted to stay strong and healthy
Stopped eating 'junk' food.
Liked sport and music but was not satisfied with a career in these.
Life was not making sense to him
Stopped drinking alcohol and became a vegetarian.
Pursuant of his dreams.
Business project grew and stagnated.
Spiritual lifestyle overbearing on his business project.
He was meditating and fasting

Right-margin handwritten notes:
Self-employed started a business project.
Health conscious
Self-help to maintain health and fitness.
Lifestyle change
Enhancing spiritual being
Dietary change
Ambitious and dedicated.
Indecision to follow his spiritual practices or focus on business project
Dilemma.

1

4.5 Contextualising the phenomenological claim

The second important interpretative component of the IPA process was drawn from the works of Heidegger (1962) (see Methodology chapter). The focus of this approach was to contextualise claims made by the participants and to locate these within their cultural, psychosocial circumstances and physical environments, and attempt to make sense of the mutually constitutive relationship between 'person' and the 'world' from within a psychological framework (Larkin et al., 2006). Throughout all the transcripts, my interpretative contribution was therefore driven by the quest to understand the meaning of an expressed experience and its given context. It was this second interpretative approach that I found most useful as it provided a platform from which to draw on contextual and cultural influences in making sense of the participants' experiences. Therefore, participants' decisions about accessing mental health services for the first time were not isolated constructs but shaped by context. As further interpretations were made within this hermeneutic circle, so my understanding continuously adapted and changed.

For example, Participant 271332, in the transcript extract below, described being isolated with no support networks at his disposal after his wife died. He states that his mental state deteriorated as he could no longer access the support of his resourceful (mental health social

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worker) wife. He was grieving for his wife and had the added stress of looking after a terminally ill son. He experienced a cultural challenge in having to physically look after his son, something that was not culturally acceptable in his native African country. His home was moved to an area that he was not familiar with and he thus felt isolated and experienced delayed input from the mental health services. He had the stress of stopping work and losing his financial resource with no access to public funds and had to wait for the Home Office Immigration services to approve his application.

4.5.1 Transcript extract from Participant 271332

Tape 271332

INTERVIEWER: Thank you very much for agreeing to participate in this study. I will start off by asking you about your personal circumstances when you first got admitted to hospital, tell me about your social circumstances, relationships and where you lived.

INTERVIEWEE: At the time I was living in ▮▮▮▮▮. I was working, always working since my wife passed away I became worse and worse. I went to social services to try to ask them to take care of me. At the moment under the care of ***** CMHT, they are the ones who look after me at the moment.

INTERVIEWER: Ok, ok, so what sort of work were you doing?

INTERVIEWEE: My last work was with the highway maintenance agency.

INTERVIEWER: Highway maintenance alright, alright. What about in terms of support networks?

INTERVIEWEE: Err

INTERVIEWER: Did you rely on your wife or anybody else in terms of support

INTERVIEWEE: Yes, she was so supportive, she was a social worker and since she passed away I just went from bad to worse, my son is also sick he has a life illness which is sickle cell, so a lot busy for me, I have no one I just have to be there, when there is a problem at school, I have to rush there to give him his medication, and even myself, I am also ill, so …

INTERVIEWER: Ok, where is your son now?

INTERVIEWEE: He is at school

INTERVIEWER: Is he doing well now?

Handwritten annotations (left margin):
- He was employed.
- Wife passed away
- Suffered a mental breakdown
- Sought support from Social services
- Under the care of CmHT.
- No longer employed.
- His wife used to support him.
- Wife was a social worker.
- He is a single parent and his son has a chronic medical condition
- No support from anyone.

Handwritten annotations (right margin):
- Collapsed support network
- Bereaved/grief stricken.
- Stressful life - single parent

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4.5.2 Transcript extract from Participant 161219

Participant 161219, transcript extract below, provides another example. He said he was distressed while sitting and crying in the churchyard as it was the anniversary of his mother's death. This grief reaction was culturally acceptable to him but the police who approached him mistook this for a mental illness. Events that followed were a catalogue of being misunderstood, wrongly accused and hoodwinked into going with the police officers, who later detained him under Section 136 of the MHA. All this made him very angry and resistive to any interventions that were being offered. Further assessments were based on his angry reaction to the mistreatment by the police force.

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Tape 161219

INTERVIEWER: Thank you very much for agreeing to take part in this study, where I am looking at experiences of accessing mental health services for the first time by people from a black African and Caribbean background. So, tell me a bit about yourself at the time you got admitted to a psychiatric hospital

INTERVIEWEE: Well I was under a lot of pressure em, because it was around the time of year, it was mother's day and obviously it is a difficult time for me because my mother passed away in 1996, ye and to add insult to injury that night, I was sitting outside the church crying my eyes out outside the church, sitting on the bench where my mum used to sit watching me playing and I was walking through town and two policemen pulled up, they are all friendly, ye, and they said we will give you a lift, this that and the other, I just wanted to go home to my Mrs. They pulled up out there , ye, one of them said wait here I'll just go and check and see she is up, I said the lights are on, of course she is up, then they asked her for my keys and, walk back round got in the car and beat me (oh), ye exactly and then they said I am going back to the police station, I just been in the police station the day before for something I haven't done, ye, someone slushed 18 car tyres round near where I live, (aha) I haven't even got the strength in my hand because my hands are disabled, (ye) you know what I mean. So you know it wasn't me that slushed the tyres either. The police were focussing on me and were trying to get me for something. That's how I ended up in the section suit, (ye, was it 136) ye, the truth is they round roped me in this man, they didn't give me my tablets at the police station for three days. I asked them to get me my tablets from my partner, they didn't give me my tablets for three days.

INTERVIEWER: So you missed your tablets as well, ha!

INTERVIEWEE: Ye, my Mrs gave them the tablets, but they didn't give them to me. It is bad isn't it. When I came out of there and they realised, I was actually unwell, because I had a seizure on the floor at the police station cell, because I was cold in that little blue suit they make you ware, (ye) they take your clothes, why do they take your clothes? (and you are cold) ye, there is not heating on in the cell. I was quite glad when they took me to the Section 136 suit, I thought I was going to be dealt with nicer people, framed for something by, - I thought I was

Left margin handwritten notes:
His mother's anniversary/crying
Remembering his mother outside the church they attended together.
Tricked to get in the police car
Assaulted by police.
Wrongly accused
Thinks he was lied on
Missed his medication while in police custody for 3 days.
Denied access to essential medications
Uncomfortable police cell conditions

Right margin handwritten notes:
Distress – Crying
Stress/pressure
Anniversary of Loss/grieve.
Police presence.
Tricked by the police
136 Detention
Police custody
Coercion
Relief – upon transfer from police cells.

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4.6 Analytic strategy

After reading through all transcripts to get an overview of the emerging themes, I selected a smaller sample of six transcripts for a more idiographic analysis process. This smaller sample of transcripts was used to help develop overarching themes that would form the basis of an explanatory framework. Following on from the guidelines of Smith (1999), the remaining nine transcripts were used to look for instances of shared themes that had already been identified in the first six transcripts, while maintaining the flexibility to identify and accommodate new themes that emerged. I was also mindful of and consciously aware not to impose any pre-understandings gleaned from the initial transcripts onto the transcripts that followed.

4.6.1 Developing an explanatory framework

This stage of the analytical process involved designing a strategy to meaningfully amalgamate the themes from the right hand hermeneutic. Guidelines on how to go about organising transcripts into low- and high-level themes were explained by Smith et al. (1999).

To start off, I created a list of themes, taken from the right-hand margin of the transcript, which captured meaning for each individual participant. See table extract below.

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4.6.2 Table 2 - showing the right-hand hermeneutic themes from an individual participant

Core themes from Participant 190643:
Stress
Inaccessible family support
Resilience
Protecting own family
Insight
Social stigma
Family dynamics
Stigma versus education
Inclusive interventions
Negative attitudes of senior clinicians
Perseverance of the nursing staff
Mental health crisis
Emergency hospital admission
Mental Health Act - coercion
Diminished liberty in inpatient environments
Stereotypical views by medical staff
Reluctance to access support
Community versus hospital-based care
Relationship with professional service providers
Negative expectations from services
Appreciation of availability of services
Cultural and spiritual beliefs
Late presentation to services
Self-awareness / reflection
Taboo of a mental health diagnosis in the family

As I listed the themes above from the individual transcripts, I was already starting to engage more with the data and observed that some of the themes could be clustered together under a unifying theme heading. However, I realised that clustering themes from an individual transcript was premature and could 'close down' the themes, subsequently restricting the process of reviewing themes across all six transcripts.

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Therefore, I designed a table with one row and six columns to represent the six selected transcripts. I listed all the abstracted themes from the selected six transcripts into their respective individual columns (see table extract below). The tabling of themes covered a few pages, but for illustration purposes I have used this single page.

4.6.3 Table 3 – extract of master table of themes from six selected individual transcripts

Core themes from Participant 238867	Core themes from Participant 300528	Core themes from Participant 161219	Core themes from Participant 271332	Core themes from Participant 300632	Core themes from Participant 190643
*Mental Health Act - Hospital order *Community Treatment Order *Criminal justice system *Anger from prejudicial practices by the court *Stress related to socio-economic circumstances *Striving for independence / self-reliant *Ruined relationships with friends *Rejection by new friends *Tarnished image *Stigma	*Self-employed – started an IT business project *Independence, left employed job to establish own project *Health conscious *Self-help to maintain health and fitness *Lifestyle change *Enhancing spiritual being *Dietary change *Ambitious and dedicated *Indecision to rely on spiritual practices *Dilemma	*Distress/ crying/ Stress/ pressure *Anniversary of mother's death/ grieving *Police involvement in care pathway *Mental health Act - S136 *Detention under the MHA *Coercion *Relief from being transferred to hospital from police cells *Fear *Physical abuse/attacked *Racial prejudice / discrimination	*Collapsed support network *Bereavement/ grief stricken *Stressful life as a single parent *Socially isolated *Home relocation *Disengage-ment *Delayed input from services *Oblivion / lack of insight *Rolling with the flow – no previous knowledge/ experience *Docility/ agreeable – anything is better than nothing *Free health care vs resourcefulness	*Lonely *Blurred memory about admission to hospital *Poor physical health – recovering from shoulder operation *Striving to maintain independence / self-reliance – resilience *Over-compensating pain by abusing painkillers *Distress – memories / motivated forgetfulness *Disorientated Confused *MHAct – coercion *Support network – family and solicitor	*Stress *Inaccessible family support *Resilience *Protecting own family *Insight *Social stigma *Family dynamics *Stigma versus education *Inclusive interventions *Negative attitudes of senior clinicians *Perseverance of the nursing staff *Mental health crisis *Emergency hospital admission

After drawing up a table to show individual themes from the six participants, I embarked on the next stage of merging the themes into unified clusters. The idiographic analysis process

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exposed themes which bore similarities and differences. It was now the task of sifting through these themes individually and collectively in order to meaningfully bring them together in a systematic fashion. Themes varied: there was divergence and convergence across all themes from the selected transcripts, representing varying experiences of accessing mental health services for the first time. I started to look for similarities between the themes across the table and colour coded them into clusters with thematic labels. These thematic labels would change from time to time as I considered more unifying labels. The extract below demonstrates how this was achieved.

4.6.4 Table 4 - extract demonstrating clustering across six participant transcripts

The process of clustering emergent themes was carried out for all six transcripts in accordance with their connectivity or divergence. The clusters were given unifying labels apropos of themes in each cluster. The remaining nine transcripts were analysed in the same fashion and emergent themes were allocated to the already established clusters developed from the six transcripts. At this stage, it was a matter of trying out different colour coded themes into clusters and allocating a higher order, or master theme name. I continued to refer back to the colour coded table of master themes and the individual transcripts with the original participant words, which were linked to the theme clusters and labels. As I continually looked for

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relationships between the grouped and colour-coded themes, other thematic labels collapsed, and their clustered themes were assimilated into other more fitting labels. However, it was essential to maintain a flexibility of the themes allocation process in order to manage newer emerging themes that could not fit in the existent clusters. I was mindful of the potential that the existent thematic labels could transform in order to accommodate important newer emergent themes, or the possibility of formulating new clusters altogether with accompanying newer unifying thematic labels.

4.6.5 Table 5 - Master table of all high-level themes abstracted from six individual transcripts

Stress vulnerability / exposition to negative psychosocial factors / Incapacitation / Emotional
Perception of mental health services
Reluctance / barriers to engaging with mainstream services
Dealing with adversities / Coping Mechanisms
Independence / Self-reliance / self-efficacy / Help-seeking behaviour
Reluctance of disclosure to families / Reluctance to seek support
Deterioration of symptomatology / Crisis breakdown / Escalation of symptoms
Perception of admission to a psychiatric hospital / Environmental factors – unsettled, noisy, risky, frightening, loneliness, negligence, uncaring
Involuntary admission / Coercion / Legal and procedural coercion
Experience of hospital admission – environmental factors
Inpatient welfare
Discrimination – indirect racism / institutional racism, segregated care practices, insensitivity to spirituality / ignorance / stigma
Relationship dynamics with professional staff / Senior clinicians / Junior clinicians / and between patients.

Finally, theme cluster names were brought together to determine high level, medium level and low-level themes. This allowed for concepts to be developed further within a hierarchical explanatory framework. Therefore, a concept that started as being overarching and vague was developed further by getting more and more specific while zoning in on the descriptors and

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interpretations of each concept. For the purpose of this study, I used a thematic hierarchy with terms such as 'Superordinate' for the high level themes, 'Subordinate' for the medium level themes - also referred to as 'Category themes' - and 'Basic' for the low level themes - which are also referred to as 'component themes'. However, these terms are used interchangeably with the terms high, medium and low themes. I developed a table to represent the thematic conceptual framework, which I used to report results of this study. Please see the table in the introduction of the following 'Results' chapter.

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Chapter 5 - Results

5.1 Chapter overview

In this chapter, I will present the outcomes of the interview transcripts analysis process. These outcomes will be categorised in a hierarchical order representing the superordinate themes, subordinate themes and subthemes. As depicted in Table 6 below, there are four main themes titled: Exposition and stress vulnerability, Coping strategies in dealing with adversities, Interaction with secondary mental health services, and Dynamics of therapeutic relationships. The findings are backed up by direct quotes taken from the study participants' own words during the interviews.

5.2 Table 6 - showing superordinate themes, subordinate themes and basic themes

Exposition and stress vulnerability	Coping strategies in dealing with adversities	Interaction with secondary mental health services	Dynamics of therapeutic relationships
Emotional instability and frustration	Striving for independence	Perception of community-based services	Relating to senior clinicians (positive and negative attributes)
Prejudicial disservice by state agencies	- Self-help - Reluctance to seek help	Perception of inpatient services - Emotional anguish (dissatisfaction) - Emotional exoneration (satisfaction)	Relating to junior clinicians - Feeling valued - Perception of victimisation - Variation in relationship experience
Feeling incapacitated	Help seeking behaviour	Enduring coercive treatment - Experiencing legal coercion - Experiencing procedural coercion	Relating to fellow patients
	Expectations from mental health services	Feeling discriminated against - Experiencing deprivation of psychological therapies - Experiencing segregated care provision - Experiencing cultural insensitivity	

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5.3 Exposition and stress vulnerability

An attempt was made to explore and understand the psycho-social, political and economic circumstances that the participants lived in, and to contextualise their first admission to a psychiatric hospital. Participants reported experiencing a multiplicity of similar and different vulnerability factors that were often clustered together and recognised by the researcher as causality hypotheses for mental health crisis. Vulnerability was observed to be multi-layered and intertwined across most of the participants' variable circumstances as they reported similarities in five main areas that potentially have a bearing on sound mental health or ill-health: these were mental stress / strain, finances, accommodation, family relations / carer support, and employment status.

This superordinate theme was further subdivided into two category subthemes for illustrative purposes by depicting 'emotional instability and frustration', 'prejudicial disservice by law enforcement agencies', and 'feeling incapacitated' in the first subtheme, while the second subtheme relates to the deployment of coping strategies used by the participants in dealing with adversities that they reported. Themes aggregated from this category theme include 'striving to be independent', 'help seeking behaviour', and 'expectations from mental health services'.

5.3.1 Emotional instability and frustration

In reflecting on the occurrence of psychiatric morbidity, some of the participants described going through emotional upheavals at the time due to grieving or bereavement. Participant 161219 was grieving in his local churchyard as it was the anniversary of his mother's death.He acknowledged that he was distressed and wailing as a grief reaction in the churchyard when police came and arrested him.

Participant 161219

> *"I was under a lot of pressure em, because it was around the time of year, it was mother's day and obviously it is a difficult time for me because my mother passed away on mother's day in 1996… ye and to add salt to injury that night, I was sitting outside the church crying my eyes out, sitting on the bench where my mum used to sit watching me play… two policemen pulled up, they are all friendly, ye, and they said we will give you a lift, this that and the other, I just wanted to go home to my Mrs but they took me into custody after wrongfully accusing me of slashing 18 car tyres".*

Participant 271332 had experienced a recent bereavement when his wife, and only source of support, suddenly died leaving him to look after their only little child who had a life-

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threatening health condition. It appeared to be a double tragedy for him as he struggled to look after his ill son single-handedly. He highlighted the stress that engulfed him by stating:

*"…she (*wife*) was so supportive, she was a social worker and since she passed away, I just went from bad to worse, my son is also sick he has a life time illness which is sickle cell anaemia, so a lot busy for me, I have no one, I just have to be there, when there is a problem at school, I have to rush there to give him his medication…"*

In some participants, emotional instability was a direct result of a great sense of loss in terms of an inaccessible family support network, relational dynamics within their families, or loss of livelihood. These are some of the factors that may have contributed to a sense of helplessness and feelings of stress as experienced by the participants.

Participant 190643 described a collapse in her support network as her mother was physically unwell and there were some ongoing relationship tensions within the family. She narrated her emotionally unsettling circumstances by saying:

"At the time there was a lot of turbulence in the family, my family is based in ***** which is not too far from *****, but my mum's health had deteriorated all the time so I had to take the responsibility of my brother. I didn't want to bother them at home with it so it's like, at that time my most important support network had kind of collapsed in a way"

Participant 300528 described experiencing emotional frustration when his business venture could not take hold after borrowing money from his family to finance the project. He seemed to have felt embarrassed and had lost his personal pride, both of which made his life very stressful:

"…I didn't know what to do, I was ashamed. Most of the money, my family had given me, I couldn't go back to my old job."

5.3.2 Prejudicial disservice by the law enforcement agencies

Accessing mental health services for the first time by the participants was often characterised by the involvement of police, or courts and other emergency services at the initial stages of their pathway. Some of the participants described experiencing unfair and prejudicial practices at the hands of these agencies, making them feel vulnerable and defenceless. To them, the police and the courts seemed to represent a force that could not be opposed or negotiated with towards exoneration. Participant 161219 felt that there was a misinterpretation of his cultural reaction to grief by the police, and he ended up being arrested for something he said

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he had not done. Detention under the MHA suggests that his grief reaction was medicalised into a psychiatric problem by the police when in fact his reaction was culturally appropriate to him. He appeared upset for apparently being lied to when the policemen hoodwinked him into getting into the car by making him believe he was being dropped off at home.

Participant 161219

He described how the police misinterpreted how he was grieving in a cemetery yard and arrested him. This participant may have felt misunderstood. However, being arrested after all the misunderstandings must have felt like added stress in a situation that was already stressful. It seems like it was a double jeopardy for this participant as it should follow that when one is grieving, one should expect sympathy. To be arrested and put in police cells after being wrongfully accused would therefore have been a harrowing experience of insensitivity by the police:

> "…I was distressed, I was thinking of my mother, …crying, and I thought the policemen were going to help but they detained me… How could they arrest me for crying when I was distressed?"

He was later detained under Section 136 of the Mental Health Act and transferred to a psychiatric intensive care unit.

Participant 238867 talked about how she had been entangled in the criminal justice system for unfounded accusations but ended up by being lawfully committed to a psychiatric hospital. She described being angry at the prejudicial practices of the court. To her, it appears, this was a miscarriage of justice:

> "I hadn't been charged so, sorry I haven't been found guilty of anything, yet still I was sent to hospital, eventually I was found not guilty afterwards, so that's one of my upsets at the moment, I still went to hospital, when I wasn't found guilty of anything"

5.3.3 Feeling incapacitated

The theme of incapacitation was derived from various personal circumstances that the participants highlighted as significant during their pathways to mental health services. The theme emerged as participants described their varying psycho-social circumstances which included exhaustion from overworking, limited resources to meet personal and familial obligations, lack of suitable and adequate housing, poor physical health, financial stress, the inability to work due to restrictive immigration status, diminished mental capacity, and living in an alien environment with no social contacts. Others felt unable to seek support from their

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families, or else the families were simply not available or chose to ignore the predicaments of their loved ones.

Participant 190643 stated that she was working in three part-time jobs whilst studying full-time at university. She had to look after her adult brother, with whom she lived and who slept in the same bedroom of a shared student apartment. She was reluctant to access support from her family after taking on the extra responsibility of financially supporting her brother. She carried further responsibilities from her church where she was an active member, and felt all her responsibilities were negatively impacting on her studies. It would appear that she was under immense physical and mental pressure from all her commitments. She described her psycho-social circumstances by saying:

> *"…my mum's health had deteriorated all this time, so I had to take the responsibility of my brother. I didn't want to bother them at home with it so it's like, at that time my most important support network had kind of collapsed in a way"*

> *"…I was a student, studying at the University of ****, I was living with three friends who were also students in *****. I had my brother lodging with me at the time. There were four bedrooms and me and my brother were sharing a room at the time"*

> *"My brother was 18 years old and financially, it was a bad time because I had taken on his responsibility and care, financially as well. So financially I was in a bad way at the time of admission and at the time, I was also working while studying. I was working in a number of jobs. I worked at a call centre for market research and I was working part-time at the university alongside my studies and I was also working as a supervisor for a teaching agency covering ***** and *****. So, I was working three jobs and studying full-time and looking after my brother."*

Participant 271332 experienced financial stress as he was not employed and could not be employed due to his immigration status. He did not have access to public funds and felt unable to support his little son who had a terminal physical health condition. His late wife had been the bread winner and his source of psycho-social support. Looking after his child as a single father and single-handedly, presented a cultural challenge to him as he felt it was unnatural for men to practically look after children. As an immigrant to the UK, he had no immediate family to turn to for support. He had been moved to an unfamiliar housing estate where he had no acquaintances and found it difficult to formulate a new friendship network. He felt socially

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isolated as even his neighbours would not talk to him. He highlighted the stress that engulfed him by stating:

> *"…she (*wife*) was so supportive, she was a social worker and since she passed away, I just went from bad to worse, my son is also sick he has a life time illness which is sickle cell anaemia, so a lot busy for me, I have no one, I just have to be there, when there is a problem at school, I have to rush there to give him his medication …"*

He further described the added stress of trying to secure income support and have his visa renewed by the Home Office:

> *"Since my wife passed away, I became worse and worse. I went to social services to try to ask them to take care of me. At the moment I'm under the care of *******
> *CMHT, they are the ones who look after me at the moment."*

He said he is no longer employed and is trying with difficulty to apply for income support as he has visa / immigration issues. He added that:

> *"I used to live on food bank because I had to send my documents to the Home Office and waited for them to respond. It just took forever, so I couldn't do anything until the Home Office responded."*

Participant 238867 reported feeling unsupported and ignored by her family as she struggled with a shoulder injury. Due to a surgical operation on her shoulder, her ability to perform routine household chores became compromised and her mental state gradually deteriorated into a crisis as a result.

She described losing all her independence and personal achievements that she had gained over time through hard work, and blamed this on being pursued by police and the courts. She had attained a status she considered admirable and was living in an affluent area, but all this was lost upon her being accused by the court. It seems she believed the police and court intervention was bent on character assassination as her life was reduced to a begging status and resulted in her living in supported group accommodation. In the process, it appears she became isolated, as friendships that she had made were ruined because of a perceived tarnished image:

> *"I was living here at ******* (supported living), I was actually working, self-employed, I wasn't signing on. I was having trouble with the housing benefit because I wasn't earning so much, but I was self-employed I was very busy doing a lot of things*

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and they just came in and, and just had no regard for my lifestyle outside, none what so ever. But I was still an independent person, I wasn't signing on or anything, you know, yeh".

"I was living in a really nice, a well to do area. I lost that property because of what was happening to me there, I became homeless and moved here."

Participant 172548

This participant talked about how she was struggling with a multitude of problems. It would appear she was under a lot of pressure and stress from having inadequate financial resources. Her housing situation as a single mother was under threat and this made her feel anxious and unsettled. She also had the added stress of a debilitating physical health condition and had contemplated taking her own life as she could not see a way out of her predicaments. Her historical child abuse experiences – physical and sexual – and poor upbringing seems to link to her incapacity to deal with challenges that occurred later in her life. She stated that she had multiple changes in her social circumstances:

*"As a single mother… I was living in *****, and I think it all came to a head when I was losing my home and I was in financial difficulties and all sorts of things. Also, I have physical health problems as well, I had a breakdown and I decided it was worth trying to commit suicide. I was admitted at ****, that's when I first got admitted to hospital."*

"In my background, I had lots of issues growing up, …this impacted quite a bit on the way I have been brought up. There was physical abuse, sexual abuse, … and all those kind of things."

Participant 161218

A few of the participants disclosed their psycho-social circumstances with reluctance but when they did, it was clear how they had become incapacitated by these circumstances. Participant 161218 talked about the divorce and separation of his parents and the passing on of a close relative occurring at the same time. He seemed to be bottling up his emotions and had no means of dealing with these emotions but to cover up by overworking himself:

"Okay, I lost confidence, I was very quiet, I was very shy, my mum and dad split up at the same time, that was another stress, …somebody close passed away at the same time… there was a lot going on. There were lots of stressful things happening at the time, ye, ye. I was extremely stressed last year, holding things

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in, feelings, emotions, family problems and some problems from colleagues. I was just over working myself, it was a build-up with a lot of things at times."

5.4 Coping strategies in dealing with adversities

Given all the various challenging psycho-social circumstances that the participants experienced with negative implications for their mental health, they all reported an attempt or attempts to deal with their personal circumstances in order to ameliorate any negative impact. Dealing with such adversities was on different levels for different individual participants. Some described self-help attempts to ease their situations, while some turned to their families for support and advice. Other participants had the perception that they were on their own and with no readily available or accessible family support networks. Others simply expressed a reluctance to access support from their families because they were resilient, or hesitated due to the implications this would have on their wider family unison. Within these dimensions, participants further reported how they tried religious prayer and spiritual practices such as mediums to alleviate their mental distress. It appears this self-help mode of thinking and response was triggered by what participants expected the experience of accessing mental health services would be. However, other participants declared a position of help-seeking when mental distress occurred because they lacked insight and resourcefulness.

5.4.1 Striving for independence

Self-help

This sub-subtheme is primarily to do with what the participants used as coping strategies to deal with their emerging mental health crises. Some of these practical steps include those reported by Participant 300528 - a change of lifestyle in the form of choosing a healthy diet, stopping alcohol, taking physical exercise, innovative self-help through music therapy, and practicing spirituality. **Participant 300528** said:

> *"I was looking at ways to keep myself as strong as possible,… trying to stay as healthy as possible, and I started looking into self-help types things, always looking into my health and fitness. I changed my lifestyle, cut out all the junk food, became a vegetarian and stopped drinking alcohol. I was really trying to find my place within the world so, I started writing music which helped…"*

Of note is that this participant denied having mental health problems. His opinion was that of accepting his uncomfortable situation as a spiritual process that follows an order of sacrifice and discomfort before realising reward or success.

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As with other participants, a denial or partial insight of the mental health problem was reported. Other participants described becoming withdrawn, and resorting to prayer while avoiding engaging their families for support.

Participant 275789 stated that he did not engage and preferred to self-help through religious prayer:

> *"CATT team started coming to see me at home. I didn't think I needed them, so I just prayed… I am still praying."*

However, the participant was able to engage after being discharged from hospital,

> *"…CATT Team got involved again afterwards, after discharge."*

Reluctance to seek help

There was a general reluctance to seek professional help reported by the participants. Reasons for reluctance to seek support from families, carers or friends were reported differently by different participants. Some wanted to face their difficulties head-on and without being a burden or seeking assistance from anyone. Some wanted to preserve an outward self-image of strength and cheerfulness, while inwardly they were emotionally riddled and distressed.

Participant 172548 strived to maintain her independence and self-reliance despite enduring post-operative shoulder pain. She started to overcompensate for her pain by taking more than the stipulated dosage of her painkillers in order to be able to look after herself and perform her household chores with less discomfort. She said:

> "*Em, a couple of friends supported me and they continue to get in touch, but I think my family sort of treat me like, ...because I have mental health problems, I am stupid".*

> *"I was here literally by myself and I had nobody to rely on, nobody gave a shit and suddenly I get admitted into hospital and I see everybody."*

However, a few participants reported being proactive in seeking help from their GP and receiving input from primary mental health care services.

Participant 301101 said she accessed primary care services via her GP when she first noticed some depressive symptoms and she was referred for psychotherapy, which helped initially until she disengaged:

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> *"I was quickly referred for counselling but when I started feeling better, I stopped going there"*

Participant 275789 described a reluctance to consult with her GP based on the belief that her problems would not be understood. She believed her problem needed spiritual or religious intervention:

> *"…no, no, no that did not cross my mind at all. You know, when you actually know that this problem does not require a doctor…"*

> *"…I needed strong prayers to remove the bad spirits…that's what I did, yeah."*

Participant 161219 described his wish to maintain a level of independence with a macho attitude and avoid spreading distress amongst his family members. He later submitted that men experience emotional vulnerability but still endeavour to be secretive about their mental health crises.

He acknowledged that he could have sourced support from his family and friends but did not wish to do so at the time that he was distressed:

> *"…there is my dad, my friends but I wanted to stay away from them, because you know I was mourning, and I didn't want to bring them down and make them feel sad and that."*

It seems to me that this participant wanted to protect his own family and friends from the distress that he was going through.

Some participants described clearly that they made a choice not to involve their families, relatives or friends upon the mental breakdown and preferred to self-help because of fear of being ridiculed and stigmatised for contracting a culturally unacceptable illness.

Participant 271332 stated that he did not have any family support after his wife died. All his family and relatives are in Africa. Even so, he decided not to let them know about his mental health difficulties for the fear of stigma:

> *"I don't talk about it… I just keep myself to myself and try to do as much as I can to keep well. I only talk freely to professionals."*

It appears mental illness was perceived as a taboo subject within his family. Moreover, there was little else that his family could have done as they were all back in Africa.

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Participant 190643 was asked about availability of family support and said:

"…I didn't want to be a burden. I kind of did my own thing and another part of my support network at that time would have been church, …there again, I thought like, I was better off keeping to myself because it was a growing church. So, my support network is not like I didn't have one but at the time, it just seemed everybody was from my view, unavailable or very busy."

She added that she did not want her immediate family to know about her illness and eventual admission to hospital:

"…maybe it was my personal character, I don't like being a burden and sometimes I become paranoid whereby I feel like I am an excessive burden to everybody. However, no one told me that and at the end of the day, my mum is my mum, it's her duty, but I always kind of had that feeling where I didn't want to be a burden."

