Pathways, Barriers and Facilitators to Psychological Therapy for Members of Black African Communities in the UK

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name:

Date:

Overview

This thesis explores the experiences of members of Black African communities during the process of seeking help for mental health problems. Part 1 is a systematic review of the literature on barriers and facilitators to accessing mental health care for members of Black African communities. Findings suggest that barriers experienced include the different world views held by services compared with members of this population, stigma, and lack of information. There is a paucity of research on facilitators to accessing mental health care. Studies focussing on this have found that increasing information provision and changing services would make them more accessible.

Part 2 is an empirical study into the pathways taken by members of Black African communities to access NHS psychological therapy services. Qualitative interviews were used to find out how participants came to access psychological therapy, including triggers to help seeking and other sources of help and support. In particular, barriers and facilitators to accessing services were discussed. Barriers faced by participants included lack of information, stigma and reluctance to disclose, while facilitators included encouragement from others, and recognition of the need for help. There was no typical pathway although all involved a general practitioner.

Part 3 is a critical appraisal examining the assumptions implicit in the literature review and empirical paper, and methodological challenges raised when studying these topics.

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Part 1: Literature Review

Barriers and Facilitators to Accessing Mental Health Services for Members of Black African Communities: A Systematic Review

Abstract

Aims: This systematic review aimed to find out what is known about barriers and facilitators to statutory mental health services for members of Black African communities, as well as the quality of the evidence.

Method: PsycINFO, Medline and Scopus were searched to find all relevant papers. Studies were subject to inclusion and exclusion criteria.

Results: Fourteen articles were found which used predominantly qualitative methodologies. Thematic analysis revealed that the barriers to services fell into four main themes: different world views, inadequate statutory services, lack of information and stigma. Facilitators included changes to services, increased information and positive treatment beliefs.

Conclusion: Changes including increased information provision and working with African explanatory models may increase accessibility to services for members of Black African communities.

Introduction

Current figures suggest that around 3% of the total global population are immigrants (United Nations, 2013), and the level of international migration is increasing year on year. Mental health services therefore have to work with users from a wide variety of backgrounds and cultures, and the expectation is on services to show that they are accessible to all regardless of ethnicity. This is known as the 'equity of access' principle, and is recommended by the World Health Organisation (World Health Organisation [WHO], 2009) in its guidelines for improving mental health services. This principle is part of government mental health strategy in countries as diverse as, for example, the UK, Canada, Ghana and South Africa (Department of Health [DOH], 2011; Mental Health Commission of Canada, 2012; WHO, 2009).

However, statistics from a number of countries show disparities in service use among different ethnicities. For example in the UK, NHS primary care (Improving Access to Psychological Therapies; IAPT) and secondary care mental health services data suggests that certain ethnicities are under- or over- represented compared to their relative populations (Health and Social Care Information Centre [HSCIC], 2014; Office for National Statistics [ONS], 2011). Similar disparities have been found in countries such as the US and the Netherlands (Alegría, Canino, Ríos, Vera, Calderón, Rusch, et al., 2002; Ten Have & Bijl, 1999). It is therefore important to ascertain reasons for this disparity in order to ensure that mental health services can be accessed by those who need them.

Research conducted on disparity of access often focusses on barriers to care, that is any factor which makes it less likely that services will be accessed. Barriers

can include anything from beliefs and attitudes to lack of information or transportation. Facilitators, or factors which make it more likely care will be accessed, are also increasingly an area for research (e.g. Alayon & Alvidrez, 2007).

Black Africans make up a large proportion of the global immigrant population and are present in significant numbers in non-African countries such as the UK, France, Spain, Canada and the US (United Nations, Department of Economic and Social Affairs, 2013). For example, the rate of Black African-born immigration to the US increased by 88% in the years 2000 to 2008/09 (Capps, McCabe & Fix, 2012), and it is estimated that there are approximately 2.8 million Africans living in the UK (ONS, 2011). Underutilisation of mental health services by Black Africans is a frequent research finding from a number of countries (e.g. Fenta, Hyman, & Noh, 2007; Nadeem et al., 2007) and the onus is on services to ensure they are accessible to this diverse population.

This review aims to systematically search the literature to find out what is known about barriers and facilitators to mental health services for Black African communities. This review will focus specifically on access to statutory mental health services i.e. those provided by the state rather than third sector, private provision or culturally-sanctioned practices (e.g. traditional healers). State-run services, whether in western or non-western countries, are often based on a medical model of mental illness, are frequently staffed by psychiatrists and nurses, and use medication as a primary treatment.

Studies looking at access