5.4.2 Help-seeking behaviour

The basic theme of 'Help-seeking behaviour' emerged as a result of participants narrating their ordeals of further deterioration in their mental state. I observed that, in as much as most participants reported some level of resilience in dealing with their mental health crisis, clearly some situations became out of control. In some cases, participants appeared to lack insight into their deteriorating circumstances and did not see the need to ask their families for support or to seek professional help. Inadvertently, it appears most participants experienced a worsening of symptoms characterised by more distress, increased vulnerability, emotional instability, self-isolation, and a sense of oblivion and dilemma.

For example, **Participant 300528** reported having a dilemma to either pursue his spiritual practices or to consult medical professionals, until his family intervened and took him to a doctor. He stated that:

"CATT was involved after being contacted by my family because their concerns about my mental state and behaviour had grown. I had a decision to make, either go with my parents or pursue my spiritual practices. I didn't really feel I needed CAT Team to come and visit me at home."

He said he did not accept mental health services as he did not believe he was unwell, so he did not engage.

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Most other participants also reported that their families, carers or friends became involved at the crisis phase and helped to facilitate access to primary care or secondary mental health services.

Participant 242575 stated:

> "I got really paranoid I was like scared, I thought somebody was going to kill me, so my parents got involved and took me to the doctors as well as being seen by the Crisis Team, they were pretty concerned and angry because they blamed my cannabis use, which doesn't help from their point of view."

Participant 159205 described circumstances leading to her admission as unclear:

> "…they did not know what was wrong with me, maybe I was psychic or suffering from, late… oh you know when you have a baby and you have problems, what do you call that? …everything happened so quick and I was taken to hospital."

However, **Participant 271332,** who did not have any family or friends, was proactive in seeking help from professional services:

> "…I wanted help, any help I could get, …they are the professionals, so I just follow what they say, I am not a doctor."

Participant 190463, who remained resilient without support from her family or professional services, experienced her situation deteriorating into a public emergency where police and ambulance services got involved and conveyed her to a psychiatric hospital under restrictive measures. The participant said:

> "My first ever contact with the mental health services and probably most other contacts from there onwards would be when I was really in a bad way. So, I won't have a particular recollection of what was going on at the time but it would have been, or especially the first occasion, the first occasion, I was out of control and I told myself…, I am not in a good way, I am not very…, what I am experiencing is not what everyone else is experiencing. To be honest my first admission for me, I can't really recollect it that much."

She later said:

> "…I was told that I left the house, I left the house screaming and I left like, with no shoes on, no clothes on apparently, one of the ladies I lived with at the time she came after me and apparently, I wanted to stay away. I thought she was bad

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and had bad intentions and somehow an ambulance was called and that's how I was brought in."

Accessing the first and second tier of mental health services – GP / counselling services and secondary mental health services - provided an opportunity for any further deterioration of symptoms to be arrested. However, most of the participants reported receiving input from such services in the aftermath of crisis and therefore a worsening of symptoms was inevitable.

Participant 161218 said:

"I was not receiving any support, things kind of boiled over because I was not expressing myself that I needed help. There was no support, so things build up ye, ye. …at the time, I didn't know what was wrong with me. I don't want to talk about that... I will try to give you as much as possible, but I didn't know what was going on at the time."

Participant 169043 reported that he could not clearly remember the precipitating events leading to his admission but said he was experiencing mood fluctuations and engaging in self-injurious behaviours, including attempting to end his life by hanging:

"…on various occasions I self-harmed because this was my way of coping with many issues in my life. My mood would fluctuate on an hourly basis: I could be happy one minute and just go down drastically…"

Participant 271332 stated that he could not remember exactly what happened before he was admitted to a psychiatric hospital:

"I don't really know, I don't know anybody that has been in that situation before, …I was completely lost, I don't really know what to say to explain my situation at the time."

Participant 172548 initially said she could not remember what events led to her admission:

"I can't remember, I think I was referred to mental health services, I think that's what happened I can't remember''

"I took an overdose."

However, other participants reported having access to their GPs and counselling services, which helped in ameliorating further deterioration of the mental health crisis. As such, this slowed or halted the deterioration process that would have inevitably warranted emergency admission to a psychiatric hospital.

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Participant 238867 stated that she had a good relationship with her GP and had been referred to counselling services via the GP. She said:

"*…my GP sent me to ***** to have a mental evaluation, not because she felt that there was something wrong with me, but because of everything that was happening to me, she wanted me to feel comfortable …*"

5.4.3 Expectations from mental health services

This subtheme essentially captures what the participants anticipated upon realising the inevitability of contact with mental health services, whether instigated by families / carers, self-referrals, or by law enforcement agencies. Being their first contact with mental health services, most participants were at a loss as to what to expect from such interaction.

Participant 161219 gave a negative outlook on his expectations from mental health services. He said:

"*I didn't know what to expect really, I had like all these images in my mind of like; horror movies, strait jackets, electric shocks and that sort, but it was nothing like that at all.*"

Expectations from mental health services seemed characterised by anxiety and fear of the unknown. Some expectations seem to have also been shaped by what participants generally knew about mental health services through learning from family, friends or media. Others identified a reluctance to engage with mental health services because of their perceived stigma attaching to mental illness.

Participant 190643 described her perception and expectations from the service by recalling the admission phase:

"*Em, negative, very negative, it is really hard to look at how I would have perceived things then, but again the first day on the ward, I always say when you are first admitted to the ward, everyone looks really, really crazy (*laughs loudly*) after those negative views, generally when you think of a mental health unit, you think of these colloquial terms like the mad house, or asylums, you know what I mean, just hospitals in general is not somewhere anyone wants to be. For mental health, this carries a lot of stigma you know.*"

Participant 169043 expressed that he did not know what to expect from a psychiatric hospital admission. However, it appears he had a negative outlook and no anticipation of comfort in a

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psychiatric hospital. It also looks like he expected psychiatric hospitals to be isolated from the community settings. This is what he had to say:

> *"Well, I heard about it from people who got locked up after being taken away from the community, I knew it wasn't going to be sofas and lying down watching TV, watching films and relaxing, I knew it wasn't going to be that…"*

Most participants reported negative notions about getting involved with mental health services, and it is my interpretation that such views expedited the formation of barriers to accessing mental health services voluntarily and, conversely, acted also as motives for participants to resort to self-efficacy in the first instance. Participants described their expectations of being involved with mental health services and getting admitted to a psychiatric hospital in various ways.

Participant 300528 expressed he had initial hesitance as he thought he would be negatively judged due to his physical appearance, but his opinion shifted:

> *"…there is a bit of misconception on spirituality when it goes to a certain level, people just see someone that is out to cause problem''.*

> *"I didn't face any direct racism or anything like that, I am very wary, I am 6ft 3ins, so I think naturally, there is a certain level of judgement that occurs simply from someone's physical appearance, so I wouldn't say that there was within staff, any direct racism or anything I can pick and say, that happened because of my skin colour, or image, I think it was more misunderstanding of my spirituality…"*

It would appear that this participant was concerned by his physique and how this might have been a predisposing factor for him to be 'othered' and judged as troublesome.

Some said they expected to be in captivity within unsafe environments where they would feel vulnerable. It appears some thought being admitted would mean losing all personal freedom and liberties as well being subjected to restrictive and regimental drills.

Participant 169043 stated that he expected a psychiatric hospital admission to be like a trap, and used the term 'strait jackets' to imply the restrictive nature of such environments. He said hospitals were for crazy people, who do drugs, who hang around in streets doing nothing, and thought this was not for him.

The participant in this instance seemed to suggest that getting admitted to a psychiatric hospital was like a punishment, and therefore getting a mental health problem was equivalent to committing a criminal offense.

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It appears other participants expected to be socially isolated in scary environments with regular punishments imposed. A few participants associated psychiatric hospitals with prisons where they would be kept sedated, medically tranquilised, punished and humiliated.

Participant 172548 described having very negative expectations from mental health services. She referred to stories that she had heard about people who get admitted to mental health hospitals. She said:

> "I was really scared when it became clear to me that I was getting admitted to a mental institution. All these stories I had been told before, …I was like, now this is real"

> "It was very unsettling but… what could I do? I couldn't run away… where to?"

However, other participants expressed positive expectations.

Participant 271332, oblivious though he was about mental health services, said he was desperate to get help, and described his presentation at the time as a cry for help. He had no prior knowledge about mental health services from his native African country, and appreciated the prospect of free health care. It seems that the participant did not know what to expect from services as he had never known anyone who had experienced the same problems and been admitted to a psychiatric hospital. He gave a comparison between the NHS and his African cultural background:

> "I think money talks, if you don't have money; you are just on your own. So, if you don't have money you will suffer or even die"

> "…in my case, hospital was the answer and I agreed with everyone there who tried to help me, and I worked with them. If my family was here, they may have suggested dealing with the problem by other means".

Using the 'hermeneutics of suspicion' here, it appears this participant was at liberty to seek professional help for his mental health problems without any constraining factors. Provision of free NHS health care was one pull factor for him, but also the absence of his family made his access to mental health services a much easier and unhindered process. He said that if his family had been around, the problem might have been dealt with differently. My speculative view is that these 'other means' referred to by the participant may suggest interventions such as prayer or other traditional means where, in the initial instance, cover-up of the mental breakdown may have been used to avoid bringing shame to the family. Moreover, considering that a mental breakdown was considered as a taboo in his family, the participant may not have

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had the courage to disclose to family members about his mental health problems or have been proactive to embrace help.

Participant 242575 asserted:

> *"To be fair, I went in there not knowing what to expect really, what help they could offer but they did seem genuine and, …like they really wanted to help me find solutions if the medication wasn't suitable. They would try different steps and offer different advice and ideas for me to try, so they were very helpful in that respect".*

> *''I was very late to present myself for help but when I saw them, they were there for me, so I appreciate that, because I was very low and I did need some sort of help at the time and they were there and they helped me in the best way they could, so in the end I ended up kind of better".*

5.5 Interaction with secondary mental health services

This superordinate theme draws on participants' overall experience of the secondary mental health services: from community-based services through to inpatient services. It is subdivided into subthemes in order to categorically demonstrate the participants' experiences at different levels of the service. These subthemes are 'perception of the community services', 'perception of inpatient services', 'experiencing coercive procedures', and 'experiencing discriminatory care'.

We have seen previously that participants had a great deal of reluctance to get involved with mental health services. Participants described an array of perceptions based on experiences from interacting with mental health services, be it in the community or at a psychiatric hospital. Perceptions and attitudes about services was a mixture of positive and negative experiences, implying satisfaction and dissatisfaction.

5.5.1 Perception of community-based services

The community-based secondary mental health services that the participants predominantly reflected on were the CMHTs and CATTs. While having access to the service of a multidisciplinary team in CMHTs, participants were also allocated care coordinators or key workers. With regard to accessing these services, participants reported significantly negative experiences characterised by various factors.

Some participants expressed dissatisfaction with delayed interventions by community mental health teams and inconsistency in the allocation of care coordinators. It appears the implication of delayed intervention and inconsistencies in allocation of care coordinators by

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CMHTs is directly responsible for the further deterioration of mental health that participants experienced. The constant change in care coordinators may suggest that participants experienced difficulties in formulating therapeutic relationships with these health care professionals. It appears there was a gap in care provision in view of the lengthy periods of time that participants would spend without access to a care coordinator.

Participant 172548 commented on the lack of consistency:

> *"You don't really get that much of a relationship because, up to so many months, you get a different one, they always keep changing the care co-ordinators, people are on leave and all those kind of things, they keep changing the care co-ordinators, …you can't build up a relationship…"*

Participant 271332 also described a lack of consistency with care coordinators:

> *"…I have seen so many people already. It is like today I might see somebody else and then tomorrow another, so I can't say this one is my keyworker, as I see so many".*

In some cases, participants found it difficult to form and maintain therapeutic relationships with their care coordinators or with staff within other community-based teams, and that may have contributed to the significant disengagement rate reported by participants.

Participant 275789 stated that he did not engage, and preferred to self-help through religious prayer. He believed there was no need to get help from anywhere else except from his prayer efforts and religious community:

> *"I did not get involved with any of the community services and I did not go to ask for their help. Praying and meeting members from my church is all I ever wanted …Prayer is the answer to all problems."*

However, he later described getting support from the Crisis Team after he was discharged from the mental health hospital.

Participant 242575 was referred to secondary mental health services by his GP. He said he remained under the care of CMHT until he thought his symptoms had improved, and then disengaged. He relapsed and came under the care of CATT. He expressed that he did not engage with community mental health services after being discharged from hospital. It appears the participant was no longer interested and had lost confidence in the community services:

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> *"…I went back to work, so I was just kind of, eh, like …once I was out of their grip, I was gone. I was back to work and I lost contact with them, I even wrote a letter to them saying I don't want to be part of them and I would like to discharge myself from CATT. I was gone."*

Participant 300528 stated that CATT was involved after being contacted by his family when their concerns about his mental state and behaviour intensified. He said he did not agree with the services and therefore did not engage.

Participants also described a lack of sincerity and dismissive attitudes from community-based staff. Participants seem to have felt unsupported and ignored by the services' personnel and, in some cases, were ridiculed and embarrassed.

Participant 169043 stated that he had access to community-based care through CMHT. He was visibly still angry about a particular experience he had with an allocated care coordinator. He said:

> *"I had one negative experience on the way to being admitted to hospital, …I think he was a CPN, I wouldn't have done what I did to myself if only he would listen to what I was telling him… I was telling him I am suicidal, I am depressed and he used to tell me, just go back home and have sex …and when I went home, quite often, I was hitting a brick wall. I don't think I was getting the help I needed, I think he wasn't helpful at all, nobody would assess somebody who is suicidal or depressed without taking action to arrange appropriate care."*

Other participants expressed mixed - positive and negative - perceptions while others described positive experiences.

Participant 161218 stated that she accessed secondary mental health services through the CMHT and that her experience was mixed. She said:

> *"I got a care co-ordinator straight away, he was a social worker. I think he was a bit different; he was hard to adjust, and I don't really talk about my feelings and thoughts. At the time, I didn't know what was wrong with me, it was very hard to adjust, the second person I had was very good and she was a black lady as well. She just happened to be a nice person, in general this helps."*

On a more positive note, **Participant 190643** described having no access to community-based mental health services but acknowledged being referred to the Early Interventions in Psychosis Service (EIPS) after discharge*:*

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> *"I was allocated a care coordinator from that team and she would attend different meetings with me regarding my care."*

She also stated that she was given access to services from CATT and ADTU post-discharge.

5.5.2 Perception of inpatient services

This subtheme was derived from what participants described as their general experience once they were admitted to a psychiatric ward. Participants expressed varied opinions of satisfaction and dissatisfaction with the inpatient service. Reflecting on the period of inpatient admission to a psychiatric hospital triggered a variety of responses from the participants. While a general overview of responses gave a rather balanced outlook on these experiences as either being positive or negative, it became necessary to gain more clarity on what the participants reported. These terms and phrases have a direct reference to how the participants experienced the period of being a patient on a psychiatric ward. Participants made comments about the hospital environment, food, treatment, and therapeutic bondage with the professional staff, communal time and others. Therefore, in order to understand further, the subtheme was compartmentalised into subheadings, 'Negative attributes / Dissatisfaction' and 'Positive attributes / Satisfaction'.

Dissatisfaction with inpatient experience

Some participants described their experience of being a patient on a psychiatric unit as frightening and, at times, they felt threatened by staff or other patients. It seems the participants were scared for their own safety within actual places of safety. This juxtaposition is more precisely presented by one participant who experienced a conflict of personal attitude and opinion. He acknowledged the need to be in hospital for his own safety but, at the same time, felt scared for his own safety by being in a psychiatric hospital. There appeared to be a clear sense of experiencing isolation and vulnerability when participants expressed fear of the hospital staff and fellow patients.

Participant 169043 described how he had a personal conflict of being afraid to stay in hospital but also iidentified it as a safe haven. He said:

> *"I didn't know the mental health system at all, but it was like, I was a prisoner. When I imagined I can't get out you know, I got so frightened. It was not like being in a hospital, it was frightening."*

Later, the participant reflected on his experience and said:

> *"I knew I had to be in hospital to be honest, I knew I had to be there, but it was also my greatest fear. I was putting it off and putting it off until when police came*

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around. By then, I wanted to go there, I knew it was for my own safety, I had to go, ye, you know".

Others described the environment to be unsettling and noisy and, as such, found it difficult to rest or sleep properly. It appears the hospital and ward environments were perceived as neither therapeutic nor conducive to rest. One participant goes on to describe that the food or dietary choice was not inclusive, and he felt restricted when he wanted to attend to his own personal hygiene. My interpretation is that this participant may have felt neglected as his dietary requirements could not be met, and he could not attend to his personal hygiene as he wished without being monitored and may have found this experience to be embarrassing.

Participant 300528 commented on his experience by saying:

"…the main thing that helped me was sleep but when I first got there, I had no duvet, just a thin sheet like blanket so I was cold and my sleep was compromised, the food was not great and in terms of exercise to keep your mind stimulated, there was no encouragement to be physically active."

He also stated that:

"…the focus was on medication, no offer of alternative therapy"

"I had problems with hygiene while I was in hospital, the rooms were locked, so I was unable to get into my room and I had money stolen."

Participant 238867 described feeling angry and frustrated upon being committed to a psychiatric hospital by the courts. She expressed her distress upon being committed to a psychiatric hospital under a Hospital Order section. She said:

"I was angry, I am still angry …Why did they decide I have to be sectioned and put in hospital? …They didn't prove that I was guilty, …but they still sectioned me and forced me to go to hospital. They (court) had made their decision and I had no power to protest …I wasn't talking when I arrived there …the senior staff were disparaging. I didn't like it there, …the junior staff tried to make me feel comfortable."

Other participants referred to feeling trapped like a prisoner who is locked up with no freedom to interact with the 'outside world'.

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Participant 242575 described the ward environment by saying:

"…the set-up of the surroundings determined how you felt"

"Ye, (laughs) mad house! I can imagine being in a prison, not much of a life, hardly any actually. I can imagine people can be really down in there because everyone is on heavy medication, some of the rules can be very strict just like in prison, so that's why I wouldn't want to go there anymore."

It would appear that the above participant's opinion was that the non-therapeutic environment of a psychiatric ward could cause patients' mental conditions to deteriorate further.

Patients from a Caucasian background were seen as unfriendly, aggressive and violent at times and this made some participants fear for their personal safety. At least three participants reported that they lost their belongings in the psychiatric hospital. **Participant 161219** ended up in a fist fight with other patients who he claimed were targeting him. This must have been a frightening and unsettling experience for him as he may not have expected such incidences to occur in a hospital setting.

"…two fellow patients attacked me physically in hospital because of racism, they selected me twice, three times, …the third time I said no, this man is not going to hit me, I am going to hit him, ye, so it was a bad experience, it was horrible, I was locked in there with them, you know they hate you and that something bad is going to happen to you"

"…so, I defended myself…"

Some referred to feeling isolated and being like an outsider once they were admitted to hospital. Therefore, participants may have felt uncomfortable due to being of a racial minority on a psychiatric unit. It appears to me that the participants had to deal with some intrinsically underlying issues of 'othering' as they entered what they may have perceived to be an alien environment.

Participant 161218 stated that he felt uncomfortable to be admitted to a ward where he was of a racial minority:

"I did feel like an outsider when I went into hospital because I was the only black person there as a patient, I didn't feel like the other patients liked me. I felt threatened sometimes, but the members of staff made me feel comfortable."

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However, others derived comfort from seeing professional staff of similar ethnic backgrounds. It appears this sense of comfort was derived from the solidarity of a similar ethnic background. The symbolic order of ethnicity might have triggered this sense of comfort between the participants and ethnically diverse professional hospital staff.

Participant 161219

> *"…the cultural mix had to be good with the amount of Black, Asian and Minority Ethnic staff. Sometimes there was more black staff really* (laughs). *It was alright, ye, I am not going to say it was positive strictly because of that reason, it did put me more at ease with other things, …you are thinking, these people can't just like kill me and bury me at the back of something,* (laughs loudly). *The black people wouldn't let them."*

For another participant, the isolation was on two levels as she felt isolated both on the ward, and from her family and children to whom she had no access once admitted. She even described feeling more depressed and experienced further deterioration in her mental health.

Participant 301101 gave a comparison of two ward environments (a general psychiatric ward, and a mother and baby unit to where she was later transferred):

> *"I didn't like it there, I was a bit scared, I felt like crying and kept asking the staff for my children, as I didn't know where they had gone, I even asked them to bring the children but they didn't want to bring them, so I didn't like that place"*

> "*…the staff were straight forward but that place, I didn't like it because everything was confusing, other patients were banging doors and making noise"*

> *"…when I was on ***** ward, I was always stressed and angry because my children were not around me, when my children are not around me I get stressed, agitated and angry"*

> *"…and they did not let me out on leave. When I went to ****** (mother and baby unit)*, it was ok, I would say 10/10 because they were really good there."*

Other participants found the mental health unit to be restrictive and have limited scope for stimulating physical activities. They identified restrictions in attending to personal hygiene activities such as bathing, shaving and other physical activities. All these activities were closely monitored and only permitted at stipulated times. Some participants may have found this level of intervention to be both embarrassing and patronising. Being monitored whilst bathing or showering may have instilled a sense of loss of dignity, being intruded upon, and vulnerability.

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A female participant described a lack of hair grooming equipment suitable for black people. There was a general feeling that their needs were neglected, some referring to their dietary requirements not being met.

Participant 300632 said:

> *"…there was one black girl there and I made a complaint, I am telling you this, when you are dealing with black people you have to deal with different issues like, hair products, you don't have any hair oil? They don't come in with combs? They got little combs to comb white people's hair."*

Some of these findings are substantiated by quotations that applied across more than a single theme cluster to include other theme clusters relating to cultural sensitivity of the services, and the relational dynamics between participants and the clinicians, as well as their fellow patients. In order to avoid repetition, these quotations have been used where they are deemed to be most relevant.

Some participants made comments about the racial staff mix, but this time highlighting that it was unbalanced at senior service management level. It may therefore have felt like their needs as black patients were misunderstood, and not catered for at service management level.

While **Participant 172548** described her overall experience in mental health services to be good, she registered some dissatisfaction when she stated:

> *"…it's always just the hierarchy and all the whites, there is no mixture of black people at the top* (management)*, it's always whites at the top, there is no blacks, you know what I mean, to me all involved at the top were all white… so they don't seem to understand black people's needs."*

While other participants talked about deriving a sense of comfort and protection upon seeing some of the staff with similar ethnic backgrounds, **Participant 190043** talked about her experience of feeling stigmatised by those very clinicians. It would appear that it was inconceivable for this particular participant to experience such treatment from clinical staff, from whom other participants derived a sense of comfort just by seeing them present on the psychiatric wards. This implies that this participant might have experienced total - and possibly the worst - isolation levels compared to the other participants. It is quite possible that losing a sense of belongingness and solidarity presented to her an unsettling, hostile and castigating environment. She refers to the fact that she was not in hospital by choice, implying that the staff disbelieved her ordeal and took her to be cynical and disingenuous in her need for a service. To me, it appears the fundamentals of a caring relationship based on empathy and

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trust were simply non-existent, and this may have caused the participant to feel uncomfortable, despised, ignored and forced to struggle in a non-therapeutic environment.

Participant 190643 said:

> *"…it did seem like other staff members, particularly those from a black African and Caribbean background, despised me for being in a mental health hospital"*

> *"…seemed almost like saying, it is bad for you being in a mental health ward but even worse being a black person on the mental health ward. The attitude was like, what are you doing here?, you are not meant to be here, that kind of thing, but I was not there by choice, it was as if to say African Caribbean people don't ever get mental health issues and don't belong on the ward"*

> *"…I had staff, black African staff, advise me to go to church, everyone meant well but I thought like, there is a stigma with mental health and then a big stigma within the black community of mental health problems and even bigger stigma for black males with mental health issues,"*

It appears therefore, that this above participant was experiencing stigma from the professional staff from whom she may have expected empathy and solidarity. The participant's experience is suggestive that these ethnically diverse clinicians may have made or held assumptions that black people do not experience psychiatric morbidity and that, if they do, they ought to seek revelation through prayer rather than get admitted to a psychiatric hospital.

Those participants, who tried to be proactive in making their inpatient spell and that of their colleagues as comfortable as they possibly could, felt that they were victimised and punished by the professional staff. Participants felt they had to adhere to recommendations and conditions that the ward staff imposed on them or else they would be punished or victimised. Such experiences were interpreted as possible reprisals for over-stepping professional boundaries. Participants may have perceived this kind of treatment as threats, hence they could not freely make choices pertaining to their care. It would seem that refusal to take prescribed medication was perceived as a direct challenge to the professional staff that would likely attract punitive action or the risk of being labelled as a difficult patient. This suggests that to be spared this victimisation, one had to be compliant.

Participant 300528 did not perceive any benefits from being in hospital despite being coerced to take medication. He was eventually discharged although he had not taken any of the prescribed medication while in hospital. It seems, therefore, that this participant may not have suffered a mental breakdown that warranted hospital admission in the first place. Also, he may

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have thought that he was being punished for challenging medical authority by refusing to take medication. He said:

"…it was interesting that a week after not taking medication, I was back to the gym I was outside feeling well in myself, it just proved that to some patients, medication is not necessary."

Other participants expressed displeasure at being treated with heavy doses of medication and being experimented on with different medications. It seems the participants believed that they were being used as guinea pigs to trial medications.

Participant 159205 expressed these same sentiments when she said:

"I was just not meant to be there, I was like a zombie, doped up with medication you know! I haven't had a pleasant time in there, I wouldn't wish this to my worst enemy."

This sounds like a very strong negative expression to describe her hospital stay, that she would not wish her experience to happen even to her worst enemy.

Further expressions of feeling dehumanised in hospital were reported by other participants.

Participant 190643 said:

"Quite a lot of the time when I was on the ward, it was not a pleasant experience, your scope would be very limited, it's almost like your freedom is taken away from you"

"…often, the consultants were just demonising me like, oh! that's the bad girl, and sometimes ward rounds were intimidating."

Satisfaction with inpatient service

Contrary to the reported generally negative experiences of being admitted to a psychiatric hospital, a few participants expressed satisfaction and, in some cases, mixed feelings.

Participant 300528 illustrated his mixed experience by stating that:

"…one of the things I found amazing …there was coffee, tea and biscuits on demand, I was not interested in all that but you could ask of a fruit and get that"

"… except I have been a vegetarian of course and they did not have a vegan diet option."

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Some participants expressed that they were happy with their experience on the psychiatric wards. Others described the staff as caring and considerate. They seemed to experience being listened to and their needs being met with the support of the professional staff. Others referred to feeling comfortable on the psychiatric unit and observed that the hospital staff members were supportive and understanding.

Participant 172548 stated:

> "*…it was not so much doctors, they were rarely on the ward… but the nurses were very good. They helped me a lot and I felt cared for… some them would take time to listen to my concerns and they supported me. Yes! So, they were very good,*"

She acknowledged that there was no experience of prejudice or racism from the hospital staff and derived a sense of comfort from seeing a mixture of hospital staff from different racial and cultural backgrounds.

> "*…it's like the majority of the nurses, there were black Africans but you had whites as well, but throughout the whole place was a nice mix of different cultures within the staffing, so there was no… there didn't seem like there was any room for real racial aggravation towards you as a black person, the mix was really nice.*"

Another participant viewed the hospital as a haven where one could get rid of all the bad thoughts. It sounds as though this participant viewed the hospital as a place where he could off-load all his problems and come out as a different and new person. Therefore, psychiatric hospital admission may have been experienced by him as a salvation.

Participant 275789 described his inpatient experience by saying:

> "*It was alright, I was happy with the treatment*"

> "*Basically that was the truth, I didn't know what was going on in my head but the service was good, everyone was nice, I saw love, ye man*".

He described his expectation from being admitted as:

> "*…wanted to get well and come back a new me, that's what actually happened? I was having bad thoughts.*"

5.5.3 Enduring coercive treatment

The subtheme of coercive treatment was subdivided into two lower level themes, namely: (1) Experiencing legal coercion; and (2) Experiencing procedural coercion. Essentially, the

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subtheme demonstrates the experiential phenomenon of compulsion that participants reported within mental health care. The implication of compulsion here means clinical decisions and practices were supposedly carried out against the will or wish of the participants and therefore they were coerced to comply with the impositions. Legal coercion related mainly to the use of the Mental Health Act as executed by the judiciary, police or health care professionals to enforce clinical decisions pertaining to assessment or treatment; Procedural coercion involved non-consensual coercive treatment interventions. The following subdivision endeavours to show how participants experienced legal or procedural coercion, or both.

Experiencing legal coercion

The subtheme of experiencing coercion exposes the force and compulsion that the participants reported in their mental health care. Most participants made significant reference to their involuntary psychiatric hospital admission and expressed that some form of compulsion had been deployed. Participants reported being subjected to the Mental Health Act 1983 (as amended 2007). The Mental Health Act was used by various professional entities to compel participants into an involuntary psychiatric hospital admission. Such professional entities included approved mental health professionals (AMHPs), psychiatric doctors, psychiatric nurses, police, and the courts. In other instances, participants stated that their families or relatives were involved in the Mental Health Act application process. The implication here is that participants may have felt a sense of abandonment and rejection by their families or relatives when they participated in the Mental Health Act application process; that the bond of familial relations would have been compromised by the perceived rejection and casting of the participants into psychiatric hospital. This seems to indicate that most admissions of participants to a psychiatric hospital were not consensual; it is likely that they felt powerless to protest decisions made to admit them under a legal order and, in some cases, they viewed their families and friends as complicit in organising compulsive orders that constrained them.

Participant 169043 described that he was initially admitted to a medical ward after he collapsed into a coma from a failed suicide attempt, and was later admitted to a psychiatric ward under restrictive measures. Before the transfer, he had absconded from a medical ward where a psychiatrist had reviewed him and told him of the likelihood that he would be placed under a section of the MHA. He said:

> *"I was put on 1:1 supervision on the medical ward because I was suicidal. Before getting admitted, I had tried to hang myself, I was in a coma, they put me on the ward and basically I had done a runner from the ward because a psychiatrist came up and said he was going to section me."*

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The participant may have perceived the MHA being used as a threat to keep him in hospital against his wish, hence he tried to escape. It appears, therefore, that the threat of being sectioned led the participants to conform to any decisions made about them against their will: they must have felt contained, restricted and controlled by the clinical professionals.

Participant 300632 was initially detained under Section 136 by the police and was conveyed to a psychiatric hospital where he was later reassessed by the psychiatric doctors and detained, first under Section 2 and subsequently under Section 3 of the Mental Health Act. He felt unfairly targeted by the police. It appears that subsequent interventions from the police detention under Section 136 were biased in favour of accepting the police reports and concerns. The participant would have had no chance of exoneration from the formal detention process which was started by the police.

> "…*the police were tracking me and were trying to get me for something. That's how I ended up in the section suite, ye, was it 136? Ye, the truth is, they round roped me in this - man…*"

> "*I was told I had to stay there for 28 days but this changed to six months, that's a very long time to stay in hospital - man …*"

Participant 238867 was committed to a psychiatric hospital by the courts under Section 37/41. She said she was sent to a psychiatric hospital by the courts and felt that this was an injustice as she had not been found guilty. She must have felt betrayed and incriminated. Furthermore, she would have lost all hope upon recognising that the hospital could not overturn the court decision as it was legally binding. She would have felt angry about the report produced by the court to justify her compulsory placement in a psychiatric hospital:

> "…*when I got into hospital, their court report was really… it almost like bashed me, my lifestyle, bashed my faith, they bashed everything.*"

Participant 238867 also referred to being continually subjected to compulsory powers of the MHA via a community treatment order (CTO), even after she was discharged from hospital. She reported feeling restricted trying to resume and regain her life outside of hospital:

> "…*and also, outside with the CTO, it was a lot of ignorance and bias… they didn't understand my life.*"

It appears this participant continued to feel constrained by the legal imposition of a CTO after being discharged from hospital. This would have been most likely demoralising for her, to have further restrictions after being discharged from hospital. She may have believed that this

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imposition was not based on genuine and unbiased opinions of how she presented in the community, but on the incriminating court report documents.

Participant 164599 had a Mental Health Act assessment carried out at home and was subsequently detained under Section 2 before being taken to hospital in an ambulance with police escort. He felt he had no choice, though he initially resisted and denied the assessment team entry into his house. However, when the police got involved, he succumbed to the pressure and allowed them entry:

> *"…I didn't agree to go to hospital, when they came around for the second time, I locked myself in… bolted the door and remained silent as they knocked on the door and pushing little notes through my letter box. Three police cars turned up, sirens, blue lights and all… just like in the movies. I got very scared… - I was alone, …eventually, I opened the door and when they came in, I refused to talk to them. It was three men and one woman. The police cars were still outside but none of the officers came inside my flat. They whispered to each other in the hallway and the lady came to tell me that we are detaining you under Section 2 and you need to come into hospital now. An ambulance arrived and the police got out of their cars. I had no choice… They took me to the ambulance waiting outside and the lady came into the ambulance with me… that's how I ended up in hospital"*

Participant 169043:
> *"I went into hospital and got sectioned there, and while in there, I was still feeling suicidal and I had 1:1 nurse supervision. This would be changed to 2:1 sometimes or even 3:1. I was in a hospital network for 18 months constantly non-stop. 18 months was a long time being in hospital continuously. I got periods of leave like hourly, then two hourly, to go outside of hospital. If things went wrong, they would no doubt, stop the leave."*

The level of supervision and monitoring that the above participant refers to must have felt intrusive. He quite possibly experienced an invasion of his personal space as well as a denigration of his privacy and dignity. All this would have made him feel vulnerable.

Experiencing procedural coercion
Some participants described being subjected to coercive psychiatric interventions once they had been admitted to hospital. The quest for liberty and freedom seemed to always clash with the restrictive nature of the inpatient environments. It would appear, therefore, that any such propensity by the participants to exonerate themselves from such restrictions and entrapment

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would be met by coercive treatment or containment procedures. Coercive procedures involved being subjected to physical restraint and being tranquilised by medications. This must have been a frightening experience for the participants. For example:

Participant 161218 described that:

> "…on a few occasions I would stand by the door and shake it as I tried to get out. I was 'pinned' down a few times to stop me from leaving and was given injections which made me feel dizzy."

Participant 159205:

> "…they came and picked me up and when I was in a white van, they gave me something, I remember they gave me too much medication and they took me round to Dr *****, he was a psychiatrist and he took me to the hospital. They did it as punishment or something."

Seclusion in psychiatric intensive care units (PICUs) was one of the interventions reportedly used as a deterrent, and participants perceived this to be some form of punishment. **Participant 300632** was unhappy that he was initially admitted straight to a PICU and was deprived of an opportunity to be admitted to an assessment ward:

> "…the police won't back down to say yes we did dodgy things, they didn't admit to what they did they made out like it was all lies and they send me to ***** (Psychiatric Intensive Care Unit), when I had not done anything wrong, you don't go straight to a secure unit do you?"

Participant 169043

> "I was sent to a secure unit at ***** and on various occasions I self-harmed because this was my way of coping with many issues in my life."

My interpretation is that by being confined to a PICU, this participant's self-injurious behaviours could be closely monitored and prevented. He must have felt helpless and unsupported. However, it would have also implied that the participant could not exercise his coping mechanisms. It would appear that a PICU was an environment where one could not negotiate or contribute towards one's care planning and risk management.

Participant 159205 stated that she was transferred to a PICU after she absconded from the inpatient service a few times to go home:

> "…they said I had to be there for six months. I ran away a couple of times to come home. Afterwards, I was referred to another psychiatric hospital which

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was a big mental institution. When I got there, I kept running away because I didn't feel comfortable round there and Dr ***** said I had to go back, and the police took me back. There was one police car outside there and they took me back to ***** hospital and then I escaped again and insisted that I would stay in the community and they started bringing the medicine to me."

The above participant's persistence in running away from hospital may be perceived as a deep sense of dislike that she had of psychiatric hospitals. She must have felt so constrained that she would pursue any opportunity that arose to escape, in order to be free. Even when police became involved in returning her to hospital, she still escaped. It seems she wanted to be at home so much that she offered even to comply with medication prescription in the community.

Participant 300528 talked about his wish not to take medication, but he was forcibly injected and became physical ill due to the adverse reactions he had to this medication. He explained that taking medication was against his religion and spiritual beliefs. He was not happy with the interventions that were used as these were against his wish. Nevertheless, he could not protest as he was admitted under legal restrictions. To him, it appeared he had no choice other than to comply with the conditions of his restriction. Such conditions would have made it almost impossible for him to participate in and freely contribute towards his care. He said he was detained under Section 2 of the MHA after failing to engage with community teams:

"I was told that because of my section, I would have to take a course of medication, I refused the medication… a few days later, they forced me: they actually pinned me down, so they injected me, not exactly sure what they were injecting me but I was very ill after the injection they gave me."

Participant 161219 described being constantly moved from an acute admission ward to PICU after violent altercations with other patients. He explained that he had been defending himself from other violent patients but admitted to pushing boundaries and challenging the system when he realised that he was going to be kept in hospital longer than he had expected. He had also been found smoking in undesignated areas of the ward.

5.5.4 Feeling discriminated against

This subtheme was derived from participants' reflections on what they viewed as discriminatory care practices which disadvantageously separated them from their white counterparts in how they fared in the service. Aspects of care where the participants felt discriminated against included access to psychological therapies, segregated welfare and recreational activities, and experiencing a lack of cultural understanding and accommodation.

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In order to clarify this subtheme, I deconstructed 'discrimination' and divided it into the three care aspects that the participants identified above.

Experiencing deprivation of psychological therapies

Here the participants described how they had felt excluded from accessing psychological therapies. Deprivation in accessing psychological therapies was singled out as one aspect of the mental health care services by which the participants felt discriminated against. They identified that the biopsychosocial model of care was discriminately implemented to the disadvantage of most participants. Emphasis was put on pharmacological interventions even though a significant number of the participants did not agree with taking medication. Participants may have felt prejudged and deprived of choice to require medication as the only intervention that could resolve their psychological problems.

Participant 169043 stated that he was not referred to psychological therapy which he and his family thought he needed in order to facilitate an in-depth investigation into the root cause of his mental health problems. The participant and his family may have perceived this as an ill-considered attempt to help him and therefore felt that, somehow, they were not being listened to:

> "Dr ***** was not going deep enough to find out what the problem was, and to find out the way my mind ticks. What he was able to do was, give me medication and that was it."

Participant 238867 may have felt that her underlying problem was being ignored because she was black. Her insight and personal opinion into what sort of intervention could help her was ignored by the clinicians. Therefore, to be prescribed medication when she was expecting psychological input must have made her feel like she was being punished and racially discriminated against. Her input into her own care was not being considered. She may have ultimately felt disbelieved and unsupported in her claim about suffering a sexual assault:

> "I feel as a black female, sexual assault is not taken seriously. The more I told them about the sexual assault the less they cared, hence why I wanted the talking therapy. How can they just give somebody drugs and medication knowing the seriousness of what they complained about…"

Participant 172548 said she was only involved with psychological services after being discharged from hospital, and that the service had not been provided prior to admission. She argued that access to such services might have prevented the admission, which means she experienced delayed input and went into a crisis.

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Participant 275789 stated that he did not access primary care services, neither was he referred for psychotherapy:

> *"They gave me medication, I think it was Olanzapine, that was the medication and, that's the medication I am now taking."*

Experiencing segregated care provision

This sub subtheme arose when participants were asked to describe their welfare experiences whilst they were patients on a psychiatric ward and compare these with those of their Caucasian counterparts who were also inpatients at the time. A significant proportion of the participants gave very subtle and mixed responses.

Participant 169043 said he was unable to give a comparison of care with other service users who were in hospital with him at the same time:

> *"Not really, when you are in that state of mind you don't really think about that."*

It appears this participant was not really bothered about the discrepancies. However, when he was addressing some welfare issues about his care, the participant went on to strike some comparison:

> *"…food was fish and chips on a Friday, peas, potatoes, I wasn't brought up on that, there were Asians there and they had halal food. I thought that was not fair… they got what they wanted."*

It must have felt uncomfortable to stay in hospital where his dietary choices could not be facilitated.

Some participants pointed out what they believed were injustices that led to discriminative care and created an uneven playing field for all the participants. They made remarks on not only the food but also the care provision and availability of culturally appropriate recreational activities and other necessities. This must have instilled a sense of othering or exclusion when they realised that what was good for them was not acceptable in hospital. Furthermore, the fact that their white counterpart patients could do as they pleased created a sense of segregation where the participants felt unfairly treated.

Participant 169043 also referred to an incident involving a music recorder:

> *"…there was a bit of prejudice there, this English man would bring his music in on CDs and played them all but when we brought ours in, that sort of thing, then they would start,… you can't play those, too loud, this and that, you know."*

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Also, after reporting a verbal abuse incident by another patient, the participant believed the case was dealt with unfairly:

"The nurse said, don't worry about that because she is ill, ignore that, but if I was to say something back to them, I am sure I would have got a different response to what she got. Ye, I just said, that happens, and nobody spoke to her or nothing, so I thought that was wrong and it made things worse for me, you know."

Participant 159205 stated that she believed she was treated differently from patients of a white racial background. She felt the services were not adequately equipped to cater for the needs of patients from a black African and Caribbean background:

"…most of the provisions there, like, stuff you use to look after yourself, were designed for white people only"

"…yet they would despise you for not looking well-kempt"

"How could we possibly do this?"

Participant 300528 made a comparison between himself and other patients, drawing out a distinction that he was someone who stood up and was vocal for what he believed in, whereas other participants may have been docile. Presumably such docility was a result of these participants' fear, and possibly misplaced respect for the clinicians' authority, without which they would face reprisals and victimisation. He believed that by challenging poor practice, he may have become unpopular with the hospital clinicians who may have considered him as a troublesome patient:

"This again, would have presented a challenge to the staff who were not used to being challenged by the patients"

"…they did not like it when you challenged their authority."

Participant 238867 believed that one's social status was a determinant in the quality of care you received. The implication of her belief is that a patient gets well-looked after and respected by the clinicians if they come from an affluent background. Her argument was that the quality and level of care one received was not determined by one's racial background:

"… they were spoken to in a different way; I really do believe where you live and where you come from, determines how you are treated and not necessarily just your skin colour. I used to see a lot of women who lived in better areas being

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treated a lot better, spoken to a lot better but suffering from the same mental condition, the same condition, you know!"

It appears one's socioeconomic status / background determined how one was treated in hospital. A less impoverished background would conjure higher expectations and influence the quality of care one received rather than one's racial background. Nevertheless, she still reported observing racial segregation in relation to the allocation of psychological therapies:

"…that's the other thing about racism, I feel, that white patients get the opportunity to have psychological therapies from what I saw in hospital. This is what I saw in hospital, they were getting a lot of psychological help and treatment."

However, she added that her experience of the nurses' care was that of fairness and devoid of discrimination:

"…the nurses from what I saw, treated everybody the same. They were really nice, rich or poor patients were treated alike."

Some of the participants referred to the stigma as being a product of the world's preconceived constructions on race, and how these fuelled racial segregation and institutional racism. Participants blamed bias and ignorance of professional staff regarding spiritual awareness. Others talked about experiencing racism as a direct result of the professional staff's lack of education. They believed racial profiling, assumptions and stereotyping were prevalent in determining diagnoses.

Participant 300528 described how he was prejudiced against by his physical appearance, being tall, black and big, and believed these characteristics attracted stigma, racism, segregation and stereotypical views from both the staff and Caucasian fellow patients:

"…they would all sort of look at you like they were saying… here comes that troublesome patient."

Other participants, however, argued that there was no room for direct racism simply because of the mixed cultural backgrounds of the professional staff on the hospital wards. Participants described deriving a sense of comfort from being looked after by professional staff from different cultural backgrounds.

Participant 161118 said:

"there was not much room for racism there, the black nurses wouldn't let them, …to some extent, that made me feel comfortable a bit".

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Some participants made a further observation of a discrepancy when they pointed out that the rich mixture of cultural backgrounds of the nursing staff did not flow through to management level. Management roles were observed to be mainly filled by whites, creating a bottle neck for the blacks. As such, they may have wondered how their needs as black patients could be understood at management level and concluded that there was institutional racism:

> *"If you looked up the management structure, it was all white faces, …you would wonder how they can understand black people's needs."*

Others talked about food and how their preferred choices could not be accommodated in hospital. Vegan diets were not provided, and they observed a difference when it came to Halal diet, which was made available on request by those who needed it:

> *"I asked for vegan diet as this was not available, I could understand for the first but second week, it became an issue…"*

Participant 161119 stated that she had no problems with the food: she had become accustomed to the dietary choices that were on offer:

> *"I have been living here for some years now, and the food wasn't really an issue for me, it was fine"*

Experiencing cultural insensitivity

This sub subtheme involved participants making comments about what they considered to be their cultural needs and how these were accommodated in mental health services. Participants from a black African background expressed their views on culture clash. They gave opinions about levels of understanding and representation of their cultural beliefs by the professional staff, especially those working in service management roles, and varying views on mental health problems. They also described specific cultural issues in relation to food, personal hygiene, medication, spirituality, recreational activities and various other personal concerns.

Some participants talked about how their families' belief systems about hospital treatment clashed with the medical model. While mental illness was in some cases viewed as a taboo subject, other families still preferred to deal with any incidences of mental breakdown through religious and spiritual means. Others talked about being resolute in rejecting medication and the need to be hospitalised. Three participants described the initial cultural shock of being in hospital with mental illness and how they dealt with the culture clash and eventual assimilation. However, some participants talked about deriving comfort from the culturally diverse backgrounds of the professional staff.

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Participant 161219 referred to cultural variations in how different people react to grief and argued that his own reaction of weeping and wailing was misinterpreted as mental illness:

> *"How could they detain me and take me to a police custody simply because I was crying whilst seated in a graveyard, …that's my way of grieving. It is now all clear to me, they thought I was having a mental breakdown"*

> *"…they wanted to get me into custody."*

Participant 169043 described how his cultural background clashed with the prospect of being admitted to a psychiatric hospital against his and his family's wishes. He made comments on his family's cultural background, and about dietary choice availability and recreational activities on the ward:

> *"Certain elements had an impact on my accessing mental health services or being admitted. My family, at the time, stood up and said we don't want hospital, we don't do hospitals…, they were protective and supportive"*.

On the hospital ward, he described that he did not agree with the choice of food that was provided. He said:

> *"Food wise! No. Definitely not, the food was fish and chips on a Friday, peas, potatoes, I wasn't brought up on that, there were Asians there and they had halal food"*.

Participant 190643 talked about her family involvement with various aspects of her ordeal and how presumed medical solutions could potentially clash with the family's cultural belief system. In her family, a mental health breakdown was considered a spiritual attack and attracted shame and stigma to the family. Therefore, it is possible that the participant may have tried to deal with the problem by herself as she feared being stigmatised by both her family and the wider community. Mental illness was an unacceptable diagnosis within her own family and more so within her wider family and relations. Her mental breakdown could potentially bring shame to the family:

> *"…there is an image that has been assigned to what it is like being in mental health care, for a lot of my family back home, it is the unspeakable. The family's attitude was like, if my mental health deteriorated, it would be something that was targeted with prayer, religious prayers or something. A mental breakdown was perceived or even labelled as a spiritual attack …"*

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While the mental health breakdown was not a desirable occurrence for either the participant or her family, it appears it was a blessing in disguise in that it resulted in the formation of an experiential learning curve. The participant and her family learnt that mental health is just as important as physical health, except that mental health has stigma attached to it:

> *"…it was different and eye opening to come to a new understanding that your mental health is just like your physical health"*

> *"…but it all comes down to that stigma with mental health".*

She explained that after the dilemma of the culture shock experienced by her family, there was cultural assimilation as they accepted that her problem needed medical input and not just prayer or some other cultural intervention:

> *"Although they did pray and, you know, they have their own religious beliefs and they just pray, they did accept that this is a medical condition that needed medical attention."*

She summarised by describing her herself as a resilient person,which explains why she was initially reluctant to seek help from either family or professionals: she may have wanted to deal with her predicament in her own way and without relying on anyone else. However, using the hermeneutics of suspicions, I deduced that she may have hesitated to consult anyone as she feared the impact this would have on her family, or how they would choose to deal with the problem. It would have presented cultural and familial dilemma:

> *"…maybe it was my personal character, I don't like being a burden and sometimes I become paranoid whereby I feel like I am an excessive burden to everybody."*

Participant 161219 also talked about his cultural belief system which viewed hospitalisation to be only necessary for anyone who is physically and terminally ill. Therefore, it appears his belief system did not agree with mental breakdown being a medical condition requiring the victim to be hospitalised. For him, being admitted was going against his cultural belief:

> *"…my culture does say going into hospital is when you really need to, if you are dying…"*

Once admitted, he seemed to have derived some comfort from seeing clinicians of a culturally diverse background. It appears he felt protected and more relaxed after his initial anxieties of being admitted to a psychiatric hospital ward.

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Participant 172548 stated that she did not eat most of the food that was offered on the ward and found it difficult to source her own choice of food using her own resources as she needed a staff escort to be able to go out and buy her preferred choice of food. She said:

> "…a lot of things I didn't eat, they did not understand my background, but I think they did to a certain degree."

She also talked about her perception of service staff and described this to be racially unbalanced with white people in most top management posts; hence she had reservations about whether black people's needs were understood at management level:

> "…like I said about the structure, this should be changed a bit more, where more black people should be more involved at the top, that's again across the board in everything, it has to be changed".

Participant 242575 said he didn't agree with medication all the time but found that in mental health services, both in the community and as an inpatient, the emphasis was on him to take medication:

> "I don't really like taking medication all the time, I am not a person who believes or relies on medication, no, but they would insist that I take the medication".

Participant 301101

She prayed a lot and believed that prayer helped her. When she talked about her breakdown and being admitted, it sounded like it came as a surprise:

> "…you don't think about it, that this is going to happen to you. It was a real shock, yes, I was really shocked when I was in hospital".

She had no prior knowledge of black people having mental health breakdowns. She seemed to have tried to identify a source of her mental health breakdown, believing there was a sinister force behind it which could not be explained by a medical model of illness:

> "I have never seen someone with this illness in my culture background before, I have never been there before, because I believed a black person does not get this kind of illness"

> "I didn't know where it was coming from and I would ask myself why did this happen to me and stuff'."

When describing the choice of food made available, she explained that she did not have much trouble adjusting as she had become accustomed to the dietary choices that were provided.

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She may have derived some comfort from the acceptable choice of food that was available on the wards:

> *"I will say yes, especially the food… I was brought up here with white people so for the food and everything it was normal to me."*

She also explained that from her knowledge, in the African context all mentally ill people become ostracised from their families and society and become destitute, living in squalid conditions.

Participant 271332 talked about how he was dealing with an unusual arrangement which presented a cultural challenge to him. From his country of origin, men do not get involved in looking after their children. He seemed to have experienced a cultural transition from adapting and assimilating to the local cultural values in the host country:

> *"…culturally, I can't say, because my country is my country and I am living in a different culture, I cannot really compare"*

> *"I will do as they do here."*

> *"I also have other cultural challenges and I try to live with those at the moment, and the fact that I have to take care of my son* (as a single father)*, that's new for me. The fact that I am there, I am trying to get used to it and take it as it is, I can't do anything about that… he is my son and needs looking after."*

5.6 Dynamics of Therapeutic Relationship

This superordinate theme was derived from what the participants described as characteristics that were inherent to their relationships with the health care professionals. The relationship characteristics were drawn from participants' experiences right from the initial contact with secondary mental health services in the community, through to the inpatient spell and then aftercare. The participants expressed both positive and negative attributes of the relationships they had with senior (doctors) and junior (nurses) clinicians.

In order to zone in on the specific aspects of the relationships that participants experienced with the care professionals, the superordinate theme was subdivided to give two subthemes, namely 'Therapeutic relationship with senior clinicians', and 'Therapeutic relationship with junior clinicians'. These subthemes were further subdivided to reflect the participants' perception of positive and negative attributes of the therapeutic relationship within each subtheme.

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While participants described experiencing negative and positive relationships with both senior and junior clinicians, there was a significant inclination to more negatively characterised relationships with the senior clinicians than with the junior clinicians. Another trend of relationship dynamics therefore emerged serendipitously, and an additional subtheme named 'patient - patient relationship' was incorporated into the relational dynamics framework.

5.6.1 Relating to senior clinicians (negative and positive attributes)

Some participants described experiencing patronising relationships and an inherent imbalance of power with senior clinicians (doctors / consultant psychiatrists). They expressed that prejudice and misconceptions characterised the relationships. It appears the senior clinicians were generally perceived as having no empathy in dealing with the participants. For the participant to be portrayed as 'wicked' and 'threatening' by a consultant psychiatrist must have made him feel like he was being cast as an undesirable character. To be demonised within a caring environment may have been the last thing this participant expected to happen.

Participant 190643 said:

> *"…there has been times when, maybe I have been so ill that in my mind,… the medical staff,… the consultants, they almost demonised me like they don't care, like they don't have my best interest at heart".*

The participant felt like he was not being listened to and found the consultant psychiatrist's attitude to be dismissive and uncaring:

> *"…some Consultants are very, very abrupt and I wondered, I didn't know if I could have a conversation about things I was concerned about,… if they would listen,… if they were going to take time with me."*

He also observed that doctors were not always available when needed for personal consultations. Having no access to a doctor for more than a week would seem like a level of neglect. It appears the participant felt like he was being controlled by the power of the doctors and had no personal freedom:

> *"You wouldn't see them for a whole week and sometimes, like I said on the ward you feel like all your freedom is taken away, so you know…, it almost feels like the Consultant almost got your freedom in their hands, it can be really nerve wrecking."*

Other participants also described the senior clinicians' attitudes to be dismissive, threatening and ignorant. They reported that any dissent to the clinicians' view could easily attract threats and the imposition of the MHA.

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Participant 300632 described a strained relationship with the doctors, which stemmed from what she claimed to be a misdiagnosis and their having no regard to her opinion and cultural variation in care management:

> *"Sometimes when you don't agree with their view, then the Consultant thinks only one thing, that if you don't agree, you're argumentative and are a difficult patient."*

Participant 238867 described the first consultant psychiatrist she saw in hospital as very condescending and belittling:

> *"I wasn't on my best behaviour I was just being myself, it really helped with the shock, but it was when you saw the consultant and their disparaging ways… and the less darker skin people getting more attention and their concerns listened to"*

> *"…there was just so much room for discrimination, ignorance and bias…"*

Due to cultural misunderstandings, some participants seemed to believe that the senior clinicians might misinterpret and misdiagnose their condition, especially possibly labelling them as psychotic and thereby recommending treatment with medication rather than psychotherapy.

Participant 300528 expressed that his relationship with the doctors was strained. He believed the senior clinicians completely misunderstood him and took his spiritual practices to be mental illness. There may have been some misinterpretation of his spiritual practices as psychiatric morbidity. He would have felt a sense of deprivation when the doctors went against his wishes to not take medication in any form because of his spiritual and religious beliefs:

> *"…they do not always get it right"*

> *"…they completely misunderstood where I was coming from"*

> *"I feel that issues of spirituality are never completely understood by nurses and doctors. My problems did not require medication but yet they insisted and even forced me to take medication"*

Other participants felt medication was used in a 'trial and error' fashion when they suspected the psychiatrists were not sure of what to prescribe. Participants described feeling like they were being experimented on like guinea pigs. For some, this also resulted in lengthy hospital spells to allow for appropriate treatment medication to be identified.

Participant 159205 said the senior doctors never used to listen to her and felt that all they wanted was to give her more and more medication. Therefore, it sounds like the participants'

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opinions about their care was not considered important or was often ignored by the doctors. She did not feel that the doctors were helping her and, instead, may have suspected that they had a hidden agenda to make her condition worse. A regular change of medications might have caused the participants to believe that the doctors were not sure about what they were doing. The thought of being experimented on may have caused participants to be fearful of interventions whose outcomes were unbeknown to the doctors themselves:

> *"…they even gave me some blue tablets when I was down there and then they changed it to pink, hey! just experimenting on you. I thought they were trying to make me worse."*

Participant 300528 also talked about being pressurised and interrogated at review meetings and felt disempowered from participating or having a say in his own care. Being always called last to the ward review meetings must have been anxiety-provoking as the participant would remain in suspense until their turn. He may have felt that the doctors did not care about him because he was always at the back of the queue at ward round meetings:

> *"I didn't like them, every time I went to the ward round, I was cross-examined. I got angry another time and they restrained me, I can understand now why they did it, I was too much of a risk… I was very animated. When it was ward round, I was always the last person to be called in"*

The participant may have felt hopeless of any prospect of a good caring outcome after he identified that one of the doctors was ignorant of his needs. Even the participant's family (brother) lacked confidence in this doctor, and this may have strained the therapeutic relationship. Such a relationship would have caused discontentment and resentment for the participant and his family. On the other hand, the doctor may have developed ill-feelings about the participant, as well as animosity, enmity and hostility, all which would not help to promote a therapeutic relationship:

> *"Dr *****, I got on well with him and also another lady doctor, she still works for the NHS, I forgot her name, she was away with the fairies, she didn't know what she was doing, my brother didn't get on well with her."*

On the other hand, some participants expressed satisfaction and felt valued and listened to by the senior clinicians. This positive relationship could have helped participants to feel engaged and involved in their care. This sort of supportive relationship may have provided a pathway by which participants could freely consult with their doctors to discuss medications,

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other options, or their general care plan without fear of victimisation, reprisals or dismissive attitudes.

Participant 271332 talked about how he got on well with the doctors and voluntarily engaged with and adhered to the prescribed medication and treatment plan. He described that his CMHT doctor was very understanding and had a good relationship with him. He felt that he had a positive regard from the psychiatrist and that his views were listened to, considered and valued. It appears the participant may have felt comfortable and empowered by this relationship. He would have felt able to participate in his own care freely:

*"My consultant psychiatrist was good, she listened. Her name was ***** yeh."*

Participant 301101 expressed an overall satisfaction with the care she got from the doctors:

"…the doctors were good, they really helped me to cope"

*"…honestly, when I was in that ward I didn't see many of the doctors, I used to see just the nurses and there is a doctor there as well, Dr ******, she was really very nice, you could freely talk to her and stuff"*

*"I had never seen a black person to have that kind of illness before, because I was a bit confused, and was asking - why am I here? What is going on? Why, why, why, but the doctor didn't explain the reason why I was there. When they moved me to ***** ward* (mother and baby unit)*, the doctor there talked to me and explained my illness, so that place was really good."*

Participant 172548 also expressed some positive attributes regarding the relationship she had with the senior clinicians. She described a good relationship with a CMHT doctor whom she described as listening and understanding.

5.6.2 Relating to junior clinicians

Perception of empathetic relationship

Participants described their relationships with junior clinicians in terms such as welcoming, kindness, trust, empathy, listening, informative and supportive. Some participants expressed mixed feelings whilst others indicated negative relational experiences with the junior clinicians. The negative characteristics included being despised and stigmatised, an absence of trust, misunderstandings, and perceived rigid professional boundaries.

Participant 190643 talked about being stigmatised for being in a psychiatric hospital by junior clinicians who were of a similar cultural background to hers:

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"…*they were always asking me, what are you doing here? You are not supposed to be here. They were telling me to go to church*"

Participant 300632 expressed her anger at the nursing staff for being inefficient in their caring roles and how she took it upon herself to discharge some of the duties she felt junior clinicians should have been doing for the patients:

"…*very lazy, they would just sit in the office chatting and not looking after the patients*"

"*There was this young girl and she really was not well at all and needed help*"

I showed her the bathroom and gave her assistance and I had to tell her to sleep in her bedroom as she would just sleep on the sofa."

Participant 300528 talked about being subjected to reprisals as he constantly challenged poor practice by the junior clinicians:

"…*I think they didn't like me there, I didn't agree with a lot of things they were doing and I would ask questions and challenge them. Maybe they were not used to being questioned by patients*"

In the community, one participant described his allocated CPN as dismissive and inconsiderate:

"…*my nurse was just not listening at all, he was not taking time to understand my view on things.*"

Others described the inaccessibility of their CPNs when they needed them most and the lack of consistency in seeing their allocated key workers due to staff retention problems. As such, formulating therapeutic relationships was problematic. However, participants expressed some positive attributes about the type of relationship they experienced with junior clinicians.

Participant 271332 felt that the junior clinicians were accommodating, listening and genuine in their efforts with him. This quality of relationship would have most likely made the participant feel comfortable and confident that he was getting the help he needed. He stated that he was satisfied with the care he received:

"*I think they do their best*"

"*they are good, yeah, they are good. They tried to understand where I was coming from*"

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Participant 242575 also observed that the junior staff executed their roles in a professional manner and felt that they had best intentions of helping him. It appears the participant attributed his improved mental state to the effort put in by staff to help him:

> *"Ye, it was all positive, they seemed professional staff: I mean they do have your best interests at heart"*

> *"…offering all sorts of medications, activities and coping skills which could have helped me feel better"*

Participant 238867 talked about how she appreciated the nursing staff, but not the senior nurses' manager. She felt that the nurses were supportive and avoided interfering with participants' personal and cultural beliefs. It would appear that junior clinicians took their time to listen and to understand the participants' problems:

> *"…the hospital staff and nurses were fabulous. They were really nice, really nice people. They understood what had happened and they were not evaluating me on that court case you know"*

> *"…they didn't get in the way of anything when it came to my beliefs…"*

However, she felt the senior nurses produced disparaging clinical reports about her and blamed them for her prolonged hospital stay. She appears to have had no independent opinion from the doctors and she felt they could not be bothered. It would seem like doctors had the final say in the participants' fate regarding prolonged hospital stays. Senior nurses / managers were seen as consipiring with the doctors in making such decisions without any consideration being given to what the junior nurses had to say. Participants would have felt they lacked representation from those who spent the most time with them. Independent opinions from other clinicians would have been seen as tokenistic:

> *"…it was the written reports by the 'higher ups' that were really disparaging especially by the head nurse,… I ended up staying there for a couple of months and it was the consultant's decision no matter what the nurses and staff said to them* (consultant psychiatrists)*,… they just couldn't be bothered, but the nurses were nice"*

Perception of victimisation

Other participants characterised the relationships they had with junior clinicians as negative.

Participant 172548 described poor relations with the nursing staff. She expressed that nursing staff used to have a negative attitude towards her and believed that, because of her

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mental health problems, nurses treated her as though she was stupid. To me, it appears the participant was experiencing stereotypical attitudes and being stigmatised by the staff. Therefore, her mental health problems would have carried the burdens of stigma and othering:

"…sometimes the nurses treat you like… how can I say it? Sort of sarcastic I think, not being very nice, because you've got mental health problems, they just treat you like you are stupid"

"some of the professional staff were not helpful at all"

Participant 300528 stated that the nursing staff did not give much attention to his views. It appears his opinions about his care were not valued. He would have felt ignored and unable to participate in his own care:

"…it was very much, you are not seeing reality so because of that, there is a problem and they wouldn't listen to anything I had to say…"

Participant 161218 described a similar relationship between him and the doctors and nurses. He believed the clinicians had stereotypical views of him, and for that reason he did not receive fair treatment:

"I think the staff… one or two nurses, I think they didn't treat me fairly, I don't know if this is because of my illness or me thinking this way. …and also the consultant psychiatrist, I thought he was looking at me and thinking, I had been smoking drugs and my mum couldn't face that because I am not like that, no drugs… so, they didn't treat me differently but they looked at me differently."

Participant 161219 described his relationship with nursing staff as one that lacked trust. He would have felt prejudiced against as the clinicians would not give their own independent opinion over the police report:

"…bad, you didn't get on, because they wouldn't believe a word I said, nobody believed the police were in the wrong, never, but you alone would know the truth. You know, they do things to us and get away with it."

Variation in relationship experience

Other participants expressed both negative and positive opinions about their relational experience with junior clinicians. They described having mixed feelings about the quality of relationship they had with the staff.

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Participant 169043 said:

> "Once I talked to individuals who worked for mental health services on the ward, I found that certain staff were nice, they tried their best to help you, some didn't bother, you know, obviously some didn't like me for whatever reason, you can pick it up, but some stood out, they were very nice, on the whole I've been treated well, 8½ out of 10, 10 being the best, which is good."

Participant 301101

She drew a comparison between the relationship she had with staff from the first ward she was admitted to and the Mother and Baby unit where she eventually was transferred to: :

> "…on ***** ward, if you are talking to the nurses, they don't like, respond to you they just acknowledge you, but when I moved to ***** ward (mother and baby unit), I felt more comfortable, I felt like I was at home. That place is really, really nice there. They became more like a family, like if you are talking to them, they respond to you back, if something happened, you can feel free to talk to them, but on ***** ward you can't talk to them, they just have no time for you."

She added that one of the nurses on the mother and baby unit was very helpful. She said:

> "…I felt free to talk to her and she gave information about her condition as well as the medication and accompanying side effects."

Participant 190643 described a good relationship with the nursing staff:

> "…the majority of the staff were really good, you have more contact with the nurses and the health care assistants than you would with the consultant psychiatrists."

She acknowledged that nursing staff were working under pressure but would strive to provide the necessary care by allocating time to listen and to attend to patients' needs:

> "…I think on the whole, they do have a lot to do and there had been a problem with staffing numbers but I think the staff generally managed quite well, …the staff were very good and in terms of listening to you ,…they made time to just pay attention to your individual needs."

She however then said that occasionally it did seem like other staff members, particularly those from a black African and Caribbean background, despised her for being in a mental health hospital:

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"…seemed almost like saying, it is bad for you being in a mental health ward but even worse being a black person on the mental health ward."

There is an implication that the participant experienced a double jeopardy of stigma from this group of staff for being admitted to a psychiatric hospital and for being a black person with mental health problems. She went on to say:

"…the attitude was like, what are you doing here?, you are not meant to be here, that kind of thing, but I was not there by choice, it was as if to say African Caribbean people don't ever get mental health issues and don't belong on the ward."

5.6.3 Relating to fellow patients

Exploring the dynamics of patient to patient relationships exposed a confluence of negative and positive responses from the participants. They made comments about how they supported each other and, in some cases, how they endured relationship rifts with their Caucasian counterparts. Such experiences were characterised by solidarity and comfort derived from being with others of a same ethnic or racial background: racial abuse, and segregation, threats, being targeted, and extreme cases of being violently attacked by other patients.

Participant 169043 reported being verbally and racially abused by another patient upon his first day on a psychiatric ward. This experience would have been frightening for the participant and resultantly made him opinionated about the ward environment being unfriendly, unsettling and uncomfortable. To experience such a level of abuse on your first day in hospital would be shocking and harrowing. Patients coming into hospital because they are besieged by their own problems can experience a worsening of symptoms because of the reception they get upon admission:

"…I remember when I was on the ward and as soon as I got on the ward, I walked into a communal area… and I was called a black bastard by another patient. It just happened that I was in a state anyway, but I heard that and told the staff... To hear this direct from another patient, that just affected my mental health more, you know what I mean."

Participant 172548 expressed that she felt other patients disliked her and, for that reason, she was under constant fear that, by being the only person of colour amongst white patients, she was at risk of being harmed. However, she felt reassured by the presence of some clinical staff from BAME backgrounds and acknowledged that the presence of staff members helped

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to diffuse potentially aggressive situations. It appears the ward environment was not an easy place in which to settle and be comfortable because of the constant threats:

> *"It didn't feel like I could relax on the ward,… I was constantly fearing for my safety and life. This made me feel worse and it was very uncomfortable"*

> *"…my only source of reassurance came from the black clinical staff otherwise, I was feeling quite isolated."*

Participant 161219 described his relationship with other patients as frosty. For this reason, he never felt comfortable around other patients and isolated himself:

> *"…when I was down there last year, I never mixed with other patients because some of them would say silly things. So, I used to be a loner."*

He said this had ended up in a fist fight and he would have felt frightened and unsafe being in hospital. The fact that he was attacked more than twice by the same perpetrators and in the same environment, suggests that he was constantly alert and in fear of other attacks. It appears also that no-one was helping to manage the frosty relationship to prevent it escalating into a violent altercation. Therefore, he talks about defending himself as no-one was helping:

> *"…it was horrible, I was locked in there with them, you know they hate you and you sense that something bad is going to happen to you"*

> *"…so, I defended myself when they attacked me, yeh! Mohammed Ali style (laughs)…"*

> *"…you get all kinds of people including the racists. You can't expect them not to be there, you just have to avoid them, very difficult when you are locked up in a small place together."*

He also described that he was being stalked by a female patient at a time when he was most vulnerable, and feared the effects this would have on his partner.

In contrast, however, other participants experienced some degree of comfort from seeing other patients of a similar ethnic origin in hospital.

Participant 301101 stated that she felt more comfortable having other patients from a black and ethnic minority background on the ward. The phenomenon of 'othering' that other participants reported may not have been a problem for this particular participant. There seems to be a sense of comfort, protection and solidarity when she realised that she was not alone on the ward as a racial minority:

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"…there was this black man, he was old and never used to talk much, the other one I saw, was this little black girl, she looked more like she was from a mixed-race background."

Participant 300632 felt empowered by being with other patients from a racial minority background. She found it comforting and therapeutic that she could formulate relationships with other patients, otherwise she would have been plagued by boredom. It appears she gained a sense of empowerment such that she did not hesitate to appoint herself as an informal patients' spokesperson. She seemed prepared to ask questions and to challenge poor practice on behalf of other patients of similar ethnic background, who may have been naturally subdued or docile. She stated:

"…on the ward, I made connections with other patients there, I talked to them because sometimes, you sit there on your backside all day long and you get bored."

She also helped to support other patients with general personal care, and adopted an informal role as patients' representative:

"I became their spokesperson and other patients would come and say to me, look they have done this to me, it is not right and I know it is not right,… but I was not in a position to go and talk to them about it and say, you are punishing people, this is ridiculous."

These results are indicative of the themes identified and I will now discuss these in relation to available literature, established theoretical constructions and my own practice reflections. Therefore, the next chapter will present these discussions in line with the identified themes.

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Chapter 6 - Discussion

6.1 Chapter overview

This chapter endeavours to answer the research question, 'What are the first-time experiences of accessing mental health services for people of a black African and Caribbean background?'

Themes outlined in the 'Results' chapter described the participants' first time lived experiences of accessing different levels of mental health services. In this chapter, I will discuss the findings in relation to available literature, and demonstrate links to previous research. Explanatory frameworks for these findings are given and where applicable, links to established theoretical constructions are highlighted, as well as my own professional and personal reflections.

The chronological order of findings presented in the Results chapter has been adhered to in this Discussion chapter. This order is logically linked to the interview schedule which tracked the participants' experiential journeys through the mental health system, from the point of first contact. The findings begin to emerge from the participants' initial contact with services, their interaction with primary and secondary care services, hospitalisation, and through to discharge and aftercare. Therefore, the order in which the results are discussed does not necessarily follow the order of their importance. While some of the findings are substantiated by available literature, others constitute tentatively proffered new knowledge which supports the development of recommendations for practice and for future research.

6.2 Psycho-social exposition and stress vulnerability

6.2.1 Exposition and vulnerability

In relation to the superordinate theme of 'Exposition and stress vulnerability', the results show that participants were predisposed to psychiatric morbidity due to a multiplicity of stressful psycho-social circumstances. Participants experienced similar and variable vulnerability factors that are multi-layered and intertwined across individual narratives, and which include exhaustion from overworking, limited resources to meet personal and familial obligations, strenuous family relations and inaccessible or unavailable family support, lack of suitable and adequate housing, poor physical health, financial stress, inability to work due to restrictive immigration status or simply not having any employment prospects, as well as social isolation.

These findings echo the outcomes of several previous studies which argued that socio-economic disadvantage, adversity, deprivation and unemployment are factors found to be

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complicit in increasing vulnerability to mental ill-health (Tew et al., 2012; Karlsen, 2007; Memon, 2016; Gajwani et al., 2016). While these observations are universal to the generality of individuals, evidence suggests that people from black African and Caribbean communities are more likely to experience these adversities than their white British counterparts (Kirkbridge et al., 2012; Elliott, 2016).

Participants in this study experienced more severely than their white counterparts a distribution of negative social and environmental factors including unemployment, lone parent status, lower social class, lack of social support, housing difficulties, unsettled immigration statuses, and poverty. In support of this outcome, a longitudinal amalgamation of systematic review and meta-analysis studies show that black African and Caribbean people are more at risk of being diagnosed with psychosis or schizophrenia regardless of gender, age or being from a first or second generation of immigrants (Kirkbride, 2018).

This position is corroborated by other studies which claim that migration may result in chronic stress and disadvantage (Fernando, 2017). Another systematic review and meta-analysis showed that in cases where migration was associated with a downward social mobility, the individuals concerned were likely to experience psychiatric morbidity (Das-Munshi et al., 2012). Also, a mixed methods study on Somali immigrants indicated that there is a close link between migration and unemployment - a devalued identity which, when combined with a prolonged stay in the host country, would result in psychiatric morbidity and a poorer well-being status (Warfa et al., 2012; Kelly et al., 2016). Black women were found to be more likely to self-harm and vulnerable to psychiatric morbidity if unemployed or having housing difficulties (Cooper et al., 2013). Similar social indices are also identified as vulnerability factors to mental ill-health by the World Health Organisation (Solar & Irwin, 2010). The World Health Organisation (2001) postulates that mental health is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (Equality and Human Rights Commission, 2016). Important findings from the Office of National Statistics (2021) show significant similarities to the current study,suggesting that being widowed, divorced or separated are common psychiatric morbidity precursors. This explains that being lonely with no access to immediate support from familial links exposes and increases vulnerability to psychiatric morbidity in individuals.

The implication is that there are essential wide-ranging and interwoven psycho-social influences that cause vulnerability to psychiatric morbidity. Marx's conceptualisation of 'Conflict Theory' (Dahrendorf, 2007) – as thoroughly discussed in the Methodology chapter - provides a basis by which these psychosocial influences can be understood. Determinants of

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mental health or ill-health as explained by the World Health Organisation (Solar & Irwin, 2010), are closely linked to the overarching theme of vulnerability, and this includes being incapacitated, disadvantaged, predisposed and other elements that can be perceived as caveats of health inequalities.

However, others argue that these determinants of health inequalities can potentially affect anyone across the spectrum of different ethnicities, including the UK native white populations (Singh et al., 2013). A review of the available literature and the results from this current study demonstrate that people of a black African and Caribbean background are more vulnerable and socially disadvantaged. Participants in this study also described experiencing various disadvantages when they interfaced with law enforcement agencies, including being wrongfully accused, detained and charged.

6.2.2 Emotional frustration and disservice by the criminal justice system

Beyond the psycho-social circumstances, the results of this study show that there are superimposed vulnerability factors that caused participants to access mental health services for the first time. The theme of emotional frustration and disservice by the criminal justice system highlights the prevalent and often compulsive involvement by law enforcement agencies, such as the police and courts, in the participants' pathways to mental health services. Participants experienced a sense of profound helplessness and disempowerment, particularly when such agencies invoked the compulsory powers of the Mental Health Act of 1983 [as amended 2007] (Department of Health, 2015).

There are two poignant participant accounts that I can draw on from this theme. First, a reflection on the presumptive diagnosis of psychiatric morbidity by law enforcement agencies: Participant 161219 was grieving in a graveyard on the anniversary of his mother's death, and was approached by police officers and subsequently detained under Section 136 of the MHA before being taken to a psychiatric hospital via the police cells. Police officers may have speculated that the participant was mentally unwell because of the way he was crying and wailing, when this was a culturally appropriate grieving process behaviour for the participant.

Section 136 of the Mental Health Act 1983 (Department of Health, 2015) stipulates that police have the power to arrest a person when they believe that the individual is suffering from a mental health crisis while in a public place. However, police are not mental health professionals and therefore they cannot diagnose mental health problems. As expected, and on my professional reflection, this has become a contemporary practice issue. New guidelines require that application of the MHA - Section 136 by the police be done in liaison with mental health professionals to mitigate potential misdiagnosing and errors being made by

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professionals who are not experts in mental health care (Care Quality Commission, 2017). This observation is supported by other studies that reviewed 'legitimisation of grief' in refugee populations and concluded that ethnic or cultural factors influence behaviour and psychopathology that can be misconstrued in host nations (Arlacon, 2009; Papadopoulos, 2006).

The second case involves Participant 238867, who claimed to have been wrongfully accused and charged of a breach of law. She was subsequently tried in court and, in addition, a concurrent psychiatric evaluation that she was neither aware of nor consenting to was carried out. She believed her reaction of resentment, disgruntlement and anger upon the disservice by the criminal justice system was used as a basis for a psychiatric evaluation and influenced the decision for her to be legally committed to a psychiatric hospital.

Literature suggests that mental health problems can be viewed in the context of a reaction to disadvantage and prejudice (Dein & Bhui, 2013).This aspect of the results therefore seems to suggest that a triggered reaction of anger upon experiencing prejudice may itself attract stigmatised psychiatric 'labels', especially for disempowered, vulnerable and disadvantaged individuals (Qassem et al., 2016; Rose et al., 2017). This observation reflects squarely on the experience of Participant 238867 who claimed to have been a victim of a miscarriage of justice and believed that her psychiatric evaluation was based on her angry reaction to being mistreated by the courts. Again, the participant believed that an unconsented concurrent psychiatric evaluation that was carried out while she was being tried was unfair and biased in favour of the courts' opinion. The implication is that independent psychiatric evaluations may not always be free from prejudice but may be perceived as a 'lip service' that that skews opinions towards a more systematically desirable outcome (Memon et al., 2016). McDaniel et al. (2020) described that individuals of a black African and Caribbean background may experience 'transmitted discrimination'. This implies that some diagnoses may result from misperceptions, and subsequent reviews fail to pick up the anomaly due to prejudice.

In a review study, Frederick et al. (2018) confirmed this observation, that there can be independent psychiatric evaluations that are laden with tokenism instead of their purported empowerment value for the service users. This means a court order for hospitalisation could not be feasibly overturned by the hospital clinicians, who fall under the same jurisdiction. In my professional opinion, an unconsented psychiatric evaluation is a contravention of an individual's human rights. From an ethical point of view, informed consent about any care process should be upheld in order to enable the patient to make an informed and voluntary decision about accepting or declining medical care (McManus et al., 2016; Gage et al., 2016). I believe this experience would have made the participant feel marginalised, defenceless, and

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vulnerable, and ultimately perceiving the court system to be unfair and biased. This perception of being marginalised implied some participants in this study had a mammoth task in dealing with all these predicaments.

6.3 Dealing with adversities

This superordinate theme relates to coping strategies that the participants used in dealing with the adversities that they reported. Here, I will discuss the subthemes contained within the framework of coping strategies; these include: 'self-help, including refraining from family support'; 'help-seeking behaviour, including consultation with GP/ primary care services'; and 'dealing with expectations from mental health services'.

Given the various psycho-social circumstances of the participants and the accompanying negative implications to their mental health, they all narrated an attempt to deal with their various circumstances in order to ameliorate the debilitating impact of mental distress. Some described self-help attempts to manage their situations, while a few turned to their families for support and advice. Others had the perception that they were on their own with no readily accessible family support networks. Yet others simply expressed reluctance to access support from their families because they wanted to remain independent, or hesitated because of the implications this would have on their wider family unison. Within these dimensions, some participants described how they tried religion and spirituality, such as mediums, to alleviate their mental distress. It appears the participants' poor expectations of mental health services triggered a general reluctance to seek their help. I will now discuss further some of these adversities as they appear in their subordinate theme clusters.

6.3.1 Self-help

This subtheme primarily shows the participants' self-efficacious strategies to deal with their emerging mental health crises. Some of these strategies involved practical steps including a change of lifestyle in the form of choosing a healthy diet, stopping alcohol, increasing physical exercise; innovative self-help through music therapy; and by practicing spirituality. As with most other participants, a denial or only partial insight of their mental health problem was reported. Other participants described becoming withdrawn, and resorting to religious and spiritual means while avoiding family support. In this study, the characteristic of resilience was a common feature across the divide of participants interviewed.

The available literature does not explicitly address issues regarding self-help initiatives that people from a black African and Caribbean background deploy to mitigate difficulties they experience when beset by mental health crises. On the contrary, available literature largely

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focusses on discussing tendencies of reluctance to engage with services both by the individuals who experience mental distress and their families, thus resulting in further deterioration that potentially leads to psychiatric emergencies. This later observation will be further discussed and elaborated in this chapter.

,Parallels can be drawn between the self-help initiatives that participants reported and the social cognitive theory of 'Self Efficacy'. A psychologist, Albert Bandura, defined self-efficacy as one's belief in one's ability to succeed in specific situations or in accomplishing a task (Zulkosky, 2009). Therefore, one's sense of self-efficacy can play a major role in how one approaches goals, tasks, and challenges in life. There is evidence to show how this theoretical conception influences how the participants feel, think, motivate themselves and react in different circumstances. For example, Participant 300528 described how he refrained from both mental health services and his family's support, preferring to rely solely on spirituality. He was proactive in reducing his mental health distress by doing physical exercises, meditating, eating healthily, stopping alcohol, and so on. Furthermore, he was reluctant to be admitted to a psychiatric hospital and when he was forcibly admitted, he resisted taking any prescribed medications and carried on with his spiritual practices until he was discharged. A few of the participants in this study, such as Participant 190643, used prayer as a self-help initiative. Various participants used self-help initiatives as a coping strategy, and there was a general tendency to refrain from seeking support from their own families. Similar observations have been reported in the literature that people from BAME backgrounds, especially black Africans, resort to prayer and other divine interventions while refraining from seeking help from mainstream mental health services (Kang & Moran, 2020).

6.3.2 Refraining from family support

In addition to the subtheme of using self-help as a coping strategy, participants demonstrated a degree of reluctance to seek support from their immediate families, carers or friends. Most participants preffered to deal with their challenges personally and without feeling like they were a burden upon their relations. Other participants expressed a motivation to preserve an outward self-image of strength, resilience and cheerfulness. According to Chen et al. (2016), "Face concern" refers to an individual's concern about preserving and maintaining a social image of themselves to avoid losing face.

These findings are supported by the view that black African and Caribbean people tend to have a cultural legacy of being strong and intent on hiding distress (Sisley et al., 2011). Another study may help to explain the reluctance to involve or disclose to family members in response to a mental health crisis. Gary (2009) facilitates an understanding of the behaviours and experiences as narrated by black African and Caribbean participants in this current study.

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She argues that the response to a psychiatric emergency can be perceived as an antecedent to discrimination. Therefore, they may deploy behaviours which help them attain and maintain a degree of self-worth and sense of self-efficacy.

However, the notion that the family is used as a first port of call for support is not predominantly reflected in the current study, but rather a deliberate avoidance of family involvement is highlighted by the participants as they attempt to independently deal with their problems. In addition, participants were fearful of involving family members in the first instance because they wanted to protect their loved ones from the distress of dealing with the situation, while being sensitive to the potential effects of societal stigma on the family. Chen et al. (2016) found that while perceived public stigma and face concern were independently associated with patients' self-stigma, face concern partially mediated the relationship between perceived public-stigma and self-stigma. This suggests that there may be another level of stigma between the individual and their family where the individual is blamed for potentially bringing shame to the family by developing a socially unacceptable illness, as discussed in Larson and Corrigan (2008). This outcome implies that stigma in families can result in compromised self-esteem, difficulty in making and keeping friendships, difficulty in finding jobs, and a reluctance to admit to the existence of mental illness (Scambler, 2019). Insights from Goffman's (1963) theory on 'Spoiled Identity' aids the understanding of some of the manifestations of stigma which emanate from labeling people with mental health problems. This creates a socially rejected individual because of a societal misperception of that individual who, in turn, internalises the experience and reacts by self-isolating from the public arena. While stigma in mental illness can be experienced by individuals in a general population regardless of their ethnic background, black African and Caribbean people are often at the harsher end of social stigma, unjustified perceptions, stereotyping and discrimination which often is fuelled by negative media portrayals (Fernando, 2017).

Most of the participants in the current study perceived their families both as a conflicted source of supportive help and the undesirable source of external stigma. The reluctance of service users to involve their families is not limited to people of Black African and Caribbean origin; it is also common amongst white families and is related to previous conflicts in the family (Ramon et al., 2017). However, while white people may choose to withhold information from their families to preserve some privacy, black people must also deal with the potential stigma that they may experience from their families.

6.3.3 Help-seeking behaviour

The subtheme of 'Help-seeking behaviour' is derived from participants narrating their ordeals of experiencing a further worsening and debilitating mental health crisis. Deterioration of

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symptoms was characterised by severe distress, extreme psycho-social vulnerability, emotional instability, self-isolation, a sense of oblivion, and dilemma on how best to deal with their predicaments. In as much as most participants reported some level of resilience in dealing with their mental health crisis, the need to seek advice and guidance was inevitable as symptoms worsened into a crisis. In some cases, participants appeared to lack insight into their worsening circumstances and did not see the need to consult their families for support or to seek professional help. Inadvertently, most participants experienced a heightened level of well pronounced mental distress symptomatology.

These findings are supported by research evidence which has shown that late presentation with acute mental health crisis is thought to be linked to delays in help-seeking by people of a black African and Caribbean background. Therefore, this leads to the worsening of symptoms that characterise a mental health crisis (Bhui et al., 2018). Men were reported to have difficulty in discussing their symptoms with service providers due to the public perception of help-seeking as a weakness (Corrigan et al., 2010). This observation is likely to be responsible for increased rates of compulsory admission and restrictive treatment procedures, and poor engagement with primary care and community-based mental health teams (Rabiee & Smith, 2013).

Self-stigma occurs when an individual is consciously aware of the negative stereotypes that arise from their illness, and resolves to internalise them (Corrigan et al., 2010). Internalisation of the stigma can start when individuals notice that others act differently towards them because of their mental health problems. Subsequently, these individuals begin to normalise, and believe that the views and attitudes about people with a mental health problem are normal and justified. In the final stage of internalisation, individuals will conceptualise and apply the prejudices to themselves and act accordingly (Chakraborty et al., 2013). This process has been linked to an increase in the intensity of symptoms, and a worse overall prognosis.

Literature suggests that negative perception of mental health services can often delay help-seeking. 'Breaking the Circles of Fear Report' findings have shown that there is an real circle of fear: people from black backgrounds shun services and often view them as coercive or oppressive (Sainsbury Centre for Mental Health, 2010; Bard et al., 2021). The involvement of police and courts of law in mental health services serve to reinforce the coercive and oppressive nature of the services, thereby perpetuating a circle of fear (Williams, 2018).

In addition, there is a general fear of people with mental health problems within communities where mental health stigma is usually propagated. Through a meta-synthesis of research studies investigating stigma and pathways to care, Gronholm et al. (2017) identified six broader interconnected themes around stigma-related barriers to help-seeking. These themes

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included "a sense of difference", "characterising difference negatively", "anticipated and experienced negative reactions", "self-coping strategies" which include denial or non-disclosure, "lack of knowledge and understanding", and some "service-related factors". These themes can interact in myriad ways, further illustrating the complexity of the relationship between stigma, help-seeking behaviour, and pathways to care. Some literature sources specifically suggest that black African and Caribbean individuals are more likely to present to mental health services in acute circumstances that include self-neglect, heightened levels of agitation, and the likelihood of being perceived as dangerous by clinicians (Bhugra et al., 2014). These observations confirm the circumstances described by participants in this current study. The participants tended to refrain from seeking professional help until their symptoms had become unmanageable. A systematic review of studies in the UK suggested that people with first episode psychosis experienced a low level of social support and fewer social contacts than the general population (Gayer-Anderson & Morgan, 2013). This view seems to support the finding that participants in this study deliberately avoided support from their own families and, as a result, they suffered reclusively.

It appears that most black individuals would turn to informal mental health care providers such as family, religious leaders, or friends in the first instance. This inevitably delays early treatment initiation by mental health professionals yet it appears that informal mental health care was preferred by the participants to the mainstream formal mental health care system. The most frequently cited treatment intervention for most African migrants was spiritual healing. More specifically, female participants from both African and Caribbean backgrounds identified 'faith' as a coping strategy for mental health problems. The current study results show that family interventions for these participants were only carried out at the height of a crisis rather than in the initial stages of symptom development. Therefore, presenting to services is arguably associated with a worsening of symptoms which often require crisis psychiatric admission,usually under restrictive measures.

Only a few participants in the current study, like Participant 159205, reported accessing their GPs and counselling services, which temporarily helped to slow down further deterioration of the mental health crisis. Bhui et al. (2018) observed that encountering mainstream mental health services and subsequent crisis admission was perceived as a last resort and followed unsuccessful attempts of other treatment options. Crisis admission was seen to be correlated with extreme states of feeling confused, chaotic, having hazy memories and feeling overwhelmed, and many other advanced symptoms of mental distress.

However, one participant – Participant 300632 - who did not have any family or friends in the UK, was proactive in seeking help from professional services without support. This level of

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proactivity in seeking help is not discussed in the current available literature. However, it can be argued that this participant did not have any prior acquired knowledge of mental health services and, to him, this was a golden opportunity to get free healthcare which was not available in his country of origin. The participant had remarked that accessing care in his native country was determined by one's level of social standing and financial resource.

6.3.4 Accessing primary care services

Results of this study seem to imply that there is a poor uptake of primary care services by people from a black African and Caribbean background. Consultation with a GP or accessing counselling services via primary care teams provided an opportunity for further deterioration of symptoms to be curtailed. However, most of the participants, like Participant 300528, Participant 149043, Participant 238867 and others, reported receiving input from such services in the aftermath of crisis and post-discharge from a psychiatric hospital. Numerous other UK-based studies have looked at issues pertaining to access of primary care services by black individuals and confirmed that there is indeed a suboptimal uptake of primary mental health services, including psychotherapy (Department of Health, 2011; Bhui et al., 2014; Glover et al., 2010; Keating et al., 2007).

Findings from this UK-based study, where participants reported a low-level usage of primary care services or consultation with their GPs, are corroborated in a study by Bhui et al. (2014). Barriers to accessing mental health services were identified as: distrust of formal services; lack of trust in medication; discrimination; preference for alternative care; cultural incompetence of service providers; cultural differentiation in mental health conceptualisation; lack of collaboration between main stream services and the informal sector such as churches; embarrassment and discomfort; and self-reliance / resilience (Rabiee & Smith, 2013). Therefore, this confirms that cultural norms, stigma attached to mental health problems, and attitudes to the services are contributory to the formation of barriers to accessing the services.

Other studies have identified the English language as a prominently featured barrier to accessing mental health services for the first time by black African and Caribbean individuals (Bhui et al., 2018; Scambler, 2019). However, while this observation can have binding implications on the generality of the target population, this current study recruited participants with the ability to speak and write the English language; therefore, the language barrier had not been a limiting factor for t participants upon encountering mental health services for the first time.

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6.3.5 Expectations from mental health services

The results under this subtheme show that participants' expectations from mental health services appeared to be characterised by anxiety and fear of the unknown. The participants described their expectations of being involved with mental health services and being admitted to a psychiatric hospital in various ways. Some had the expectation of being in captivity in unsafe environments where they would feel vulnerable.

According to Singh et al. (2013), individual expectations are formed before hospitalisation and are often characterised by uncertainty, anxiety and distress. The authors also reported a sense of oblivion amongst participants in their study when they expressed a lack of knowledge of what to expect from being involved with mental health services. Participants in the current study described feeling daunted, overwhelmed, frightened, confused and uncertain. The literature also echoes further anxieties expressed by participants in the current study. Some expectations were shaped by participants' socially acquired knowledge about mental health services through previous experiences by family members or friends, or from reports from the media.

Others identified the trend of reluctance in individuals to engage with mental health services because of stigma attached to mental illness, as discussed earlier in this chapter. These findings concur with other studies which have shown that a broad range of factors, including social support networks, physical appearance, social factors, religious and cultural practices, and other factors, are intertwined in determining how expectations, perceptions and overall experience of the mental health services are shaped, and more so for the people from black African and Caribbean background (Singh et al., 2014; Bhui et al., 2018). Other participants anticipated being socially isolated in scary environments with regular punishments imposed. A few participants, like Participant 159205 and Participant 300528, associated psychiatric hospitals with prisons where they would be kept sedated, medically tranquilised, punished and humiliated.

Some participants, like Participant 238867, believed that being admitted would mean losing all personal freedom and liberties as well being subjected to restrictive and regimental practices. One participant, Participant 161219, expected hospital admission to be like a trap and used the phrase 'strait jacket' to describe the restrictive nature he expected of such environments. The same participant also expressed that hospitals were for crazy people who do drugs and those who hang around in the streets doing nothing. These themes have been confirmed by other research studies which observed that expectations and perceptions of being disadvantaged in mental health services predict risk factors that perpetuate an

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escalation in disengagement tendencies, which usually leads to further deterioration of mental health and poorer outcomes (Ghali et al., 2013; Reininghaus et al., 2010).

In my opinion, participants' stigmatised impressions are well formed about getting involved with mainstream mental health services, or being hospitalised in a psychiatric hospital. This is because of how services may be negatively portrayed by the media or in shared opinions of others who may have experienced the services negatively. Similarly, another study on immigrants' attitudes to mental health services showed that participants held negative expectations about accessing help (Rabiee & Smith, 2013). It is notable that one participant in that study expressed descriptive sentiments similar to Participant 161219 in the current study, implying that only crazy people would seek mental health care. Another more recent study (McDaniel et al., 2018) confirmed that cultural 'stereotypes' held by clinicians and the service users' traditionally-held beliefs about mental illness may perpetuate a reluctance to engage with services due to the perception of stigma and being misunderstood.

This bleak picture of participants' expectations from mental health services provides a basis for an explanatory standpoint and sheds more light on why people of a black African and Caribbean background shun mainstream services. Given that most participants reported negative connotations about getting involved with mental health services, these negative expectations may have given rise and expediency to the formation of barriers to voluntarily accessing mainstream mental health services. Conversely, motives for participants to resort to self-efficacy in the first instance can be undermined by the negative attitudes they hold about mental health services, and therefore this helps to explain the poor engagement in the initial stages (Rose et al., 2017). One participant (Participant 300528) felt that the clinicians would not understand him and his preferred inclination to spiritual practices as a mitigating measure of his mental health crisis. He believed he was predisposed to negative experiences due to his physical stature and colour of skin.

The implication here is, that he expected his own recovery initiatives to be disregarded by the clinicians once he was admitted. This suggests that service users would engage more effectively with mental health services if they expected their own self-help or recovery initiatives to be taken into consideration. What is striking is that the expectations that participants held were centred on the characteristics which would be the least expected from a hospital; the irony here is that participants' expectations were juxtaposed to the care that these hospitals and other care services are purported to deliver. Current literature does not discuss this view of 'being punished or deserving punishment' for experiencing a mental breakdown: it would appear the experience of a breakdown was seen to be the embodiment of a crime committed by an individual and which therefore deserved to be punished.

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6.3.6 Accessing community mental health services

The results of this study show that participants held an array of perceptions about their care while involved with the community-based mental health services. There is a mixture of positive and negative experiences that participants expressed about community services and that seems to expose dichotomous perceptions of satisfaction and dissatisfaction.

The community-based secondary mental health services that the participants predominantly reflected on include CMHTs, EIPS and CATTs. Within this framework of services, some participants express dissatisfaction with delayed interventions by CMHTs and their inconsistency in the allocation of care coordinators, the implication being that this is directly responsible for the further deterioration of mental health that participants experienced. The constant change in care coordinators suggests that participants experienced difficulties in formulating therapeutic relationships with them. It seems there was a gap in care provision in view of the lengthy periods of time that participants would spend without access to a care coordinator.

Satisfaction with community mental health services

Only one participant, Participant 300632, expressed full satisfaction with the range of support he received from the CMHT. While there was a delay in getting his care transferred over from his previous address, he was happy to have been allocated a care coordinator within a short period of time. Other participants were satisfied simply by having key workers of a similar ethnic background allocated to their care. It appears the matching ethnicity of care givers helped the service users to feel welcomed and instilled confidence in the service that was on offer, as well as increasing the level of therapeutic engagement.

Literature suggests that satisfaction rates with CMHT services for individuals of a black African and Caribbean background tend to be influenced by first- or second-generation immigration statuses. Satisfaction is thought to be higher in patients who have not long immigrated to the UK than for those who have been around longer (McFarland 2009; Raleigh et al., 2007). This observation confirms the experience of satisfaction expressed by Participant 300632 as he had not long immigrated to the UK. However, the initial satisfaction expressed by those participants who appreciated being allocated a care coordinator of a similar ethnic background, was not sustained. Other participants in this study expressed dissatisfaction with both the care aspects and the care coordinators, regardless of their ethnicity.

Dissatisfaction with community mental health services

With regard to accessing community-based services, participants reported significant negative experiences characterised by delayed interventions, inconsistency in the allocation of care

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coordinators, lack of continuity and disengagement, and a lack of sincerity and dismissive attitudes by staff. Participants also reported feeling unsupported and ignored by the service clinicians and, in some cases, being ridiculed and embarrassed.

These results are confirmed in the literature that discussed satisfaction rates of service users and their carers who accessed community-based services (McFarland, 2009; Raleigh et al., 2007; Warfa et al., 2006; Keating et al., 2004).

In this current study, however, while other participants expressed a sense of comfort and satisfaction upon getting allocated to care coordinators who were of similar ethnic backgrounds, it appears this comfort was short-lived. Some participants became unhappy for reasons addressed above including inaccessibility of these key workers when they were most needed: the ever-changing staffing levels within community teams did not help the situation as this led to inconsistencies and lack of continuity of care by familiar professionals. It is important to note that sense of satisfaction is about relationships between service users and staff members and not about interventions such as medication, occupational therapy or psychological interventions. These observations regarding relationships with staff are further discussed in later sections of this chapter under the theme of 'Relationship dynamics with clinicians'.

6.4 Experiencing inpatient mental health care

The results under this theme capture what participants described as their general experience once they were admitted to a psychiatric hospital. Participants expressed varied opinions of satisfaction and dissatisfaction with the inpatient service. A general overview of results gives a rather balanced outlook on these experiences as either being positive or negative. Participants made comments about the hospital environment, food, treatment / care, and therapeutic bonding with the professional staff, communal time and recreational activities, and so on.

Bhui et al. (2018) observed that not much is known about the initial inpatient experience and what informs the positive or negative appraisals given to such experiences. However, participants recruited for their review study had previous experience of psychiatric hospitalisation, contrary to those in this current study for whom it was a first-time experience. Re-admission experience might have introduced bias because the participants would have had pre-formed opinions about the service, given the assumed familiarity to ward routines and the staff.

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Satisfaction with inpatient services

Contrary to the generally predominant negative narratives about the experiences of admission to a psychiatric hospital, a few participants expressed a sense of satisfaction. Some participants described being happy and content with their experience on the psychiatric wards. They described the staff as caring, considerate and listening, and that they tried to meet their patients' needs despite staffing level constraints. Others referred to feeling comfortable on the psychiatric unit and observed that the hospital staff members were supportive and understanding.

In a study by Rabiee and Smith (2013), participants' experiences concurred with the current study participants in expressing satisfaction from feeling that they were being listened to and understood by the ward clinicians. Therefore, the participants summed up their experiences to be good quality patient-centred care that was based on compassionate and empathetic care. Participant 300528 made specific reference to the availability of refreshments like tea, coffee, biscuits and fruits. Some of the participants talked about deriving comfort from the balance of racial backgrounds of staff.

Participant 161218 viewed the psychiatric hospital as a haven where one could get rid of all the bad thoughts. This finding demonstrates that the psychiatric hospital may be perceived as a therapeutic environment or a safe place to get cured. Literature has confirmed these views that some patients of a black African and Caribbean background hold - the perception that hospitals are a place where patients feel safe and consider them as a respite and a place where one is cared for and can feel safe and secure due to the reassurance they receive from clinicians (Singh et al., 2014).

In contrast, Wagstaff et al. (2018) found that black Caribbean patients, particularly those of second-generation born in the UK, were significantly less satisfied with almost every aspect of the services that they received than either older black Caribbean patients born in the Caribbean or white patients. This trend appeared to be echoed by most black Caribbean participants in this current study. However, a study by Singh et al. (2014) argued that there was no variation in attitudes towards services between first- and second-generation migrants.

Rabiee and Smith (2014) observed that black Caribbean patients tended to provide more responses to the questions about negative experiences of inpatient mental health services than their black African counterparts. However, the literature on dissatisfaction with the inpatient mental health services seems to be greater than that of satisfaction by both black African and Caribbean individuals. It is also worth noting that some of the participants expressed mixed feelings of both satisfaction and dissatisfaction of the inpatient services.

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Dissatisfaction with inpatient services

In this subtheme, the results highlighted some negative attributes that participants ascribed to their experience of being a patient on a psychiatric unit, and these included a general feeling of being confused and disorientated after admission to a psychiatric hospital, as well as finding the hospital environment to be unsettling and noisy. Also, some participants experienced the psychiatric wards as unsafe: they feared for their personal safety and security as they perceived fellow patients from Caucasian backgrounds to be unfriendly, aggressive and violent.

Breaking Circles of Fear (2002) investigations concluded that experiences and perceptions of black African and Caribbean communities were of general mistrust for the mental health services. Secondary acute mental health services can be experienced as negative and traumatic (Elliot, 2016; Qassem et al., 2015; Gage, 2019). A review study that looked at satisfaction outcomes by ethnic minorities in UK-based studies confirmed a prominent trend of dissatisfaction derived from secondary mental health service usage (Chorlton et al., 2012).

The mental health inpatient unit conditions made some of the participants feel angry and frustrated as they tried to deal with a sense of social isolation derived from a perception of being trapped and restricted. Participants compared their spell in hospital to being like a prisoner with no freedom to interact with the 'outside world', and to feeling like an 'outsider' due to being a racial minority. Literature suggests that mental health service users may feel unsettled and restless when their freedom is curtailed (Halvorsrud et al., 2018; Gage, 2019). This experience speaks to the restrictions inherent in institutions that are often aligned with feeling closed-in, aggravated, castigated, frustrated or humiliated. Therefore, the lack of freedom to go out for walks and fresh air contributed to making patients feel ostracised, just like participants in this current study reported (Memon et al., 2016; Rose et al., 2017). Psychiatric hospitals were perceived as more isolating environments that exacerbated feelings of hopelessness, hence why others preferred receiving home-based care.

Participants reported experiencing embarrassment and loss of dignity due to the restrictive and closely monitored personal hygiene routines. This experience of 'loss of dignity' would perhaps have been the same for every other patient regardless of their racial or cultural background. However, some cultural beliefs revolve around strict privacy when attending to intimate personal hygienic routines (Weich et al., 2012). Some female participants, such as Participant 159205 described a lack of hair grooming equipment suitable for black people. There was a general feeling that their needs were neglected, and some referred to their dietary requirements not being accommodated. Parkman et al. (2018) asserted that black African and Caribbean patients may find psychiatric services less appropriate to their needs and,

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therefore, may perceive non-consensual hospitalisation as being aggravated by the mental health services (Rose et al., 2015; Wagstaff et al., 2018).

Others made comments about the racial staff mix on the wards, noting that this was unbalanced in top management, and had doubts that their needs as black patients were understood at service management level. Yet other participants talked about deriving a sense of comfort and protection upon seeing some of the staff with similar ethnic backgrounds to themselves. However, Participant 149043 talked about her experience of feeling stigmatised by these very staff members. In addition, participants experienced the ward environment as having a limited scope for recreational and physical activities. However, others derived comfort from seeing professional staff of similar ethnic backgrounds, though others felt threatened by these very clinicians. This outcome suggests that what other participants may have perceived as satisfactory was not necessarily satisfactory for the other participants.

There are confirmatory studies that assert that individuals from a black African and Caribbean background have dissatisfactory inpatient experiences (Bhui et al., 2018). In their study, one of the major aspects surrounding the theme of negative experiences within inpatient mental health services from people of a black African and Caribbean background relates to the perception of culturally insensitive service provision, being misdiagnosed based on featuring cultural contexts, and misinterpretation of personal expressions. McFarland (2009) observed that black African and Caribbean patients' experiences were overwhelmingly negative about inpatient services, but community services were perceived more positively.

Other qualitative studies have identified the commonality of negative experiences in relation to inpatient care with participants describing loss of control and a profound sense of feeling isolated (Weich et al., 2012; Qassem et al, 2015; Memon et al., 2016). It appears though that these themes would still emerge regardless of the ethnic or racial differentiation. What stands out from these studies is that participants from a black background experienced more negativity from inpatient care services where, for example, language barriers become an issue, or the service was experienced as socially isolating.

Halvorsrud et al. (2018) argued that predictive positive outcomes from mental health services are based on the initial perception of the admission process. They identified that dissatisfaction was influenced by multiple key factors including being a formally detained patient, being admitted to a locked ward, and the experience of coercion. These observations are corroborated in a European cross-sectional study that reviewed factors associated with satisfaction from inpatient mental health services by individuals in general (Bird et al., 2019). Further, hospital was regarded as a place that made patients feel worse, and participants were

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observed to lack bargaining leverages and feeling powerless in negotiating their care and the admission process.

Participants in the current study also remarked that being a patient in a psychiatric hospital felt like being in a prison where regimental procedures were practiced with no regard to personal privacy. Patients were routinely searched upon admission and have their personal items and valuables removed, leaving them feeling vulnerable and defenceless. They experienced further invasion of privacy and personal space when they were subjected to constant observations and being monitored while bathing and toileting, which often led to loss of dignity. Inpatient environments were described as chaotic and noisy due to some fellow patients being agitated, and a lack of recreational activities meant they were bored. Staffing levels were observed to be over-stretched and there was poor communication of information regarding ward rounds or orientation to the ward. These findings are again supported by a recent study by Bhui et al. (2018).

While the results of this current study are confirmed in the literature above, there are some interesting observations to note. It is very concerning that those participants who tried to be proactive in making their inpatient spell - and that of their colleagues - a bit more comfortable, felt that they were victimised and punished by the professional staff. Participants viewed the reactions by staff as reprisals for over-stepping professional boundaries. This seems to suggest that participants viewed the inpatient environments as deliberately designed to be uncomfortable for patients, so any attempt to change that design would be met by reprisals from the staff. Some participants simply perceived the inpatient phase as enduring discomfort, and the hospital staff as uncaring and inefficient. Participants may have derived a sense of solidarity from seeing other clinicians who resembled their ethnic background; however, others experienced a sense of 'othering' upon being admitted to a ward that was numerically dominated by Caucasian fellow patients. Therefore, the consequences of 'othering' can have detrimental effects on black individuals in the UK NHS. This can negatively impact on both physical and mental health, and general well-being, and deter full participation and engagement for those marginalised as 'Others' based on racialised identity constructions and the mediating effects of skin colour (Bhopal, 2018; Bonilla-Siva, 2014; Udah & Singh, 2019). The general discomfort participants experienced, together with the amount of coercive interventions within hospital, would have probably aggravated and exacerbated their feelings of vulnerability and hopelessness.

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6.4.1 Experiencing coercive interventions

The theme of coercion is drawn from participants' reports of experiencing force and compulsion within mental health services. They experienced the coercion in the form of legal or procedural interventions, or both.

Being legally coerced

Most participants made significant reference to the involuntary nature of their admission to a psychiatric hospital through being subjected to the Mental Health Act (MHA) 1983 [as amended 2007]. Participants were subject to various Sections of the MHA depending on the professional body or representatives who applied the Act. A significant number of the current study participants were initially detained under Section 136 by the police and transported to a psychiatric hospital where they later were reassessed by the psychiatric doctors and detained under Section 2 and, subsequently, Section 3 of the MHA. Others were formally committed to a psychiatric hospital by the courts under Section 37/41. Another – Participant 238867 - also referred to experiencing a continuation of compulsory powers of the MHA via a Community Treatment Order (CTO), even after being discharged from hospital. This participant reported feeling too restricted to resume and regain her life outside of hospital, and resultantly lost her job and a house.

These results show that people from a black African and Caribbean background encounter mental health services through complex routes. This includes a reluctance to engage with primary care services, hence the lack of timely referral to specialist services leading on to involuntary admission to a psychiatric hospital, often with the involvement of police, the criminal justice system and the application of the MHA (Bhopal, 2018; Bhui & McKenzie, 2007). Several other studies have explored these phenomena further and confirmed similar findings where black African and Caribbean people experienced more complex pathways that involved some form of coercion (Ghali et al., 2013; Morgan et al., 2014). Also, a systematic review by Singh et al. (2013) produced consistent findings in support of the above observations.

More recently, findings from the Independent Review of the Mental Health Act (Hawkes, 2019) showed that black African or black British individuals were four times more likely to be detained under the MHA than white people. While this review was based on figures collated via NHS Digital for the period 2017-2018, the disproportionate numbers of black people who were detained is reflected in most of the earlier studies, suggesting that the discrepancies remain to this present day. The review further exposed the disproportionate representation of black individuals who are detained under CTOs and found the total numbers to be eight times higher than for white people. However, a south London study by Bhugra et al. (2014) found an

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insignificant shift in the pattern of care pathways for black people when compared to their white British counterparts. They concluded that the pathways to specialist mental health services by black African and Caribbean people were not significantly different from white British people.

In the wider European context, studies have explored ethnic variations in pathways to care and shown that black African and Caribbean patients are more likely than white patients to experience coercion and compulsory admissions (Singh et al., 2014; Frederick et al., 2018; McDaniel et al., 2020). Also, Rose et al. (2017) found that psychiatrists' cited reasons for compulsory admission presented a stark variation based on ethnic differences, with black African and Caribbean people being more often admitted under compulsive measures due to violence towards others. This study seems to imply that institutional racism and racial stereotyping clinicians perceive black patients as being violent and aggressive. This implies that these participants carried a higher risk of having restrictive measures meted out to them.

Systematic reviews and meta-analysis results have shown that people from black communities are disproportionately detained under the MHA (Chorlton et al., 2013). These findings are substantiated by subsequent studies (Bhui et al., 2014). Further studies were undertaken and highlighted the imbalance of the ethnic variation in the application of the MHA, where ethnic minorities and, especially, the black African and Caribbean individuals, were over-represented (Singh et al., 2013; Anderson, 2013; Mann et al., 2014; Centre for Mental Health, 2013).

However, a UK-based prospective study covering a period 2008 to 2011 inclusive gave contradictory findings (Singh et al., 2014). The study suggested that ethnicity was not an independent predictor of involuntary admission to a psychiatric hospital but that factors such as lack of social support, having an existing diagnosis of psychosis, being female, living in London, and presenting with elevated risk, were plausible predictors.

Though my study does not use control variables as in the study above, literature has clearly shown that individuals from a black background assume a disadvantaged position in society fraught with debilitating psycho-social factors. Above all, my study participants were first-time users of mental health services and were unlikely to have had existing diagnoses, or pre-formed opinions about mental health services.

However, an overarching 'Count Me In Survey' that investigated the experiences of inpatient environments by people from BAME backgrounds, showed that, compared to their white counterparts, these individuals were more over-represented in the total number of people under restrictive measures or sections of the MHA, including CTOs (Care Quality Commission,

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2011, Independent Review of the Mental Health Act, 2019). This trend of inequalities was also evident in how participants in this study experienced mental health services in general despite their being legally coerced. Participants described the general care procedures and interventions to be coercive in nature.

Being procedurally coerced

Participants described being subjected to coercive psychiatric interventions once they had been admitted to hospital. They referred to the restrictive nature of the inpatient environments and how any attempts to escape from perceived bondage were met by reprisals. Similarly, some participants who resisted taking prescribed medications reported being coerced to comply while constrained under physical restraint. It would appear therefore, that any propensity to pursue freedom from such restrictions and entrapment would be met by coercive treatment procedures. Participants reported being subjected to physical restraint and being tranquilised by medications. Seclusion in psychiatric intensive care units (PICUs) was one of the interventions reportedly used as a deterrent, and participants perceived this to be punishment.

BAME service users found the process of accessing help to be shaped by the experience of being quickly pushed into the system and compromising with that very system in order to get the help that they needed (Gajwani et al., 2016). Participants in the current study described services as lacking flexibility, so much so that it sounded more like it was a taboo to express one's spiritual needs lest these should be misconstrued as psychosis and attract coercive treatment procedures.

According to Keating (2009), men from black African and Caribbean backgrounds were over-represented in mental health services and usually came to the attention of services via the criminal justice system, and were more likely to receive the harsher end of services by means of being secluded in PICUs, and controlled and restrained. Also, the Commission for Healthcare Audit and Inspection (2007) observed that individuals from BAME minority backgrounds experienced higher than average rates of detention in medium and high secure PICUs. Further, Keating (2009) discussed the misconceptions that clinicians may hold in associating black individuals' physical features of being black, tall, big, bad, and dangerous to be less deserving of treatments that bring about recovery; instead, they experience more punitive and restrictive measures.

Pilgrim and Rogers (2014) singularly identified psychiatry practice to have a legal role to forcibly treat, restrain and control individuals. They argued that because of racial biases, individuals from a black African and Caribbean background experience disproportionate rates

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of care from specialist mental health services, often involving coercive procedures and compulsory treatment. However, forced treatment violates Article 12 of the European Human Rights Convention (ECHR) and, more specifically, the right to personal integrity (Article 17), freedom from torture (Article 15) and freedom from violence, exploitation, and abuse (Article 16). The ECHR perceives forced treatment to be a denial of the legal capacity of a person to choose medical treatment, therefore classifying it as a violation of Article 12 of the ECHR (Hoffman et al., 2016).

Recent critical discussions of the literature suggested that the response from mental health services to these legislative remarks has been adamantly defensive. It would appear there had been wanton attitudes to advance coercive interventions in practice while, on the other hand, advancing accusations at the ECHR for undoing hard-won victories in order to accommodate the Human Rights law (Duffy & Kelly, 2017). Concerted efforts were conducted with the aim of discrediting the Convention's stipulations where they contradicted the notion of a common-sense approach to protecting citizens who were incapable of protecting themselves (Applebaum, 2019). However, Bennewith et al. (2010) observed that ethnicity was not a determining factor amongst individual service users who experienced coercion in mental health care and that there is more evidence suggesting the participants experienced more inequalities in other aspects of the care. These inequalities meant that participants felt, somehow, segregated and discriminated against.

6.4.2 Experiencing discrimination
The theme of discrimination was derived from participants' reflections on what they viewed as discriminatory care practices which disadvantageously separated them from their white counterparts in terms of how they fared in the service.

Deprived access to psychotherapy
Deprivation in accessing psychological therapies was singled out as one such aspect of the care services where participants experienced discrimination. They identified that the psychosocial model of care was discriminately applied much to the disadvantage of most participants in this study. Participants expressed that the emphasis of treatment was on pharmacological interventions, even though a significant number of these participants did not agree with taking medication.

Research evidence has shown that there are common concerns amongst black individuals in relation to accessing preferred treatment options. Black people were reported to be dissatisfied with lack of access to, or being referred for, talking therapies (Raleigh et al., 2007). The AESOP study also supports these findings and showed that individuals from black

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backgrounds were less satisfied with elements of the care they received. Black Caribbean people are singled out for being dissatisfied by their admission processes and disagreed with prescribed treatments, or believed they received the wrong treatment (Boydell et al., 2012).

Participants in the current study described experiencing restrictions in accessing psychological therapies, but observed an overreliance on pharmacological interventions that clinicians preferred as a favourable treatment option. A supportive study by Carr et al. (2017) reported that black individuals expressed beliefs that their backgrounds, including race, ethnicity and culture, influenced the type of service they received. Further studies have asserted that black individuals are less likely to be diagnosed with personality disorders and to be referred for specialist interventions such as psychotherapy (Raffi & Malik, 2010; McKenzie & Bhui, 2007). However, it is believed that psychotherapy can be widely and inclusively tailored to any diagnosis that has a component of psychological distress (McGilloway, 2010).

Deacon (2013) also discussed cultural discrimination and asserted that there is a lack of holistic approach in mental health. She added that no due consideration is given to spiritual dimensions of conceptualising mental health problems but there is intentional bias emanating from the assumption that medication is the only source of healing. According to reports by participants in this current study, prescription of medication appeared to be generally an unwelcome intervention, a phenomenon that is mirrored in other studies (Naz, 2019; Beck & Naz, 2019).

The concept of a bio-medical model in health care provides a more vivid explanatory framework for this discrepancy in illness attribution and recognition. Different cultural, religious and spiritual beliefs influence illness and recognition (Turnbull, 2020). Compared to their white counterparts, black people are less likely to adopt biological explanatory models of mental illness and more likely to attribute mental illness to some social, cultural or spiritual factors (McCabe & Priebe, 2004; Mzimkulu & Simbayi, 2006; Olugbile et al., 2009). In the current study, the attribution of socio-cultural factors is unambiguously captured by Participant 169043, who claimed that her family believed mental health breakdown was viewed in the context of a bad omen or spiritual attack. Therefore, a prescription of medication was perceived as the least likely intervention to deal with such incidences rather than psychosocial measures.

Commissioning in the NHS is largely based on the medical model entrusted to the 'expert' clinician.The psychosocial model is based on the quality of relationship between the clinician and the patient. The New Horizons Report (2018) suggested that the psychosocial model was considered more effective in supporting BAME individuals than the medical model. Further

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supporting arguments were put forward that, while a psychosocial model of care was recommended for being efficacious for everyone, it was more so for people of a black African and Caribbean background because of their predisposition to debilitating psychosocial factors (Mental Health Foundation, 2014). Having earlier discussed how BAME populations are inadvertently predisposed to negative psychosocial factors, it is imperative that participants in the current study accessed psychotherapy. In most cases, participants rejected medication as a form of treatment and believed that it was inappropriate for their needs as well as being culturally, religiously and spiritually unacceptable to them.

However, participants both from immigrant populations in the US-based study and those in this UK-based study were less likely to take psychotropic medications when compared with non-immigrants. This seems to reinforce the earlier observation that these individuals are likely to be more receptive to psychosocial interventions, and reject medications on cultural, spiritual or religious grounds. The implication of being denied access to psychosocial interventions for the participants in this current study would have felt like they were being ignored and alienated from accessing evidence-based efficacious interventions.

Socio-cultural insensitivity

The subtheme of cultural accommodation evolved from participants making comments about what they considered to be their cultural needs and how these were accommodated in mental health services. Participants expressed their views on culture clash, preservation and assimilation, especially those from a black African background. They reflected on their level of understanding and how their cultural beliefs were represented by the professional staff. Significant focus was placed on the lack of understanding by staff working in service management roles and their variation in opinions on mental health problems. Participants observed that cultural discriminatory tendencies within services created disparities of inequalities for individuals of a black African and Caribbean background.

Some participants talked about how their families' belief systems surrounding anti-hospital treatment clashed with the medical model. They perceived mental illness as a taboo subject; other families still preferred to deal with the incidences of mental breakdown through religious and spiritual means. Others talked about their resolve in rejecting medication and the purported need to be hospitalised. Three participants; Participant 169043, Participant 238867, and Participant 161218, describe the initial cultural shock of being in hospital with a 'mental illness' and how they dealt with the culture clash and, in some cases, the eventual assimilation to the status quo. There is growing evidence from specific studies on African communities which confirm that African cultures are linked to the beliefs that mystical or supernatural

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powers are to blame for the occurrence of mental illness (Ventevogel et al., 2013; Tuffour & Simpson 2019; Bard et al., 2021).

The current study participants blamed bias and ignorance on the part of the professional staff regarding the provision of care that reflected spiritual awareness. Other aspects of cultural insensitivity and lack of cultural accommodation were elaborated by several participants, such as Participant 159205 who talked about segregated provisions like toiletries and hair products or hair grooming equipment, and who believed such provisions were not versatile and suitable only for use by people of a black African and Caribbean background. Others, like Participant 300528, expressed concerns about food and how their preferred choices of vegan diets could not be accessed in hospital compared to other patients of different ethnicity. Another participant – Participant 161219 - referred to experiencing segregated attitudes from the ward staff when he was disallowed to play his Caribbean music as it was deemed noisy, but who observed that his counterpart white patients could play their music CDs at will.

The subtheme about cultural misunderstanding and alienation echoes other research findings which have shown that black African and Caribbean patients may experience a lack of cultural accommodation in mental health services (Maguire et al., 2016). Literature has shown that black people are less likely to adopt biological explanatory models of mental illness and are more likely to attribute mental illness to some social, cultural or spiritual factors compared to their white counterparts (Abbo et al., 2008; Mzimkulu & Simbayi 2006; Olugbile et al., 2009).

However, Fernando (2017) have argued that explanations for health outcomes for BAME populations often invoke the concept of acculturation but that the over-reliance on cultural explanatory frameworks can obscure the impact of structurally discriminatory factors in the experience of mental health disparities. Therefore, to gain a full picture of discrimination that the participants in this study expressed, it is worth discussing other factors of discrimination, including racism.

Experiencing interpersonal racism

This subtheme emerged as participants talked about experiencing racism as a direct result of professional staff's lack of education. Some participants believed that racial profiling, assumptions and stereotyping were prevalent in determining diagnoses. Of note, is Participant 300528, who described how he was predisposed by his physical appearance - with prominent features like being tall, black and big - and believed these characteristics attracted stigma, racism, segregation and stereotypical views from both the clinical staff and Caucasian fellow patients.

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Literature has shown that experiencing interpersonal racism and perceiving society to be racist doubly increases the risk of suffering mental health problems (Karlsen, 2007). Even with social support, racism on its own can cause mental health problems (Karlsen et al., 2005; Bhui et al., 2018). Studies that examined the social determinants of health have long stressed racism's role in the production of health inequalities (Chakraborty et al., 2013). The outcomes of these studies reliably identified racism as a bi-product of social and economic inequalities which are fundamental causes of disease (Tew et al., 2012). The implications for the current study participants are that the day-to-day experience of racism and unfair treatment intersect with other forms of oppression and marginalisation to influence mental ill-health. Participants talked about experiencing the coalescence of criminalisation and medicalisation if their pathways to care involved police or criminal justice services and perceived a lack of genuinely independent psychiatric reviews. They also perceived the care givers as holding cultural stereotypes (Fernando, 2017) when dealing with patients from a black African and Caribbean background.

A qualitative study to examine incidences of discrimination and unfair treatment between black Caribbean and white British patients diagnosed with psychosis, showed that black patients were more likely to attribute the unfair treatment to racism rather than to mental health stigma which was predominantly reported by their white counterparts (Chakraborty et al., 2013). While the results above are truly reflective of the experiences for some of the participants in my study, a significant number of them denied ever experiencing direct interpersonal racism but confirm that they did experience institutional racism, as shown in my Findings chapter. Some participants, Participant 161218, Participant 161219 and Participant 159205, suggested that the availability of staff from BAME backgrounds may have negated any potential incidences of direct racism. However, one participant suggested to the contrary – Participant 169043, reported experiencing mental health stigma from BAME clinicians who suggested to her that a psychiatric hospital was not a place she should be in, and told her to seek divine intervention.

Experiencing institutional racism

This subtheme is derived from the results which suggest that participants experienced more of institutional racism than interpersonal racism. A few individual participants allude to the experience of racist implications in relation to individual clinicians but more significantly so when referring to the organisational characteristics that resembled institutional racism.

Participants referred to stigma being a product of the world's preconceived frameworks about race and how these became a fuelling source for racial segregation and institutional racism (Participant 300528). Other participants, however, argued that there was no room for direct racism given the presence of the mixed cultural backgrounds of the professional staff, perceiving this as helpful in instilling a sense of comfort (Participant 161219). Some

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participants identified a discrepancy when they observed that the rich mixture of cultural backgrounds of the nursing staff did not flow through to management level (Participant 159205). Management roles were seen to be mainly occupied by whites with no physical representation for blacks in service management. Therefore, these participants were not confident that their needs as black patients could be understood at management level and contended that the service was institutionally racist. Yet other participants believed one's socioeconomic status influenced the quality of care one received rather than their racial background (Participant 238867).

The McPherson Report (1999) reviewed institutional racism in the NHS and concluded that it was a failure by NHS mental health services to provide appropriate and professional services to people of a minority race, culture and ethnicity. The report sums up that institutional racism involves discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping that disadvantages ethnic minority people (McPherson, 1999).

Coid et al. (2008) argued that individual psychiatrists cannot be blamed for clinically misdiagnosing black people that they care for; however, looking at the bigger picture poses an explanatory position on why this may be the case. Psychiatrists and related clinicians operate within parameters of a systematic framework that is based on Diagnostic Statistical Manuals or International Classification of Diseases (Fernando, 2017). Therefore, relying on these statistical classification manuals to make clinical judgements may be restricted within the frameworks and guidelines of Western psychiatric ideology - which emerged from the setting of the historic 'Eugenics' concepts. As discussed in the 'Literature Review' chapter, Kraeplin and Bleuler's theory on schizophrenia, as cited in Kaplan (2015), put forward that black people carry a tainted gene that was linked to disruptive and dangerous behaviour, and believed in the inheritability of schizophrenia. In addition, the ICD and DSM frameworks are both derivatives of Germanic eugenic medicine and psychiatry. This suggests that clinical opinions on diagnosing can be influenced by biased historical preconceptions about race and ethnicity that the current study participants refer to.

Additional literature sources suggest that institutional racism is often blamed for misdiagnosis of people from black African and Caribbean backgrounds (Chakraborty et al., 2013; McKenzie & Bhui, 2007). Therefore, institutional racism can be responsible for the fuelling of despondency when considering alternative explanations for mental distress among ethnic minority individuals by clinicians. As a result, participants in this current study described feeling as though they were being alienated and punished with little or no regard for their psychosocial and cultural backgrounds. This suggests a reason why other participants tended to disengage from mental health services.

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A review of literature on the prevalence of misdiagnoses confirms that this phenomenon can be based on clinicians' bias and several other vulnerability factors, including isolation, social exclusion, and racism towards black African and Caribbean patients (McKenzie & Bhui, 2007, Singh et al., 2013; Bard et al., 2021). However, other comparative studies have shown that the claim regarding clinicians' bias when diagnosing could not be sustained as prevalence rates remained high for black African and Caribbean patients regardless of their diagnosis being decided by ethnically matched or blinded clinicians (Pinto et al., 2008; Fearon et al., 2006). To counter this argument, I will refer to the two paragraphs above where I discussed the impact of using pre-determined frameworks in diagnosing psychiatric morbidity. The implication is that ethnically matched, blinded or so-called 'independent assessors', may have their opinions skewed by pre-determined diagnosing frameworks that are enshrined in the ICD and DSM guidelines. Black African and Caribbean individuals' cultural and religious beliefs or practices may clash with western values, hence it may be viewed as unassimilable into western-based systematic assessment processes. A more recent study by Bhui et al. (2018) confirmed that clinicians may hold cultural 'stereotypes' which are buttressed by traditionally held beliefs about mental illness by both the service users and their carers, and which perpetuate diagnostic errors and a reluctance to engage with services due to the perception of stigma and being misunderstood. Fernando (2010) argued that the standardised assessment and diagnostic processes have a limited scope, enough to consider the complexities of social, cultural and political factors that underpin the lives of individuals from a black African and Caribbean background. In support of this standpoint, Singh et al. (2013) agree that psychiatric diagnoses are socially constructed categories that are designed to serve a Westernised social purpose.

In terms of the physical representation of blacks in service management roles, the Workforce Race Equality Standard in the NHS identified that BAME staffs are significantly underrepresented in senior management positions and at board level. In 2012, just one per cent (1%) of NHS chief executives came from a BAME background, compared to 16% BAME representation in the NHS workforce (CQC, 2015). This observation speaks to the participants' experiences of being culturally misunderstood and having unmet needs due to mistrust, lack of faith and confidence in the service. This finding is unique in that it is the first time that service users have identified a discrepancy in the representation of BAME staff in senior NHS service management positions, and contest that the current arrangement is not reflective of the diversity of the service user population. Participant 159205 strongly expressed her dissatisfaction at having no representation of BAME staff in senior NHS management and was not confident that needs of black people were understood and considered higher up the

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management tree. This suggests that ethnic diversity in NHS management would conjure more effective and responsive services for the participants in this study.

The 'Critical Race Theory' (CRT) may provide a holistic explanatory framework that aids understanding of the different types of racial discrimination that individuals from a black African and Caribbean background may experience in mental health services (Ford & Airhihenbuwa, 2018). This concept helps in broadening the understanding of intersectionality of various other factors that interplay to produce discriminatory practices, including unconscious bias. Critical Race Theory works towards the elimination of racial oppression as part of the broader goal of ending all forms of oppression (Bell, 2008). According to Yosso (2005), CRT emerged as part of concerted efforts to confront and oppose the dominant societal and institutional forces that maintained the structures of racism and by so doing, dismantle all forms of racial discrimination. Delgrado and Stefanic (2017) posit that CRT takes into consideration similar issues that are central to conventional civil rights organisations and ethnic studies discourses. Bell (2008) situates CRT in a unique position as it challenges the universality of white experience and judgement as the authoritative standard that binds people from BAME and normatively measures, directs, controls and regulates the terms of proper thought, expression, presentment and behaviour. These observations, therefore, indicate the notion of white supremacy over non-white ethnicities that has been passed on through generations while it has been intertwined within social institutions, including education and health care. This helps to explain what the participants in the current study experienced once absorbed into the mental health care system.

6.5 Dynamics of therapeutic relationships

The theme of relationship dynamics is derived from participants describing their relationships with the health care professionals as well as with fellow service users. The relationship characteristics are drawn from study participants' experiences that begin with the initial contact with secondary mental health services in the community, through to the inpatient spell and aftercare. The participants expressed both positive and negative attributes about their relationships with both senior clinicians (doctors) and junior clinicians (nurses).

While participants described experiencing both negative and positive relationships with the senior clinicians, as they did with junior clinicians, there appeared to be a more significant inclination towards negative narratives for the senior clinicians. Another trend of relationship dynamic emerges serendipitously and fits in with the subtheme of 'patient – patient relationship'.

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6.5.1 Relating to senior clinicians

Supportive partnership

Only one participant - Participant 161218 - talked about her positive experience of feeling cared for and listened to as well as being given information about her condition and feeling empowered to participate in her own care. This positive experience followed her transfer from another ward where she had experienced disparaging and dismissive attitudes from the senior clinicians.

These outcomes seem to directly relate to results of a study by Rabiee and Smith (2013) who observed that some of their participants experienced positive therapeutic relationships with senior clinicians. The participants felt that they were cared for, listened to, kept informed about their care plans, given enough information about their illness and medication as well as updates and reassurance.

Over-powering insensitivity

The results under this theme capture participants' narratives of experiencing nontherapeutic relationships underlined by an imbalance of power with senior clinicians (doctors / consultant psychiatrists). Literature suggests that there is an imbalance of power and authority when mental health service users' interface with psychiatrists (Memon et al., 2016).

Participants in this study expressed that prejudice and aspersions prominently characterised the relationships and communication patterns. Other participants, such as Participant 300528, described the senior clinicians' attitudes to be overpowering, dismissive, threatening, and ignorant of the participants' expressed needs. Joseph-Williams (2014) went further to demonstrate that power imbalance prevents service users from participating in shared decision-making. Similar observations on shared decision-making were made by Ramon et al. (2017).

The study participants believed that any dissent to the clinicians' opinion could easily attract threats and imposition of restrictions under the MHA. Some participants, like Participant 238867, talked about observing collusion amongst senior clinicians when providing independent opinions, particularly in the context of the MHA. While some of these experiences can be similarly expressed for the white individuals, blacks are more at risk of denigration because of their predisposition and vulnerability to being detained under the MHA and attracting cultural stereotypes from clinicians. Therefore, this resulted in the participants' lack of trust and confidence in the clinicians and rendered the appeals process to be tokenistic. Laugharne and Priebe (2006; 2012) found that trust, choice and power interplay to influence partnerships in care between psychiatrists and service users.

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Participant 300528 talked about feeling restricted when he was prescribed medication against his wish. Therefore, service users can feel overpowered when there is an absence of trust and choice and are likely to be uncooperative with care plans in which they do not have a meaningful say. McCabe et al. (2013) suggested that shared understanding of psychiatrist – patient communication is associated with better treatment adherence and outcomes. Therefore, any perception of cooperative relationships would likely result in cooperation and partnership in care between clinicians and mental health service users.

A few participants talked about experiencing pressurised and interrogative attitudes during ward round / review meetings and felt disempowered from participating or having a say in their own care. Participant 238867 expressed her distress upon being psychiatrically evaluated without her knowledge while concurrently being tried in a court of law. However, one participant, Participant 300632, talked about how he got on well with the doctors and voluntarily engaged and adhered to the prescribed medication and treatment plan. Other participants, however, felt like they were being threatened with coercive measures if they did not comply with prescribed medication, or disagreed with any of their care aspects.

In support of these observations, Rabiee and Smith (2013) reported that participants in their study experienced fear of being judged, and therefore perceived the staff as threatening and untrustworthy. Ward rounds were experienced as pressured and intimidating with no opportunity for important questions and decisions to be made especially regarding hospital discharge decisions. Participants reported feeling uncomfortable as though being 'ganged-up on' by a team of multi-disciplinary professionals

Bhui et al. (2018) further observed that meetings with doctors during ward rounds and reviews were perceived to be a gateway between hospital and the outside world. This observation reinforced the notion that hospitalisation represented being socially ostracised and penalised for unfounded transgressions within institutions. On-going assessments and reviews after admission seemed to be undertaken without a sense of urgency, and participants observed abuse of power where staff positioned themselves as superior to patients (Memon et al., 2016). Similarly, participants in this current study made specific comments about feeling anxious when waiting for their turns to be invited in for the ward review meetings: when it was their turn, they felt rushed and unable to ask questions, or to contribute to the decision-making process over their care.

Due to cultural variations, some participants, such as Participant 161219, believed that senior clinicians carried the risk of misinterpreting and misdiagnosing, especially by assigning psychotic labels and, therefore, recommending treatment with medication as opposed to psychotherapy. These observations are supported by literature which confirmed similar

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patterns of experiences (Keating, 2007; Faulkner, 2014). Other participants felt medication was used in a 'trial and error' fashion when the psychiatrists were not sure of what to prescribe. Participant 300528 described feeling like he was being experimented on with different types of medication as if he were a guinea pig. For some participants, this resulted in lengthy hospital spells to allow time for appropriate treatment medication to be identified. However, on my clinical practice reflection, trial and error are sometimes inevitable in medication prescribing. Given that the impact of a specific medication on the metabolism of a specific person is not known in advance of application, doctors are recommended to prescribe a lower dose to begin with, and increase it over time.

Clinicians' preferred treatment options of medication were perceived as damaging, and these clinicians were perceived to be difficult to engage and form therapeutic relationships with. Some service users described them as intrusive in manner; power differentials were reported in relation to both junior and senior clinicians; coercive and threatening interventions were perceived to be prevalent (Bhui et al., 2018). Similar themes were replicated in a follow-up qualitative study by Faulkner (2014), which investigated the experience of ethnic inequalities in mental health care and observed that service users were concerned about the influence of race, ethnicity and culture, including cultural misunderstanding.

My study goes further to reveal an element of 'cultural stereotypes' (Maguire et al., 2016) that clinicians may adopt as they appear to be more inclined towards the medical model while ignoring spiritual dimensions which may be central to patients' wellbeing. Also, themes relating to the experience of treachery, collusion and tokenism do not seem to be adequately addressed in the literature. However, from my own clinical practice experience, there are some truths to what the participants expressed. I have observed clinicians consult their chosen colleagues to fulfil second opinion roles in relation to application of the MHA, or when determining clinical diagnoses and treatment regimes. While this is good practice when all professionals perform their duties diligently and on merit, some service users may perceive unfairness and a lack of being genuinely and independently reviewed. Such experiences can lead service users to feel disempowered, belittled, ignored; and they therefore will hold the belief that services are inconsiderate of the service users' opinions in decisions made about their care. While these observations provide general explanatory models of the therapeutic relationship between service users and clinicians who may have vested interests in the medical explanatory model, there is a further impact to the relationship dynamics experienced by individuals from a black African and Caribbean background. As shown earlier, institutional racism and racial stereotyping is blamed for clinicians who only see black people in the light of being violent or aggressive. Therefore, these individuals carry the risk of having restrictive measures imposed on them.

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In a study to measure the quality and quantity of staff-patient interactions in two inpatient mental health wards, Myklebust and Bjørkly (2019) reported that, in spite of a broad common understanding among staff and patients about the importance of therapeutic staff-patient relationships, it is unclear how and to what extent therapeutic staff-patient interactions unfold in clinical practice. However, it was noted that when it comes to the most tense and demanding situations, staff-patient interactions play a central role both as antecedents of aggressive episodes and as measures to prevent the escalation.

6.5.2 Relating to junior clinicians

Therapeutic partnership

Some of the participants in this study described their relationship with junior clinicians as welcoming, kind, trustworthy, empathetic, listening, informative and supportive, amongst other qualities. Some participants expressed mixed feelings whilst others described only the negative relational experiences with the junior clinicians. Most participants narrated experiencing a sense of solidarity in the form of brotherhood / sisterhood from being cared for by nurses who were of similar or shared ethnicity backgrounds. Participants believed this helped them feel at ease within case settings. Jackson et al. (2007) reported relative satisfaction, and perception of helpfulness by the staff, in relation to the use of formal mental health services by patients from a black African and Caribbean background.

These results concur with findings by Bhui et al. (2018), who observed that their participants expressed positive sentiments about their relationship with nurses, with qualities such as being friendly, efficient and patient, thus making them feel cared for. They further reported that their participants experienced meaningful care from nurses who 'went the extra mile' to make the patients feel comfortable despite the staffing shortages. This observation is mirrored in this current study when Participant 159205 and Participant 169043 observed that the nurses tried their best regardless of staff shortages. The participants described experiencing positive therapeutic relationships when they felt nurses could relate and understand their patients' needs and formulate caring partnerships.

A study by Bhugra et al. (2000) found that inpatients in a South London psychiatric hospital were generally satisfied by the nursing staff attitudes and care, but were less satisfied with certain aspects of their treatment, particularly their limited involvement in treatment planning and decision-making about medication. In relation to the current study, Participant 300528 expressed being satisfied by other care aspects from nurses but reported feeling constrained when nurses demonstrated failure to understand his spiritual needs. Further research observed that mental health service users were happier with the personal rather than

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professional qualities of their psychiatrists, and having the opportunity to talk to professionals was perceived to be the most helpful aspect of care (Bhui et al., 2003).

Bressington et al. (2011) suggests that service users' satisfaction with forensic services is strongly associated with their experiences of the therapeutic relationship with their keyworkers and the social climate of the ward. The findings emphasise the importance of forming and maintaining effective therapeutic relations and reinforce the need to maintain a therapeutic environment that is free of aggressive tensions and threats of violence. Black African and Caribbean service users were generally satisfied with services, rehabilitation and the perceived safety, which were all viewed positively. Service users' perceptions about the social climate of the ward were found to be correlated with satisfaction rates for the forensic mental health services.

Other literature sources suggest that nurse – patient relationships can be viewed as dichotomous in nature and do not always support therapeutic bondage but undermine therapeutic potential (Ramjan & Fogarty, 2019). The authors argued that the principle behind the ability to engage service users by professional staff is to understand the person and their experiences as well as avoiding being authoritative. In the current study, Participant 300528 perceived the nurses to be unsympathetic and authoritative regarding provisions for physical exercise.

Unsympathetic relationship

Some participants expressed anger at the nursing staff for being inefficient in their caring roles, being lazy, sitting in the office chatting, withholding ward round and other important information and not discharging duties they ought to have been doing. Participant 300528 described being subjected to reprisals if he challenged poor practice by the junior clinicians. There are similarities of these study outcomes in a study by Cummins (2018) where poor patterns of communication were identified between clinicians and patients. Both nurses and doctors were experienced as distant in their interactions and made service users feel as though they were not being treated as individuals. Nurses were perceived as making assumptions that all black patients were equally difficult and a challenge to manage. Patients described experiencing the superiority of nurses over patients and how nurses isolated themselves in the nurses' station with no meaningful interaction with the patients.

In the community, Participant 275789 described his allocated CPN as dismissive and inconsiderate. Others described the inaccessibility of their CPNs when they needed them most, and the lack of consistency in seeing allocated key workers due to what they observed as staff retention problems. However, while experiential observations made by the study

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participants may similarly affect white service users, these are more profound for black service users. Participants in the current study had to deal with issues of acceptance and compassion by clinicians in the community including stigma and stereotypes associated with black people. Therefore, formulating continual therapeutic relationships based on trust was problematic. Literature suggests that there is a need for nurses to respect patients' rights to influence their care, and contemporary nursing practice advocates nurses to work in partnership with patients (NHS England, 2019). Therefore, nurses are encouraged to share their power and facilitate empowerment in their patients by giving them important information about their care and relevant support.

In communicating with mental health service users, observations have been made that indicate discriminatory practices by some clinicians who deliberately make communication processes more complicated as they try to maintain professional boundaries from the patients within acute inpatient mental health units (Clearly et al., 2012). Most participants in the current study talked about the need for improvements in information sharing and being given essential information about ward rounds. Some of them were unhappy to be kept in suspense and waiting to be called up when it was their turn to be seen in ward rounds. They believed this caused them to feel anxious.

The study by Duxbury et al. (2010) suggests that the acute ward environment usually has a negative bearing on how professional staff formulate relationships with the service users. They suggested that failure to communicate and form therapeutic relationships with the service users may be hampered by the acute environment and task schedules which they deemed not conducive to therapeutic relationships. In the current study, some participants identified that the nursing staff were so task-oriented that they failed to find time to sit down and talk to the patients. Therefore, information giving and sharing is pivotal in establishing therapeutic - rather than strained - relationships within acute inpatient ward environments.

Another study identified multiple factors that negatively impacted on the therapeutic relationship between black African and Caribbean patients and the nursing staff. Stereotypical beliefs, lack of understanding among staff about culturally based issues, lack of culturally competent practices, language barriers, and institutional racism have all been cited as reasons why black people frequently receive less appropriate interventions, and experience less satisfaction with service provision, than white people (Rabiee & Smith, 2013). Participant 300528 talks about all these factors, except the language barrier which was conveniently excluded at participant recruitment stage.

However, it appears nurses are not always successful in making patients feel empowered to make informed decisions. Findings from this current study show that most nurses were

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unwilling to share their decision-making powers and this created a situation of power imbalance with subsequent restricted patient input. In some cases, participants identified that nurses believed that they knew best what the patients needed. They also perceived the nursing staff to have an attitude that suggested patients lacked medical knowledge which justified their need to hold on to power and maintain control (Green & Jester, 2019).

In the present study, there are some contrasting opinions that participants expressed. Of note is the general view that they felt more at ease and comfortable being cared for by staff of a similar ethnic make-up. One participant – Participant 169043 - reported a rare experience of being alienated and stigmatised by the very clinicians who matched her ethnic background. In another case, Participant 238867 felt that assumptions were made by the clinical staff on how best her needs could be met. She observed that she was allocated a care coordinator of similar ethnicity on the assumption that her needs would be addressed by such a clinician, when all she needed was someone who could understand her needs regardless of their ethnic background.

My view is that over-reliance on part-time and agency workers in NHS mental health services is probably responsible for the inconsistency that participants described in accessing allocated key workers: a high staff turn-over that produces an ever-changing range of clinicians may create a barrier to the forming of trusting therapeutic relationships as patients would perhaps feel uncomfortable in disclosing their intimate personal information to different clinicians on a continual basis.

6.5.3 Relating to fellow service users

Exploring the dynamics of patient-to-patient relationships exposes a confluence of negative and positive attitudes held by the participants about their relational experiences with other patients. The participants commented on how they supported each other and, in some cases, how they endured relationship rifts, especially with their Caucasian counterparts. These variable experiences were characterised by the solidarity and comfort derived from being with others of the same ethnic or racial background; by racial abuse and segregation; threats; being targeted and, in extreme cases, being violently attacked by other patients. Therefore, the relationship experiences described by the participants were either of solidarity or animosity. In this study, solidarity was experienced between those of a similar ethnic background whilst animosity was common across the racial divide.

Solidarity

These results show that mental health service users from a black African or Caribbean background feel more comfortable and experience a sense of belonging and solidarity in

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environments where they can physically identify with other fellow service users of a similar ethnic background. In the literature, a recent study highlighted that patients of a black African and Caribbean background reported a sense of camaraderie towards other patients who had similar shared experiences and belonged to similar ethnic backgrounds (Cummins, 2018).

While most participants in this study referred to feeling doubly isolated from being in hospital and having no one to physically identify with on the ward, like Participant 161218, some experienced a sense of comfort from meeting patients that were of a similar ethnic resemblance, as in the case of Participant 159205. They talked about sharing moral and practical support and deriving a sense of security and togetherness from these partnerships.

While there is not much literature that discusses patient – patient relationships, it appears 'Social Identity Theory' (SIT) helps provide an explanatory framework for some of these findings (Hogg, 2018). SIT suggests that there is a sense of belonging, camaraderie and solidarity between individuals who share similar backgrounds regarding experiences, social, cultural and racial belongingness (Tajfel & Turner 1979). The tenets of SIT, therefore, would have likely enhanced the emotional connection that participants in the current study expressed as well as their deriving a sense of security, safety and comfort from seeing members of the same social group. This implies that social consensus and cultural backgrounds interact when there is an emergence of shared identities, which explains why some of the current study participants felt comfortable in hospital. In addition, Hogg (2018) observed that Critical Race Theory embraces several interrelated concepts and theories that underpin social-cognitive, motivational, and social-interactive factors of group life.

Therefore, CRT focuses on the social identity theory of intergroup relations which are largely based on analysis of intergroup relations and generate group and intergroup processes. This means social categorization has the potential to depersonalise individual group members and affect their behaviour based on self-conception and misperception by others. The implication of this observation is that, while CRT and SIT may have worked in favour of those few participants who experienced solidarity in this study, others experienced animosity within the same group parameters.

Animosity
On a negative note, some participants felt and perceived themselves to be different from other patients while in hospital and this triggered a sense of 'othering' that could have potentially created a barrier to social interaction, resulting in self-isolation. This 'othering' led some participants to keep to themselves as they perceived other patients to be more unwell, vulnerable, noisy and unpredictable. The 'sense of being different' often led people to

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anticipate negative labelling and judgmental reactions from other service users, which led them to employ strategies such as denial, non-disclosure and non-engagement all of which could delay the help-seeking process (Gronholm et al., 2017). 'Othering' - experiences of stigma - consequently leads to negative outcomes which is consistent with the reported theme of "sense of difference" as a barrier to help-seeking where people may anticipate negative labelling and judgmental reactions from others resulting in a decision not to disclose or seek help (Halvorsrud et al., 2018).

Participants had the perception of being at risk from other patients who did not respect personal boundaries and displayed threatening behaviour to others. Literature shows that when conflict is managed effectively, such interventions can contribute to a safe environment and reduce the demands that conflict puts on the institution (Shapiro & Tippet, 2002).

Participants described a lack of adequate support to help them to integrate with their Caucasian counterparts. Another participant in this study – Participant 161218 - felt she was a misfit on a ward because she belonged to a racial minority. As a result, she felt even more isolated in hospital; which may explain why black individuals may be unwilling to engage with mental health services. Rabiee and Smith (2013) suggested that when conflict is properly addressed it can result in improved interpersonal relationships and a positive organisational culture. Therefore, this suggests that participants experienced a hospital environment that was not inclusive and accommodating for the racial minorities.

Participant 275789 reported being racially abused by another service user and was surprised that the hospital staff did not intervene. Another participant – Participant 161219 - reported being attacked by another group of Caucasian patients who ganged up on him. However, he described feeling safer when he was moved to another ward where the clinicians' ethnic backgrounds were predominantly black African and Caribbean. Wright et al. (2002) highlighted the concern regarding violence in mental health settings and strategies for its prevention and management. These authors remarked that while clinicians are right to be concerned about violence, racial biases were thought to be prevalent, especially in how black individuals were perceived as dangerous. Therefore, this observation shows how patient management can be potentially influenced by inherent biases. Another study that compared black and white patients reported that black patients were usually perceived as being more dangerous despite having lower scores of aggressive behaviours (Bhui et al., 2018). In addition, Turnbull (2018) reviewed the subjective experiences of black African and Caribbean patients within the first few days of admission to a psychiatric hospital ward and reported confirmatory patterns of conflict that perceived black patients as perpetrators of violence.

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On a background of literature suggestions that black African and Caribbean ethnic groups are statistically more likely to be assessed and detained under the MHA than whites, it can be argued that this may have a contributory effect to the animosity between different ethnic groups in this study. Detention under the MHA for most of these participants was precipitated by their having a serious mental breakdown that was associated with a presence of high risk of violence. Therefore, this observation implies that the encounter of black and Caucasian patients in an inpatient environment may result in social categorisation that views blacks in the light of being threatening, non-compliant and violent. Given the above observations, it is plausible that if these constrained relationships and conflicts are not managed timely and effectively, it can potentially lead to negative and undesirable outcomes for service users, families and carers.

Having discussed in full the issues raised by the participants in this study in relation to the available literature and theoretical constructs, I will now summarise the main findings of the study in the next chapter. In my conclusion remarks, I will identify implications of the study to practice and for future research. Strengths and weaknesses of the study will be discussed as well as my own personal reflections in carrying out this study.

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Chapter 7 – Conclusion

It is imperative that the NHS provides mental health services that are safe, of high quality and responsive to the sensitivities of a multicultural UK and inclusive for people of a black African and Caribbean background. Whilst improvements have been made through diversity and inclusivity policy developments, persistent disparities remain evident with far reaching implications on accessibility of, and satisfactory outcomes from, these services. This study presented an exploration of the views and experiences of adult black African and Caribbean mental health service users from the south east of England. Several reports in the literature have identified shortcomings in mental health services that contribute to the poor quality of the care and treatment provided for many black people, resulting in disengagement and poorer outcomes.

7.1 Chapter overview

In this chapter, a summary of the main findings is presented together with new learning that evolved from these outcomes and their implications to practice. There is a brief description of the study strengths and limitations followed by recommendations for future research, and my own summative reflections.

7.2 Summary of main findings

7.2.1 Vulnerability

The findings of this study indicate that the participants understood mental health and illness in terms of the impact on their lives of several underlying factors, including social, cultural, economic and political environment. The study aimed to explore the experiences of accessing services among black African and Caribbean service users in relation to a range of factors, which include: cultural appropriateness; the extent to which the services met service users' needs; the impact of factors such as racism, discrimination, culture and religion; and issues relating to psychosocial predisposition to vulnerability and psychiatric morbidity. These factors translated to experiences of stress, vulnerability, and psychological trauma. In relation to the theme of exposition and vulnerability, there were more inextricably wide-ranging and interwoven psychosocial influences that disadvantageously predisposed black African and Caribbean individuals to psychiatric morbidity more than their white British counterparts. Participants seemed to be trapped in a cycle of psychosocial oppression which resulted in

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incapacitation, disadvantage and predisposition, all of which dovetailed to compound the experience of health inequalities.

7.2.2 Disempowerment

Individuals from a black African and Caribbean background experienced a sense of helplessness and disempowerment when there was involvement by the criminal justice system in their pathways to care. Police and courts were experienced as prejudiced and lacking in the appreciation of cultural diversity when determining psychiatric distress, which led to the erratic evocation of powers enshrined within the Mental Health Act. The Care Quality Commission has published contemporary practice guidelines that require mental health professionals to use clinical input in order to ratify or disapprove the imposition of formal detention under the Mental Health Act. However, participants in this current study felt that clinical opinions were biased and unfair as they tended to be inclined in favour of the criminal justice system position. This observation also speaks to how much the clinical professionals embraced diversity and multiculturalism in executing their duties in providing independent opinions.

7.2.3 Coping mechanisms

These results indicate that individuals from a black African and Caribbean background deploy their own coping strategies in the event of mental distress. Available literature does not explicitly address issues regarding self-help initiatives that people from a black African and Caribbean background engage in to mitigate their mental health challenges. Self-help initiatives are an important starting point in a person's recovery journey, hence they should be acknowledged and incorporated into care packages, and failure by clinicians to recognise, accord and build on these initiatives is regrettable. Regardless of these individuals presenting late to services, often in dire heightened crises, efforts to establish the individuals' coping strategies are essential in developing care packages and formulating recovery care plans that help enhance self-efficacy.

7.2.4 Stigmatisation

The initiation of self-help strategies inevitably led to another important finding. While the available literature points to the discrepancy of black individuals having no family or carer involvement in negotiating and supporting care pathways into mental health services, it is interesting that participants in this study viewed family support in a different light. Most participants demonstrated a reluctance to involve their families or carers because they wanted to cope independently with their difficulties and not burden their families. The participants showed resilience in the face of potentially attracting societal stigma to their families, and it is also possible that they perceived stigma from their own families and that they were being

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blamed for developing a socially and culturally stigmatising illness. This shows that participants may have experienced some form of dilemma when deciding how best to deal with the emergence of psychiatric morbidity. Therefore, the preservation of cultural and familial values may contribute to the participants' motivations to supress symptoms, and to their lack of insight when experiencing further deterioration of symptoms, leading to psychiatric crises. This explains why individuals from a black African and Caribbean background may turn away from services and, as a result, present in dire crises that more often involve law enforcement agencies and the use of the MHA rather than primary care services.

7.2.5 Primary care services input

Participants in this study reported a poor uptake of primary care services which is corroborated by available literature. While this trend is supported by the notion that there is a paucity of specialist mental health care within GP surgeries and other primary care services, there is a counter-argument from international studies that show over-subscription of such services by BAME individuals with mental health problems. Given that the remit of such services is general medicine, individuals view them as less stigmatising and more acceptable than presenting to a specialist mental health service. Therefore, the incorporation of specialist mental health professionals within UK-based primary care services may help to shift this trend: BAME individuals would be able to access much-needed help from less stigmatising services before psychiatric emergencies unfold. Mainstream mental health services were perceived as representing everything most of the participants tried to avoid: this may explain the increased despondency towards services felt by BAME mental health service users.

7.2.6 Barriers to help-seeking

Expectations and perceptions of being disadvantaged in mental health services continue to exist and perpetuate disengagement tendencies by individuals of a black African and Caribbean background, as shown by participants in the current study. There are variations of perceptions in individual participants from a second-generation of immigrants who appeared to have an insight of how the services function. Therefore, they were more outspoken on issues regarding discrimination and unfair treatment than those from a first-generation of immigrants. It is interesting that these negative expectations were juxtaposed to the care that is purportedly offered by mental health services. On the other hand, those from first-generation immigrants seemed to be less expressive in their reflections on their experiences than those from the second-generation. They were generally satisfied with getting a free service provided by the NHS but, with no previous experience or knowledge of similar services from their countries of origin, they lacked the comparative view. In further comparison, black Caribbean participants seemed more expressive in their reflections than the black African participants. It

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could also be the case that the second generation had higher expectations from services than the first, and hence were more disappointed when these were not met. However, there are no significant variations in terms of experiences between different genders.

7.2.7 Community mental health services input

Participants' experiences of accessing community-based mental health services were significantly characterised by poor practice, delayed interventions, unavailability and inconsistencies in the allocation of care coordinators. Over-reliance on and a high turn-over of agency staff is responsible for this finding which brought considerable challenges for participants in forming therapeutic relationships with clinicians. There seemed to be an assumption that black service users' needs are best served by black clinicians, but some participants in this study preferred clinicians who were knowledgeable, understanding and reflective on diversity rather than focusing on their colour of skin. Therefore, the implication is that any mental health professional who embraces the ethos of cultural diversity and inclusivity has the capability to provide satisfactory care to BAME service users, regardless of their own ethnic background.

7.2.8 Inpatient service experiences

Mental health hospitals were experienced by most participants as unsafe, insecure, scary, uncomfortable, isolating and regimental, although a few perceived them to be safe havens that provided respite. Participants derived a sense of being understood, of solidarity and security by the mere presence of clinicians who resembled their own ethnic background. However, this sense of solidarity diminished when they looked at the service management structure which they perceived to be dominated by whites; they then manifested doubts about their needs being understood at service management level. Other participants experienced the 'othering' phenomenon upon being admitted to a ward dominated by patients of a Caucasian background; they experienced being unassimilable outcasts from a racial minority. Participants blamed the clinical staff for not making the effort to help them to integrate with the dominant groups of patients. This points to the fact that participants may have experienced being doubly isolated and lonely when hospitalised - they were isolated from both their families and from the white patients they met in hospital.

7.2.9 Coercive treatment interventions

The experience of force and compulsion was evident for most of the study participants within various levels of the mental health services. This involved legal coercion, which alludes to being subjected under the MHA. Another form of coercion was procedural, which may indicate the use of force during treatment interventions such as restraint, forced injectable medications and general disenfranchisement of liberties. Recent research findings, as discussed in the

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previous chapter, concur that individuals of a black African and Caribbean background have a higher prevalence rate of detention under the MHA than their white counterparts. In addition, negative experiences of mental health services also included feelings of guilt and inadequacy, confusion, being unaware, or a lack of insight, which were exacerbated by coercion within mental health services - including the process of being sectioned, which participants perceived as criminalising.

7.2.10 Modalities of service engagement

The results of this study show that black African and Caribbean individuals may experience barriers to accessing mental health services due to distrust of formal services, lack of trust in the efficacy of pharmacological interventions, and the discriminatory allocation of preferred alternative therapies. Individual participants from a black African and Caribbean background experienced multidimensional discriminatory care in mental health services. They were comparatively less likely to be considered for psychotherapy than their white colleagues and believed the adoption of the biopsychosocial model of care was disproportionately applied to their disadvantage. Instead, a bio-medical model was used to determine their illness attribution and recognition and they felt 'short-changed' by the model's lack of a holistic approach in accommodating implications of psychosocial and cultural aspects of their mental health. Therefore, participants were concerned about the disproportionate emphasis on the medical model of service provision, but welcomed the option of talking therapy. They felt that this approach would help them to overcome some of the psychosocial issues that were affecting their mental health. Only a few participants talked about the positive aspects of medication; however, most of them were doubtful about its efficacy and preferred psychotherapy. Participants were also concerned about the dosage of medication and approaches used by clinicians to prescribe, which some thought was trial and error so they felt like they were being experimented on.

7.2.11 Diversity and multiculturalism

Regarding cultural accommodation, some participants had to deal with different phases including culture clash, culture preservation and cultural assimilation. They grappled with a cultural belief system that viewed mental illness as a taboo subject which does not require hospitalisation or treatment with medication: a position that appeared at odds with the medical model. Participants experienced cultural insensitivity in terms of basic inpatient provisions such as preferred dietary choices, personal hygiene consumables and recreational activities. Therefore, these individuals experienced cultural incompetence from the service providers, and cultural differentiation in mental health conceptualisation where collaboration between mental health services and the service users and their carers was absent. The results have

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shown that stereotypical beliefs, lack of understanding among staff about culturally based issues, lack of culturally competent practices, and institutional racism, have all been cited as reasons why black people frequently receive less appropriate interventions than white people, and experience less satisfaction with service provision. This is also particularly so in relation to lack of understanding of the socio-economic and political disadvantages that black African and Caribbean people may experience in their lives.

7.2.12 Racism

Only a few participants experienced direct interpersonal racism in hospital. They believed racial profiling, assumptions and stereotyping were prevalent in determining diagnoses, and blamed the clinicians' lack of professionalism in discharging their duties along racial lines. However, a much more significant number of the participants denied ever experiencing direct interpersonal racism and believed the physical presence of BAME clinicians may have helped to diffuse potential incidences of racism. This seems to suggest that direct interpersonal racism is no longer prevalent within mental health services.

7.2.13 Ethnic representation

Most of the participants referred to the NHS organisational structure as a matrix with no significant representation of BAME clinicians within senior management positions, and contended that the service was institutionally racist. While participants derived a sense of comfort from being cared for by staff from mixed cultural backgrounds, they were doubtful that their needs were appreciated by a service management structure without BAME representation. Given that major clinical decisions and allocation of resources rested with the senior management personnel, these study participants perceived no chance of getting their needs met simply by representation from junior staff. They viewed the service to be anchored on rigid lines that did not accommodate different explanatory models of mental ill health. This is a discrepancy that has also been acknowledged by the Care Quality Commission, which is presently endeavouring to redress the imbalance of BAME representation in NHS management boards via the Workforce Race Equality Standards. Therefore, the relationship between senior management and senior clinicians to the service user participants may have been compromised by reciprocal prejudice.

7.2.14 Relationship with clinicians

Participants experienced more challenges in accessing and formulating therapeutic relationships with senior clinicians (doctors) than with junior clinicians (nurses). There was an imbalance of power and authority that characterised the doctor-patient relationship; therefore the study participants felt disempowered to participate in shared decision-making about their care. Ward rounds were experienced as interrogative, frightening and threatening, and doctors

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were believed to be ignorant of the diversified backgrounds of the service users because they remained resolute to the medical model of care. Participants experienced deprivation of the right to negotiate treatment options when doctors advanced medication as the only preferred form of treatment. Nurses, however, were seen to be more supportive, listening and understanding, especially those who shared ethnicity backgrounds with the study participants. One participant observed her relationship with nurses to be fractious when she suggested experiencing stigma from nurses who were of a multicultural background. This means that discrimination and stigma can occur between people of the same ethnic background and is not singularly generated between different races.

7.3 Study limitations

A total number of 15 participants were recruited for this study and this figure is ordinarily acceptable for qualitative based studies. However, Smith et al. (2009) suggest that a much smaller sample of about five participants is appropriate for IPA. There was need to deal with the potential ethical implications of turning away participants who had voluntarily agreed to take part in the study. Therefore, of the 15 transcripts, the best six were selected for in-depth analysis and to help to develop a framework of themes. However, Smith et al., (2009, p 51) asserted, *"it is more problematic to try to meet IPA's commitments with a sample which is 'too large' than with one that is 'too small'"*.

The remaining nine transcripts were then used to make inferences with the initially identified themes. Direct quotes from these remaining nine participants were used to crystallise emerging themes, as demonstrated in the 'Results' chapter. Notably, there was more convergence than divergence between and across all the participants' experiential accounts, except that the accounts of the black Caribbean participants tended to be more detailed than those of the black African participants. However, themes between the two ethnicities did not vary significantly.

There are cross-cultural differences that exist between black African and black Caribbean individuals. In recruiting the study sample, there may have been an assumption that black African and Caribbean people are a homogenous group; however, there was evidence of slight variation between the two ethnic groups. As indicated earlier, despite the belongingness to a first- or second-generation of immigrants, black Caribbean participants were more vocal about their experiences, while black African participants appeared quieter.

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7.3.1 Heterogeneity versus homogeneity of sample

It is striking that the Commission for Healthcare Audit and Inspection (2007) and the Mental Health Foundation (2019) both suggested that, while individuals from BAME backgrounds experience poorer outcomes from mental health services, those from a black African and Caribbean background were the worst affected. Conveniently, this study focused on the experiences of black African and Caribbean individuals who, by nature of their ethnic and cultural belongingness, made up a heterogenous sample which is not entirely compatible with the IPA process. In contrast however, my experience of over two decades of working as a registered mental health nurse is that these individuals are erroneously considered a homogenous group based on their racial symmetry. Ethnicity has been used increasingly as a key variable to describe health data and is further galvanised by ethnic monitoring activities carried out in the NHS (NHS Digital, 2020; Bhopal, 2018; Kirkbride, 2018). These authors identified some fundamental problems with ethnicity in epidemiological research, including: inaccuracies of ethnicity descriptions that are recorded by NHS staff; difficulties of measuring ethnicity; the heterogeneity of the populations under study; and ethnocentricity which affects the interpretation and usage of the data. They have suggested how the value of ethnicity as an epidemiological variable may be improved: ethnicity should be differentiated from race; its own complexities and fluidity should be acknowledged; and ethnic classifications should be made more explicit.

My choice to include both black African and Caribbean participants in the study sample was deliberate and not misguided by the misconception of race as a unifying concept. The aim was to understand the black participants' experiences using the same lens with which they were perceived within NHS mental health services – black 'African-Caribbean'. The assumption was that their experiences would be similar, although I was intrinsically mindful of the dichotomous ethnic and cultural variations between the two groups.

7.3.2 Recruitment of active service user participants

Only recruiting participants who remained actively involved with mental health services suggests that opportunities may have been missed to gain insights into the experiences of those who disengaged from services. There might have been potential participants who never accessed services at all because their mental health concerns resolved before encountering mental health services, but this means their experiential stories could not be accounted for in this study. These insights could have been potentially useful in informing on the self-efficacious recovery trajectories they pursued, and to illuminate the reasons behind their decisions to disengage from services. However, the main aim of the study was to gain an understanding of the experiences of accessing different levels of NHS mental health services by people from a black African and Caribbean background and, on reflection, some of those

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who had disengaged after their initial contact with services may not have had the full spectrum of experiences which I wanted to explore. In addition, tracking down potential participants who had disengaged from services could have proved to be an arduous and time consuming undertaking.

However, it might be useful to consider outreach work to access the experiences of such people so that the results can be more representative. Using tracer studies to track these potential participants through medical records may help to extend the reach of exploratory research. Input from these participants could potentially increase the transferability of study results to this target population.

7.3.3 Use of 'gatekeepers' in sample recruitment

I was consciously aware that studies which involve vulnerable populations or discussion of sensitive topics are deemed to involve higher ethical risk, because of control and power dynamics that may arise between the researcher and the participants. In addition, I observed that when research is conducted within the gatekeeper's workplace there is the possibility that the dissemination of negative research findings may result in a deluge of criticism or embarrassment for the gatekeeper and their service. This can put the gatekeepers in a compromising position within their work environment and with their employers. The implication is that gatekeepers might adopt a protective stance over the participants by preventing them from participating in a research activity that could inadvertently expose the service and its personnel's shortcomings. On the other hand, this level of protection could jeopardise the potential participants' rights to participate in a research activity (Beauchamp & Childress, 2013).

Gatekeepers could also decide to select only those participants who would speak positively about their service and the personnel, hence introducing sampling bias with a compromised sample's representativeness. Therefore, it was essential to engage the gatekeepers right from the start by giving them the relevant information to facilitate an understanding of the research purpose. It was also fundamental to allay any of their anxieties or reservations about access to their patients. This means sharing study information with gatekeepers may have helped to create strategies that promoted lasting credibility and trust (Gray, 2013). However, considering the time constrains in undertaking a research study, this was the most feasible approach to enable a smooth recruitment process of the potential participants. The gatekeepers could conveniently select the participants based on the study inclusion and exclusion criteria. My aim was to comply with ethics guidelines by reinforcing to the gatekeepers the need to avoid recruiting anyone who lacked the mental capacity to participate in the research study.

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7.3.4 Reflections on researcher subjectivity

I observed that understanding of other cultures cannot be taken for granted but that a researcher ought to maintain an openness towards participants' subjective facts that may seem rational, true and coherent, because these can conceal some data that is deeply unfamiliar. There are fundamental implications for the current study in that the researcher had to be able to systematically scrutinise his own hermeneutic prejudices. These included having insider knowledge of the provision and management of mental health services as he worked for NHS as a Community Psychiatric Nurse. He was privy to the general inequalities experienced by this target population through his own first-hand observations in practice, and his knowledge of media and literature output which contextualises black people and mental health services in a negative light. His individual characteristics, such as being black and from an ethnic background of black African, resembled that of the study participants' .. This may suggest that the researcher adopted a more empathetic stance in exploring individual experiences of the study participants when they recollected their experiential stories. Unlike in quantitative studies where researchers try to distance themselves as far as possible from the research participants, the adopted approach facilitated a closer relationship which enabled an in-depth exploration and understanding of the participants' experiences. The declaration by the researcher of his own experiences of discrimination and racism in other life modalities, albeit not to the study participants, may be construed as cultivating a platform for solidarity with the participants' life stories. However, his prior knowledge of the socioeconomic, cultural and political lives of black people in the UK, was not permitted to preclude his critical realist approach in the research processes. The participants' accounts were given precedence over any preconceived ideas that the researcher might have held.

The declaration and management of these preconceptions can result in what Schleiermacher (1998) referred to as the 'stricter' version of hermeneutic practice. However, though an open approach is an indispensable aid to strengthen hermeneutic practice, 'stricter' as opposed to 'laxer' hermeneutic practice does not necessarily guarantee a just or fully adequate understanding (Schleiermacher, 1998). Nevertheless, this approach helped the researcher to avoid a common tendency to filter through participants' data through his own sociocultural or philosophical frame of mind.

7.3.5 Reflexivity

After acknowledging my own researcher subjectivity and the intention to adopt a critical realist approach, I kept a field journal of the research activities. I used this diary to record any interview observations that significantly varied based on the 'researcher – participant' socio-cultural connectivity. Smith et al. (2009) asserted that meaning-making during interviews with any sample is culturally and interactively constructed. Some of the diary entries include those

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from an interview held with Participant 238867. This participant expressed a lot of anger about her experiences and seemed to misconstrue the interview as a forum that gave her the opportunity to complain and report all the injustices she had experienced within mental health services. Another participant - Participant 300528 - who appeared to be still quite distressed by his experiences, went to great lengths to explain how he had been mistreated at every level of the service. These two examples stood out because the interviews lasted longer than the envisaged 60 minutes. I observed that it would have been unethical and insensitive to stop the interviews while the participants were still talking about their emotive experiences. I was aware that any sample could present responses based on the varying social contexts of the participants and other ascribed characteristics, such as gender, class, race and age (Ridgeway & Kricheli-Katz, 2013).

Given the symmetrical race and socio-cultural characteristics between some of the study participants and myself, I observed that they probably looked up to me as a representative who had come to resolve their experiential concerns and complaints about mental health services. They could therefore have felt more at ease to express themselves freely, which may have helped with my aim to get rich and detailed personal accounts. However, I had to remain focused on the interviewing task at hand and reminded participants about the clause in the participant information sheet, that I had the duty to immediately report any information that suggested immediate risks or danger to the participant or the public. After the interviews, and due to the heightened states of distress of two participants, I had to advise them to seek further support from their care coordinators.

According to Rollock (2013) and Vass (2017), researchers who have a racial symmetry with the study participants can potentially introduce various advantages, entanglements and dilemmas. This means shared identity can be beneficial in that it helps the researcher to understand the cultural nuances of the participants' narrations as well as grounding the interpretation of the data in the participants' own cultural worldview.

The similarity of the researcher's ethnic background to that of the study participants may have helped to foster solidarity, and trusting and empathetic relationships. This may be responsible for how the participants felt more relaxed and at liberty to share and express sensitive issues about their life stories: it helped to instil collaboration and decrease the 'distance' between the researcher and the participants. Participants may have chosen to relate to the researcher whose racial or ethnic descent has similarities with theirs, as a brother or sister, a compatriot, a sympathiser and helper who possessed privileged inside knowledge of the participants' experiences. Raitoharju et al. (2009) argued that without the insider help, culture-bound expressions or references can be difficult to understand and interpret. Emotional connection

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can be enhanced when members from the same social group, social consensus and cultural background, interact based on their shared identities (Social Identity Theory [SIT] – Tajfel and Turner, 1979). However, Barbour (2001) also sounded warnings about the risks of entanglements and dilemmas when there are symmetrical characteristics between the researcher and the participants. She stated that while these characteristics can help advance thoroughness and rigour, the relationship between the researcher and the participants can become too cosy, so that it leads to collusion or 'romanticising' of the participants' narratives. McCambridge et al. (2014) referred to this as the 'Hawthorne effect' and stressed the need for this to be managed in order to improve the rigour of studies.

7.3.6 'Researcher – participant' power dynamics

Central to caring professions is the need to notice and respond sensitively to the experiences of participants and their relationships with care professionals. With this in mind, researching in your own practice area may pose some challenges. Therefore, there is need to develop your own sensitivities and awareness and make these known. The Royal College of Nursing (RCN) guidance suggests that the ethics of nursing research must reflect the ethics of nursing (Epstein & Turner, 2015). The implication is that, as researchers, we must be attuned to fresh possibilities when they are needed and be alert to such a need through awareness of what is happening at any given time.

Constructivism is a research paradigm that is often seen as a 'researcher–participant' coproduction of knowledge in which the division between researcher and participant is blurred, and the control of representation is shared (Gergen & Gergen, 2000). This implies that there should be a commitment to power redistribution in conducting qualitative research, and to the ethical and methodological complexities inherent in clinical research. The focus should be on reducing the power differences and promoting the participants' equal participation by democratising the research process.

The health care system is often portrayed as a setting where the distribution of power is unequal and hierarchical (Karnieli-Miller & Strier, 2009). This is related to the concept of clinician-centred care in which the clinician is the focus of attention and sole decision-maker. Therefore, during the personal collection of data, I created a welcoming, non-threatening environment in which the interviewees could willingly and freely express and share their personal experiences. According to Taylor and Bogdan (1998), this approach creates a sense of empathy for the participants and allows them to 'open up' about their intimate experiences and beliefs. The sense of empathy was further enhanced by the semi-structured design, anti-authoritative and non-hierarchical atmosphere in which the qualitative researcher and participants established their relationships in an atmosphere of equitable power. Kvale (1996)

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argued that the warm, caring, and empowering character of qualitative interviews might conceal huge power differences, and the dialogue that takes place in the interviewing process might be a cover for the exercise of power.

The implication is that creating a democratised approach encourages disclosure and authentic collaboration between researchers and participants. It clearly departs from the traditional conception of quantitative research, whereby the researcher is the ultimate source of authority, and the partnership between the researcher and participant is mutually exclusive. To the contrary, qualitative research fosters a rebalancing of power in the researcher–participant relationship and encourages a focus on marginalised understandings and experiences (O'Connor & O'Neill, 2004).

Having declared to the participants my dual role, it was useful to reassure them about confidentiality for any information they shared during interviews. I observed that it is essential to reflect on and address the questions of power distribution in qualitative research and that this could be achieved by analysing power relations that characterised my interaction with participants during interviews. Care was taken to avoid interviewing participants who had been directly under my professional care because of how this might have affected the power balance and control of the interviews. The unique contribution of researchers and participants to a research project creates an inseparable union of knowledge coproduction (Lincoln & Guba, 2011). However, a balance needs to be established between developing mutual relationships with participants and maintaining the distance that allows professional judgment of the generated data.

In a research activity, a consensual partnership is formed between the participants and researchers (O'Connor & O'Neil, 2004). Therefore, participants feel involved because it is their personal experiences that are being investigated. On the other hand, researchers' investment is based on their motivation to study and understand participants' experiences. The partnership is such that, participants who are clients or patients provide the data through their experiential accounts, and the researchers are the data collectors who go on to process it. This approach is related to themes of patient-centred or relationship-centred care where both the clinician and patient make significant contributions within a democratised framework of rights and obligations.

My experience of delivering patient-centred care as a mental health clinician meant that I possessed transferrable skills in relation to the concept of 'participant-centred' research. However, in qualitative research, the concepts and relationships are not fully defined (Berg & Smith, 1985). These relationship dynamics vary based on the researcher's personality, world

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view, ethnic and social background, professional discipline, perception of the participants' role and the research design and goals.

7.3.7 'Bracketing' – Critical realist approach / Dual position in data collection and analysis

On a personal level, and to some extent, I have some similar personal characteristics to those of the participants' ethnic background descriptions; however, I have not experienced mental health services as a service user but as a practitioner. As a person, I understand the experience of being racially segregated and discriminated against because of one's ethnic background. Somehow, my experience gave me an advantageous platform from which I could empathetically understand the experiences that participants reported. I personally know other people, related to me and who are of the same ethnic background as mine, and who have either voluntarily or involuntarily accessed mental health services And this provided me with a pre-understanding of what it may feel like being a mental health service user from a black African and Caribbean background.

From a socio-cultural perspective, I have a preunderstanding of some life aspects of people from a black African and Caribbean background acquired through my own socialisation. One such understanding is that black African and Caribbean people - amongst other ethnic minorities - experience racial discrimination and stigma in their day-to-day life (Dijk, 2015). This position can be largely linked to the reported health inequalities experienced by this target population and its reluctance to access services, and the negative perceptions they hold about mental health services. Other public services, such as the police, have been viewed as exercising a 'heavy hand' and having discriminatory attitudes when dealing with people from a black African and Caribbean background (Delsol & Shiner, 2015). Through the media, stigma of the research target group can be magnified and can influence attitudes of a general population against a specific culture (Udah, 2019). Also, because black people receive negative publicity and hold negative perceptions of the mental health services, they tend to shun mainstream services and turn to religion for help and support regarding mental health ailments (Kang & Moran, 2020). This resistance to accessing services may translate to poorer outcomes where this target population experience yet further deterioration of mental ill health.

Reflections on data collection

In conducting the interviews, I realised that participants held a degree of control and ownership as the process depended on their willingness to participate in the research and share their personal experiences of accessing mental health services for the first time. My aim was to elicit rich, detailed and authentic participants' accounts to inform my study. Therefore, it was

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paramount to establish a good rapport with the participants, and a relationship based on trust and empathy.

Providing the participants with reassurance about anonymity of their personal identifiable information increased their willingness to participate and share intimate details about their experiences. In addition, this gave them the confidence to consent to the information they shared to be digitally recorded, analysed and published. The fact that I declared my professional status to the participants might have been perceived in an authoritative 'clinician-patient' light, which posed a sense of threat and fear of reprisals if they did not participate, and this could have resulted in participants giving disingenuous experiential accounts about accessing mental health services. Therefore, I observed that in order to gain access to the authentic participant's private and intimate experiences or their life stories, the researcher must effectively engage the participant by enhancing the sense of rapport between them, building a considerate and sympathetic relationship, and creating a sense of mutual trust. Again, my experience of delivering care to mental health patients, based on trust and empathy, meant that I possessed transferrable skills that could get me over some of these hurdles. This involved being sensitive and flexible with the semi-structured interview schedule design.

As in my earlier reflections, the racial symmetry between the researcher and the participants may have helped to create an atmosphere of solidarity and heightened empathy. This inspires richness of the data gathering process although there are caveats that can propagate vulnerability and distress, especially for participants who reluctantly decide to share deep, privately-held personal experiences (Krayer, 2003). This suggests that participants can potentially retain power if they decide to withhold some information from the researcher. For example, Participant 275789 decided not to discuss some of the issues on the interview schedule as they would cause him distress and a possible relapse in his mental health.

Interviewees can control their own level of cooperation during interviews, and this may introduce various problematic behaviours by the interviewees, such as flattery, flirtation and social desirability (Barbour, 2001). The implication is that this compromises the representativeness of the research outcomes. However, interviewers still maintain a considerable degree of control and power as they initiate the interview, decide on the topics to be covered, control the directional flow of the interview and when to stop it (Brinkman & Kvale, 2005). It is important to realise that interviews can easily 'derail' and become unfocused on the study at hand. It is therefore essential to maintain control of the interview; hence the researcher familiarised himself with the purpose of the study and the interview schedule, as well as asked appropriate and prompting questions in order to get the required information to answer his research questions (Patton, 2002).

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Reflections on data analysis

In considering the reasons discussed earlier, I aligned my stance to that of Heidegger's conception of interpretative phenomenology over Husserl's descriptive phenomenology. Furthermore, my aim was to comprehend the lived experiences of the participants within their given 'worlds'. Therefore, this entailed adopting a critical realist approach in contextualising interpretations and meaning of the experiences in the participants' given environmental aspects, including historicity, cultural, socioeconomic, and political and other factors. This means that understanding the phenomena is grounded in the environment from which it emerges. The philosophy distinguishes between the 'real' and 'observable' structures, and this implies that unobservable structures cause observable events and the social world can be understood only if people understand the structures that generate events (Fletcher, 2017).

While some level of bracketing could be achieved by using qualitative data analysis computer software, I made a deliberate decision to stay away from it. I chose to analyse the data manually and the rationale behind this decision was mainly anchored in the prerequisite to maintain a 'clean platform' for the phenomenological process between the researcher and the participant. Using computer software for analysis would have meant implicitly introducing another layer of interpretation into the research process, with the implication of interference within the interpretation phase of data such that the phenomenological process would cease being a strict activity between the participant and the researcher.

My professional pre-understanding involved all that I knew from my caring role as a mental health practitioner, and my knowledge of literature surrounding the use of mental health services by people of a black African and Caribbean background. In proofing the transcripts, I decided not to focus much on the established literature, therefore avoiding contextualising participants' responses too early in the process of data analysis. However, I clearly knew that negative experiences of mental health services by people of a black African and Caribbean background were prevalent.

7.4 Study strengths - contribution to literature

The results of this study should be considered tentatively, given the limitations pointed out. However, the study does give insight into a range of health inequalities that individuals from black African and Caribbean background experience from the various levels of NHS mental health services, including primary care services, secondary community mental health services, inpatient mental health services, their experiences with statutory bodies pertinent to mental health care, and their relationship with the clinicians.

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This study possibly provides the only research that explores the participants' experiences of journeying through the whole mental health services from primary care services through to admission and aftercare. Therefore, the study provides the first holistic picture of these experiences, which may provide understanding of what is being done well and what could be done better and at what level of the service, based on the positive and negative experiential perceptions of the participants. The outcomes of the study may be used to form mental health performance indicators which influence the tailoring of a service delivery that is equitable and inclusive to target populations as represented by the study participants.

As indicated earlier in the Introduction and Methodology chapters, there is scant qualitative research work that explores individual experiences and the meanings thereof of accessing mental health services for the first time by BAME service users. This study, therefore, endeavoured to address this limitation by contributing to the qualitative empirical evidence base. While the findings of this t study concur with findings from previous other studies, they also add a deeper understanding of the views and experiences of service users from black African and Caribbean backgrounds: therefore, a deeper understanding of these issues brings to the fore some of the challenges that call for action in redressing wider health inequalities.

The Interpretative Phenomenological Approach (IPA) used in this study provided a sensitive tool that can engage participants on pertinent and intimately held individual life experiences. It enabled the exploration of life experiences with an idiographic focus that allowed insights to be drawn on how a given person, in each context, makes sense of a given phenomenon.

The researcher, who happened to be the interviewer, was directly related to the participants' physical characteristics, being a black African himself; this may have helped to foster solidarity and brotherly or sisterly relationships that put participants at sufficient ease to talk about their closely guarded and intimate life experiences.

The findings of this study support the notion that understanding and responding to mental health crises in people of a black African and Caribbean background is subject to wide-ranging and interwoven psychosocial determinants. This complexity provides an explanatory framework that can be conceptualised for the benefit of mental health practitioners to unpack the intricacies that surround vulnerability to psychiatric morbidity for these communities. This study also provides support in shaping and tailoring individually based services with a flexible approach, which will empower individuals from these minority ethnic groups by giving credence to other explanatory models of psychiatric morbidity rather than singularly relying on the bio-medical model.

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7.5 Implications to practice

7.5.1 Addressing socio-economic challenges

The main implication of this study to healthcare services is that the understanding of socio-cultural aspects of human behaviour and an overarching knowledge of transcultural mental health problems is paramount. It is equally essential to facilitate meaningful interventions, and the development of more universally applicable and accommodating cross-cultural competent mental health care. In order to reduce health inequalities and improve outcomes, the social inequalities of people's lives must be understood and confronted at the point of initial contact with services. The present research highlights how stigma and other psycho-social vulnerabilities negatively impact the ways in which black African and Caribbean individuals experiencing mental health problems access services for the first time. This suggests that mental health and primary care service providers may facilitate treatment by addressing stigma at the outset. These services can engage in interagency working with other essential services such as Social Work to help address some of these vulnerability issues, which include housing, finances, employment, and immigration, amongst others.

For example, service providers might address the different types of stigma that exist and acknowledge the ways in which they may have affected an individual's journey to accessing services. Cascading health promotional material may enhance engagement.

7.5.2 Addressing stigma

The study has shown that stigma and discrimination undermine people's help-seeking behaviour, engagement with available services, recovery, and chances of life-fulfilling trajectories. It has also shown that black African and Caribbean people experience a higher prevalence of psychiatric morbidity because they encounter multiple prejudices and socio-economic disadvantages within society. This target population usually experiences superimposed challenges of migration trauma, racism, acculturation and constantly being 'othered' (Berry, 2019). Equally, families also experience stigma when a loved one has a mental health problem or is subsequently admitted to a psychiatric hospital. Families may perceive mental illness as shameful and therefore may 'internalise' the problem by hiding it from society. Mental health services may also be perceived as culturally inappropriate by families, relatives and friends.

In terms of addressing stigma, initiatives such as anti-stigma campaigns have not been very useful, especially for black African and Caribbean people, or other ethnicities. These campaigns were often dogged by shortcomings including inaccessible or inappropriate language, negative imagery and media portrayal, and the rigidity of western biomedical

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concepts of psychiatric morbidity and diagnosing. Therefore, it may be helpful to consider national campaigns that focus on community cohesion, and the development of appropriate, diverse and inclusive services. Campaigns could also be targeted towards cultural events where multilingual informational posters and leaflets could be displayed and distributed. Posters and leaflets may be a good way of distributing information about mental health awareness and the services that are available.

In addition, direct engagement work can be done through positive contact and dialoguing with families to dispel any potential cultural misunderstandings, as well as acknowledging the ramifications of individual, family and societal stigma. This may also be an opportunity to do a needs assessment and deliver responsive packages that endeavour to address socio-economic disadvantages, which may contribute to the aggravation of stigma in this target population. Similar initiatives can also be conducted in conjunction with churches or faith leaders and social youth forums to raise awareness and increase the likelihood of engaging with services. Such campaigns should foster development of effective partnerships with at risk communities, and dismantle structures that propagate inequalities. This may involve mapping such services to respond to the demographic distribution of black African and Caribbean people, who tend to live mainly in urban areas. Long-term funding can be availed at commissioning level to ensure training, supervision and capacity-building are energised. Such initiatives should be considered together with the involvement of service managers, service users and community engagement, including monitoring and evaluation of such initiatives.

The frontline mental health staff should be trained in legislative and policy context for advocating engagement and facilitating the required diverse and inclusive access to services. A community level engagement of black African and Caribbean people may help shape standards for service development that are considered appropriate and destigmatising. This means that addressing stigma for BAME people with mental health problems can have wider positive implications in alleviating the additional socio-economic stigmas that they may experience. Aside from the patient and their family, relatives or friends, the public's perception of stigmatising mental illness needs to be addressed through psychoeducational campaigns. Campaigns that use prime-time TV and radio broadcasting slots, including social media platforms, may be useful, plus the enrolment of celebrity or sports personalities on campaign programmes as role models.

7.5.3 Innovative engagement strategies

These results also point to the need for primary and secondary mental health services to be strategically innovative in engaging black African and Caribbean service users. This may include providing service information online, and even social media, while dispelling service

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recipients' anxieties about anticipated negative experiences. Equally, the same information should be provided to carers and families of service users using channels of information that keep up with the changing face of communication. Outreach work should be undertaken to engage in interagency initiatives linked to communities, religious, spiritual or social groups to fortify the engagement efforts and enhance acceptability of services.

7.5.4 Capacity building

Another implication relates to capacity building and the incorporation of a mental health speciality within GP surgeries and other primary care services to help improve non-stigmatised access to services. This means that mental health service users may engage more readily with services that are attached to their local GP surgeries where they may derive a sense of comfort from knowing that the potential of being stigmatised is minimal. However, it may never be possible to eradicate all forms of stigma as experienced by people of a black African and Caribbean background who experience mental health problems. It means GP surgeries may be a preferable service to approach for help, but the question is, do they have enough capacity to adequately attend to mental health issues in the 15-minutes slot they ordinarily allocate to each patient?

7.5.5 Delivering accommodating services

The notion of accommodating religion and spirituality remains a relatively challenging perspective for healthcare professionals. This study has shown the relevance of integrating the service users' spiritual and religious needs at every level of the service to promote well-being. This observation is in sync with other studies that have also demonstrated the therapeutic link between the role of religion or spirituality and BAME people with mental health problems. Further, this accommodation points to the development of advocacy strategies that promote patient-centred and holistic care.

Health care professionals should try to establish and acknowledge the coping strategies that service users from a black African and Caribbean background utilise to mitigate mental distress before seeking help. These individual coping strategies are essential in developing care packages and should be adopted when formulating recovery care plans that help enhance self-efficacy. This approach would contribute immensely towards reassuring BAME mental health service users of their involvement in all stages of care planning and management. In addition, the rate of engagement with mental health services may be vastly improved for people of a black African and Caribbean background when they perceive the services upholding and respecting diversity and inclusivity principles. The focus should be on capturing patients' experiences and engaging them to improve support by developing tailored and patient-centred services to address their unmet mental health needs. Therefore, the

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debate around the extent to which religion and spirituality should be integrated into routine mental healthcare must be encouraged.

These results suggest that cultural stereotypes advanced by service clinicians and the traditionally held beliefs of service users should be logically challenged and managed in order to expedite negotiated person-centred recovery care plans based on empathy. This may help dispel myths about cultures and traditions and facilitate reciprocal acceptance, understanding and agreements between service providers and users. Therefore, service providers could benefit from education and training that challenges their own biases, given the prevalence of perceived stigma reported by the study participants. Service providers can develop and use informational campaigns targeted at disseminating information about available services to affected populations. Interagency working between CMHTs, EIPS, CATT, and social services will be useful for early detection of needs and the offer of community-based services that are easily accessible to individuals who may be in the early stages of symptom development. Therefore, early detection and intervention for the identified communities will be enabled by trained professionals across agencies, who can quickly intervene in the earliest phases of mental distress. The early intervention is particularly important as it serves as a means for reducing and preventing mental health crises that would inevitably involve coercive procedures through the law enforcement agencies and the use of the Mental Health Act, and mitigate added pressure on NHS beds.

7.5.6 Reducing coercive interventions

Cultural misunderstandings by law enforcement agencies, and indeed by other health care professionals, may still be the biggest contributor to rampant detentions under the MHA that individuals from black African and Caribbean background experience. This means training initiatives in multiculturalism for these vital services may pay dividends in reducing such anomaly. These study findings echoed the recommendations by the CQC to facilitate involvement of mental health professionals each time service users are detained by police under Section 136 of the MHA, and to mitigate potential misrepresentation of black African and Caribbean people. In addition, the imbalance of BAME staff representation in senior NHS service management roles, as reported by participants in the current study, translates to avoidable costs and loss of opportunity to staff and for the poor-quality patient care that emanates from unfair practice. This study has shown that diversity in service and management teams aids critical awareness and innovative practice, and increases organisational effectiveness in delivering a responsive service to those in need. Furthermore, participants in this study reflect this as an important issue that potentially erodes trust and confidence in the services if not addressed.

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Professional staff within the service provider organisations would also benefit from these multiculturalism training initiatives. These initiatives will help break down the coalescence of criminalisation and medicalisation tendencies by introducing merited independent psychiatric reviews that embrace a broad-based psychiatric definition which reflects variability of modalities in diagnoses.

7.5.7 Shared decision-making

This study has shown that the provision of alternative interventions, engaging users and carers in the decision-making processes and working closely with the cultural and spiritual dimensions of black people's communities can help to improve engagement, adherence, and clinical outcomes, and foster patient-centred care. On the other hand, cultural and institutional exclusion can compound the problem of disengagement, leading to the continuing of insensitive attitudes towards the needs of black service users within both hospital and community-based services, and resulting in poorer outcomes.

Staff should accommodate and incorporate service users' coping strategies in developing care plans, and engage service users' families and carers and acknowledge their varying views and conceptualisations of mental health problems. A flexible, non-judgemental and accommodating approach will help to cultivate meaningful engagement where service users and their carers will feel valued and empowered to participate in their own care planning. This approach also helps to create a platform where treatment options can be discussed and negotiated without necessarily having to use coercive methods to manage service users' symptoms. Central to this approach will be transparency in giving and sharing relevant information with service users and their carers to empower them to make informed decisions about their care, and this will translate to meaningful engagement with services.

7.5.8 Professional competence

All staff should be adequately trained in multiculturalism and have an awareness of the impact of racism, discrimination, cultural and religious beliefs, as well as understanding the disadvantaged socio-economic backgrounds that black service users come from. Right from the outset, staff need to be proactive in interagency working - especially with social services - to address issues of psycho-social and economic disadvantages, including housing, finances, employment, and immigration issues, and adopt a multicultural approach in delivering services.

However, there is a caveat when it comes to direct patient care by front-line staff from multicultural backgrounds. Assumptions should not be made that simply matching the ethnic background of clinicians to patients will result in quality and satisfactory care outcomes. The

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clinicians' knowledgeability and ability to understand and embrace multiculturalism, diversity and inclusivity should suffice, regardless of ethnic resemblance. This speaks to the professional aptitude of the clinicians in treating everyone fairly and equitably.

The findings of this study also suggest that black African and Caribbean service users do not necessarily prefer to be looked after by black clinicians but just need competent staff regardless of their ethnicity. The implication is that having blacks'-only services is not the answer, but having competent staff who engage a multicultural, empathetic and non-judgemental approach in discharging their duties certainly is. Developing blacks'-only services would unnecessarily exclude these service users from the mainstream services and deprive the white professionals of the learning opportunities integral to providing care in a cosmopolitan environment.

7.5.9 Empathetic patient – clinician relationship

Therapeutic relationships between healthcare clinicians and service users in mental healthcare require respect and a good understanding of the service users' perspectives on health and illness. Therefore, a patient-centred approach may help to foster therapeutic relationships based on compassion and empathy. Patients feel valued when they are empowered to participate in the decision-making process of their own care plans and management, especially in relation to treatment options. A patient-centred approach has been argued as the way to improve clinical outcomes, by empowering patients and involving them in healthcare planning and management to ensure that services are culturally appropriate. Therefore, cultivating better relationships with black communities helps to foster understanding of patients' perspectives and the destigmatisation of mental health problems. Results of this study indicate that this approach increases help-seeking behaviour and promotes mental health at both individual and community level.

The study findings show that it is essential that clinicians and patients work as partners and for clinicians to make every effort to equalise the 'patient – clinician' power imbalance. One way to do this is for clinicians to share and give information to patients and to be open and accommodating in their communication with the aim of empowering service users and, ultimately, developing the 'expert patient'.

7.5.10 Service development

While there are complex factors that underline the experiences of mental health services by people of a black African and Caribbean background, any exposure to mental health services is central to forming attitudes. It is, therefore, essential to consider making all areas and levels of mental health services accessible and responsive to this client group in order to improve

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their outcomes. The clinicians and service managers can help to set up service users' networking groups among BAME communities, where they can discuss and channel issues of satisfaction or dissatisfaction to service management without fear of being victimised. Service managers can ensure satisfaction surveys are carried out for BAME service users at every level of the service, and identifying problem areas and taking remedial action where appropriate will increase satisfaction scores.

The assumption that BAME service users' interests are best served by BAME professionals needs to be re-visited and matched by competent staff regardless of their ethnicity. This means costly innovations of developing specific services for only black people can be avoided. Results of this study indicate that service users do not necessarily want to be cared for by black professionals simply because of their similarity in ethnic backgrounds. They would rather be cared for by professionals who are knowledgeable and embrace multiculturalism as well as being considerate of the service users' socio-economic disadvantaged backgrounds. Inadvertently, blacks'-only services may in fact serve to further alienate BAME service users from mainstream mental health services and result in poorer understanding of their needs.

7.6 Recommendations for future research

Future studies should be based on co-production of research with individuals who have lived experiences of the phenomenon being investigated. Mental health service users should be considered as important stake holders in participatory research and be involved in all processes. In relation to the current study, involving service users in the data collection processes may help give more insights about the first-time experience of accessing mental health services by individuals of black African and Caribbean background.

Given the wide variation of experiences by participants from first- and second-generation immigrants in the current study, it may be prudent to recruit all participants from the same generation of immigrants in order to control ubiquitous variables and achieve purity of circumstantial experiences. In the same line of thinking, there is a need to be mindful of the socio-cultural heterogeneity of black African and black Caribbean individuals as they belong to different cultures. Therefore, a homogenous sample may rise above these challenges and increase applicability of results to specific populations.

Little is known about individuals who successfully use self-help skills to avert further deterioration and mental health crises. It may be useful to gain insights of what worked for them by tapping into their success stories. However, there are challenges in relation to

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recruitment of such participants as they may never be known to services when recovery comes about through self-efficacy and without involvement of the services.

7.7 Final self-reflections

Carrying out this study has been intriguing and educating throughout its duration, although the completion took longer than I initially anticipated for several reasons. While I am satisfied with the outcome, the process and management of the project has been demanding and conflicting with both my professional and personal life. However, I kept my motivation and persevered by balancing out my priorities. I benefited tremendously from my supportive and inspiring academic supervision team.

For the research activities, it helped that from the outset I was certain about the research question I wanted to address. From the beginning, I had this personal vision of how the study would pan out together with how I would achieve set milestones in a timely fashion, but was completely oblivious to the inherent challenges of undertaking a study of this magnitude. To my advantage, however, I had internal knowledge of the research setting as I was working within the organisation that accorded me access to the research field. My background knowledge of the research setting strategically positioned me to execute my plan based on the central requirements of the NHS Research and Development Department. Previously, the same Department had offered me guidance on obtaining ethics approval when I carried out another study that was linked to my MSc degree.

Obtaining ethics approval for the current study involved re-visiting a few compliance issues which I promptly addressed with the support of my supervision team. My supervision team was not always fully-fledged but efforts were made to locate both subject and methodology specialists and this paid off in the end. I am very grateful for their unwavering support and guidance throughout my journey. Having an IPA specialist on board meant reviewing my Methodology section and aligning it with the intended Interpretive Phenomenological Approach. Carrying out these adjustments was laborious but broadly educating. I met with the supervision team regularly to discuss progress of the sections of my study. We also communicated by email and exchanged documents and feedback, which all helped to keep my efforts focussed.

However, data collection proved to be a challenge as I needed to carry out 15 one-hour long interviews. Some potential participants decided to withdraw from the study at the last minute. Some of my colleagues in CMHTs, who assumed gatekeeping roles in the recruitment

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process, were not forthcoming during the selection of potential participants; however, after consulting with service managers about this, recruitment of potential participants improved significantly.

On a personal level, I experienced a debilitating health condition that forced me to take time out from both my study and work. Thankfully, I recovered well enough to be able to resume working and studying but, sadly, my mother passed away and I had to travel to and from Zimbabwe on a few occasions. Following this, I assumed full responsibility of my younger siblings' schooling and upkeep in Zimbabwe as well as my own three children here in the UK. Financially, I was not in a good place, and had to agree a payment plan for my fees with the University as I was partly self-funding.

Despite all the mishaps and challenges involved, the experience I gained in conducting a study at this level has been valuable and puts me in good stead to better manage challenges that I may encounter in my future research endeavours.

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Appendices

Appendix 1 – Interview schedule

REC reference – 15/EE/0297

Protocol Reference Number – HSK/PG/NHS/00345

Version 3

Date: 11/11/2015

<u>**Interview Schedule**</u>

Introductions - tell me a bit about yourself at the time you got admitted to a psychiatric hospital.

Where you lived, with who, employment status, education, financial status, psycho-social well-being and relations / support networks.

How did you first come into contact with mental health services in Hertfordshire? What happened / tell me about the processes that were involved? Is this what you expected, yes / no, Why?

Describe to me your experience of accessing mental health services for the first time. Reflect on your thoughts / feelings / attitudes / perceptions of the services and staff at the time.

Could you please let me know if you consider that elements in you background may have impacted on your decision /s and those of other involved people, concerning how to access mental health services for the first time.

Who was involved in your care pathway and what roles, if any, were played by; Yourself, Police, GP, Court of law, Approved Mental Health Professional, Psychiatric doctors, Family, carers or friends etc.

This being your first contact with mental health services, how would you describe the relationships you experienced with different professionals and how this impacted on your experience of the services as a whole? …it might be useful to describe your experiences at different stages of your care pathway through to admission to a psychiatric ward.

Describe to me the personal circumstances you believe led to your admission?

Was it a voluntary or involuntary admission?

What were your thoughts / feelings at the time?

How did your family / friends /carers feel about your admission and the way it happened?

How much do you think professionals involved in admitting you to hospital understood your circumstances and background, as well as those of your family / friends / carers?

Accessing mental health services for the first time: the black African and Caribbean experience.

To what extend were you involved in making decisions about your care? (e.g. Care Planning, Care Programme Approach, Risk Assessment and Management.

Why do you think you had to be admitted given, your circumstances at the time of admission?

What options / choice of care pathways were made available to you prior to being admitted?

Describe the support that you were receiving before your admission?

Who provided the support and how effective was this, in relation to your circumstances at the time?

Please compare the treatment you received before, during and after admission.

What were your expectations upon admission?

Did your expectations materialise? If yes or no, please tell me what happened?

Reflect on any aspects of care you may have experienced, and compare your experience with that of others who had similar circumstances.

How do you value the treatment you received, given your circumstances at the time?

Please commend on the cultural appropriateness of the service you received.

Do you have anything to add to what we have talked about?

Is there something that you expected I would ask you which I missed?

Thank you very much for participating in this study.

If any of what we talked about brings back distressing memories that you may find difficult to deal with, please contact your care coordinator who will facilitate counselling support for you. However, if you require urgent support, call your care coordinator now on this number ……, and I will also update your GP and Consultant Psychiatrist about your distress.

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Appendix 2 – Participant Information sheet

REC reference – 15/EE/0297

Protocol Reference Number – HSK/PG/NHS/00345

Version 4

Date: 10/12/2015

Participant Information Sheet

Study Title: - <u>Accessing mental health services for the first time: The black African and Caribbean Experience.</u>

Invitation
I would like to invite you to take part in the research study titled above. Before you decide to take part or not, you need to understand why the research is being done and what it would involve for you.

Please take your time to read the following information and you can discuss contents of this document with others if you wish. If anything is not clear or you need further information, please feel free to contact me using the details provided on the last page of this package. Please take time to decide whether or not you wish to take part in this study.

What is the purpose of the study?
The purpose of this study is primarily educational and will contribute towards the award of a Doctorate in Health Research from University of Hertfordshire. The study will try to understand your experience of accessing mental health services in UK for the first time. Therefore, it will contribute towards gathering research evidence based on your individual experiences.

Why have I been chosen?
I am inviting all mental health service users of a Black African and Caribbean ethnic background who were admitted to in-patient services in the last 2 years, to participate in this study. Your care coordinator identified you as a potential participant as you are aged 18 years and over and considered to be mentally stable to take part. Literature suggests that there are still some discrepancies in how black African and Caribbean people access and experience mental health services hence, your individual views will aid an understanding of this care aspect.

Do I have to take part?
The decision to participate in this study is entirely yours. Your participation in this study is completely voluntary and you are free to withdraw from this study without giving any reasons. Withdrawing from the study will not affect the standard of care you receive.

I will explain the information sheet and will give you a copy to keep. If you agree to take part, I will invite you to sign a consent form to show that you agree to participate and be audio-recorded during interview.

Accessing mental health services for the first time: the black African and Caribbean experience.

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What will happen to me if I take part?

If you agree to take part, I will ask you to attend an interview with myself at your local community mental health team base. For convenience, I will book an interview room on a day that coincides with your routine appointment at the base. Alternatively, a convenient time and venue can also be arranged.

The interview will be held once and will last approximately 1 hour. Thereafter, the researcher will contact you once more by phone, to verify any of the interview records. With your consent, the interview will be audio-recorded in order to preserve the accurate description of your experiences. The interview records and transcriptions will be kept strictly private and confidential in my locked cabinet in my team's NHS office and disposed of 5 years after the study concludes.

What are the possible benefits of taking part?

There are no immediate benefits to you in taking part in this study. However, your views and experiences about accessing mental health services may build on the research evidence and shape future services.

Expenses and Payments?

If you incur extra expenses above your usual expenditure of attending for a routine appointment at your local community mental health team base, this will be reimbursed.

A £10 gift voucher will be offered as a gift for participating in the interview rather than as an incentive to participate.

What are the possible disadvantages and risks of taking part?

There are no disadvantages of taking part in this study. In the unlikely event that you get distressed by reflecting on a particular stressful experience, counselling will be facilitated by your care coordinator at your request.

What if there is a problem?

If you become concerned about any aspect of the research, please do let me know and I will do my best to try to resolve it. Please see contact details at the end of this form. Should you wish to raise any concerns or complain to the NHS regarding any aspect of this research, please contact your care coordinator who will guide you through the NHS complains procedure.

Will my taking part in the study be kept confidential?

All information collected about you during the course of the research will be kept confidential. The audio records will be transcribed only by the researcher and the transcripts will be anonymised so that you cannot be identified. Anonymised transcripts will be accessed only by the researcher and his academic supervisors.

All the audio recorded material and equipment will be securely stored in the researcher's NHS office and disposed of 5 years after the study concludes. Although unlikely, the researcher is required to adhere to the Nursing and Midwifery Council – Code of Professional Conduct (2015), to determine when and where to rightfully disclose confidential information without your consent. The researcher will abide by the guidelines and procedures to address any concerns to the appropriate authorities when there is clear evidence of imminent risk to yourself or others.

Accessing mental health services for the first time: the black African and Caribbean experience.

Involvement of your GP, Consultant Psychiatrist and Care Coordinator

With your consent, your GP, Consultant Psychiatrist and Care Coordinator will be informed about your participation in this study once you have agreed to participate. Contents of the interview will be kept confidential and only shared with your GP, psychiatrist and care coordinator only if in the researcher's professional opinion, you would benefit from extra support after participating in the study.

What will happen if I do not carry on in the study?

If for any reason you decided not to carry on with the study, all person identifiable material will be destroyed however, with your permission the audio records may be used up until the time of your withdrawal.

What will happen to the results of the research study?

The results of the study will be assessed as part of the educational programme from the University of Hertfordshire. Afterwards, the researcher will work towards publishing the anonymised results in a reputable peer-reviewed mental health journal. I will also consider presenting the results to the practice teams and make them available to you in form of; a hard copy handed in person, emailed or posted to you.

All the research materials and equipment like interview transcripts and audio records will continue to be securely stored for a further 2 years. This will allow the researcher to return to this material for cross reference in preceding stages of the research study. Similarly, word processed information will be kept for a further 5 years on an NHS encrypted computer. Thereafter, everything will be destroyed by following NHS guidelines on data protection disposal / destruction.

Who is organising or sponsoring the research?

University of Hertfordshire

Further information and contact details?

Should you require any further information or clarification, please do not hesitate to contact the researcher on the details below and he will do his best to help.

Godfrey Muchena (Principal Investigator)
East Crisis Assessment and Treatment Team
Rosanne House, Welwyn Garden City
Hertfordshire
AL8 6UB
01707364005 / 07733361867

Godfrey.Muchena@hpft.nhs.uk

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Appendix 3 – Participant Consent form

REC reference – 15/EE/0297

Protocol Reference Number – HSK/PG/NHS/00345

Version 3

Date: 11/11/2015

Participant Consent Form

Title of Research Project: <u>Accessing mental health services for the first time: The black African and Caribbean Experience.</u>

Name of Researcher: Godfrey Muchena

Please put your initials in each box if you agree.

1. I confirm that I have read and understood the contents of the participant information sheet   explaining the above research project.

2. I have had the opportunity to ask questions about the study and sought clarification where needed.

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without any impact on my care or treatment.

4. I understand that audio records from the interview will be transcribed only by the researcher and that the transcript will be anonymised to protect my personal identity.

5. I accept that the anonymised interview transcript will only be accessed by the researcher and academic supervisors.

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6. I am assured that contents of the interview will be kept confidential and only shared with my GP and direct care team if, the researcher believes that I would benefit from extra support after participating in the study.

7. I voluntarily agree to participate in an audio-recorded interview and accept that the researcher will contact me once more by phoning for clarification of the interview records.

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Researcher   Date   Signature

Copies:

Once the consent form is signed and dated by you and myself, you will get to keep a copy of this and the study information sheet.

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Appendix 4 – University of Hertfordshire Sponsorship

University of Hertfordshire UH

Dr Tricia Scott &
Mr Godfrey Muchena
CRIPACC
School of Health and Social Work

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax   +44 (0) 1707 284115
Website   www.herts.ac.uk

16 March 2016

Dear Dr Scott and Mr Muchena,

Re: **UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:**
RESEARCH STUDY TITLE: Accessing mental health services for the first time: the black African and Carribean experience
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Tricia Scott
NAME OF INVESTIGATOR (Student): Mr Godfrey Muchena
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: HSK/PG/NHS/00345

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements. It is also essential that evidence of NHS Trust Management Permissions (formerly known as R&D Approval) is sent as soon as it is received.

Permission to seek changes as outlined above should be requested from myself before submission to an NRES (NHS) Research Ethics Committee (REC) and notification to the relevant University of Hertfordshire Ethics Committee with Delegated Authority (ECDA), and I must also be notified of the outcome. It is also essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as it is received. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)

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Appendix 5 – Health Research Authority – Ethics Committee Approval

NHS

Health Research Authority

East of England - Cambridge Central Research Ethics Committee
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839 440

15 December 2015

Dr Patricia Scott
Centre for Research in Primary and Community Care
University of Hertfordshire
College Lane Campus, Hatfield
AL10 9AB

Dear Dr Scott,

Study title:	**Accessing mental health services for the first time: the black African and Caribbean experience.**
REC reference:	**15/EE/0297**
Protocol number:	**HSK/PG/NHS/00345**
IRAS project ID:	**151436**

Thank you for your letter of 10 December 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 09 December 2015

Documents received

The documents received were as follows:

Document	Version	Date
Covering letter on headed paper [Covering Letter to REC]	Version 4	10 December 2015
GP/consultant information sheets or letters [Letter to GP]	Version 4	10 December 2015
GP/consultant information sheets or letters [Letter to Consultant Psychiatrist]	Version 4	10 December 2015
IRAS Checklist XML [Checklist_11122015]		11 December 2015
Participant information sheet (PIS) [Participant Information Sheet]	Version 4	10 December 2015

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Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering letter on headed paper [Covering Letter to REC]	1	30 April 2015
Covering letter on headed paper [Covering Letter to REC]	Version 2	01 October 2015
Covering letter on headed paper [Covering Letter to REC]	3	11 November 2015
Covering letter on headed paper [Covering Letter to REC]	Version 4	10 December 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity Insurance doc]	Version 2	01 October 2015
GP/consultant information sheets or letters [Letter to Care Coordinator]	Version 2	01 October 2015
GP/consultant information sheets or letters [Letter to GP]	Version 4	10 December 2015
GP/consultant information sheets or letters [Letter to Consultant Psychiatrist]	Version 4	10 December 2015
Interview schedules or topic guides for participants [Interview Schedule]	Version 3	11 November 2015
IRAS Checklist XML [Checklist_11122015]		11 December 2015
Letter from funder [Employer contribution letter]	1	27 April 2015
Letter from sponsor [Sponsor's Approval Letter]	1	11 July 2015
Letters of invitation to participant [Invitation letter to participants]	Version 2	01 October 2015
Other [SP1 Form - University Approvals]	1	05 June 2015
Other [NHS Management approval]	1	10 July 2015
Other [Research Degrees Board Outcome]	1	30 April 2015
Other [Research Timeline]	1	03 May 2015
Other [Research Gantt Chart]	1	15 July 2015
Participant consent form [Participant Consent Form]	Version 3	11 November 2015
Participant information sheet (PIS) [Participant Information Sheet]	Version 4	10 December 2015
REC Application Form [REC_Form_17072015]		17 July 2015
Referee's report or other scientific critique report [Registration form - critique / outcome]	1	17 May 2015
Research protocol or project proposal [Research Protocol / Proposal]	Version 2	01 October 2015
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	11 July 2015
Summary CV for student [Principal Investigator CV]	1	13 July 2015
Summary CV for supervisor (student research) [Academic Supervisor CV]	1	22 July 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Protocol flowchart]	1	17 May 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

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Yours sincerely,

Rebecca Morledge
REC Manager

E-mail: NRESCommittee.EastofEngland-CambridgeCentral@nhs.net

Copy to: *Professor (Pro-Vice Chancellor) John M Senior*
                Professor Tim M Gale, Hertfordshire Partnership NHS Foundation University Trust

Accessing mental health services for the first time: the black African and Caribbean experience.

Appendix 6 – Project timeline

Phase Number:	Sub-heading:	Activities:	Date:
Phase 1	Ethics Application	- Submit IRAS form to Research Ethics Committee. - Research Passport application - Register study with local NHS Research and Development Department - Application for Indemnity – University of Hertfordshire	04-05/2015 06-07/2016 06-07/2016 06-07/2016
Phase 2	Research Instruments	- Attend focus groups and refine interview schedule - Application for access to the research field - Pilot interview schedule and obtain expert opinion	07-08/2016 08/2016 08/2016
Phase 3	Sample Recruitment	- Send out letters to care coordinators to introduce study - Care coordinators identify potential participants - Care coordinators give out participant information sheets - Chief Investigator collects names and contact details of the potential participants - Chief Investigator secures personal identifiable information of potential participants - Chief Investigator contacts potential participants as follow-up on non-responders by post and telephone	09/2016 09/2016 10/2016 10/2016 10/2016 10-11/2016
Phase 4	Data Collection	- Progression Viva – Phase 2 - Prepare interview material and equipment - Agree time and venue for interviews with participants - Booking of interview rooms at respective community mental health team bases - Commence interviews after administering consent forms for each participant - Transcribe audio-recorded interviews - Carry out member checking	11/2015 11/2016 11/2016 01/2017 01/2017-04/2018 12/2016-04/2018 12/2016-04/2018
Phase 5	Data Analysis	- Carry out initial analysis of the transcripts - Final analysis	04-06/2017 - 06-10/2018
Phase 6	Writing up Results	- Draft findings report - Editing of findings report - Discuss the results in relation to available literature - Final thesis write up and submission	10-12/2018 12/2018 01-05/2019 05/2019 – 04/2020

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Appendix 7 – NHS Research and Development Department approval

Hertfordshire Partnership **NHS**
University NHS Foundation Trust

Dr. Patricia Scott,
Centre for Research in Primary and Community Care,
University of Hertfordshire,
College Lane Campus,
Hatfield,
Hertfordshire
AL10 9AB

R&D Department
Learning and Development Centre
The Colonnades
Beaconsfield Close
Hatfield
AL10 8YD
Tel. 01707 253834
Tel. 01707 253837
Email: t.gale@herts.ac.uk

11th March 2016

Dear Dr. Scott,

Permission for research

I am writing to inform you that permission has been granted on behalf of Hertfordshire Partnership University NHS Foundation Trust, for the following research project, on the basis described in the application form, protocol and supporting documentation.

Study details:

Study Title	Accessing mental health services for the first time: the black African and Caribbean experience.
Chief Investigator	Dr. Patricia Scott
Principal Investigator	Godfrey Muchena
Sponsor name	University of Hertfordshire
HPFT study number	HPFT/167
REC ref.	15/EE/0297

NHS organisations and locations:

Organisation giving permission	Date of permission	Sites to which permission applies
Hertfordshire Partnership University NHS Foundation Trust	11/03/16	All sites within this organisation subject to local management approval.

Our **✓**alues
Welcoming Kind Positive Respectful Professional

Accessing mental health services for the first time: the black African and Caribbean experience.

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), the Data Protection Act (1998) and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the REC or university ethics committee and which have been authorized by the MHRA (if applicable).

The following local conditions will apply:

1. Sponsorship of Study

The research Sponsor will be the organisation named above; the management and design of the study is not the responsibility of the Trust or Trusts giving permission.

2. Confidentiality

You are required to ensure that all information regarding participants remains *secure* and *strictly confidential* at all times. You must ensure that you understand and comply with requirements of the Data Protection Act (1998) and the NHS Confidentiality Code of Practice. Furthermore, you should be aware that under the Data Protection Act (1998), unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

3. Researcher Authorisation

Only those researchers holding a letter of access or honorary research contract, as appropriate, from Hertfordshire Partnership University NHS Foundation Trust may have direct contact with the participants of this study or to their patient files, unless they already have a substantive honorary contract with the Trust.

4. Urgent Safety Actions

The research sponsor, the Chief investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. This office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. This office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

5. Serious Adverse Events

Should an SAE occur during the course of the project, this office must be notified immediately. This is in addition to your legal duty to report such events to the Sponsor.

6. Amendments

All amendments (including changes to the local research team) need to be submitted in accordance with guidelines in IRAS. This office should be informed at the same time as the REC or university ethics committee is notified in order to avoid any unnecessary delays.

7. Indemnity

You must check with the Sponsor that the indemnity arrangements, as confirmed in the Sponsor's Declaration and described in the application forms, are in place before any participants are recruited.

8. Study Progression

You will inform us of any significant developments that occur as the study progresses. You will complete and return any report forms that we send you and provide up to date information on the number of participants recruited when asked.

Our ✅alues

Welcoming Kind Positive Respectful Professional

Accessing mental health services for the first time: the black African and Caribbean experience.

9. Audit of Study You may also be subject to a random audit of research which will involve a site visit, a requirement to view study documents and a request to interview researchers.

10. Study Completion You will notify the Chief Investigator and this office when the study has completed recruiting participants and when the study has finally finished at your site. You will complete and return the final report that we send you and inform us of any publications relating to the study.

11. Presentation of Findings HPFT expects that the findings of this study will be presented to members of the appropriate service line. You should contact the service line research lead upon completion of the study to arrange a suitable venue and time.

Finally, I wish you every success with the study.

With kind regards

Dr Tim M Gale
Manager, Research and Development Department
Visiting Professor, Dept Psychology, UoH

Our Values
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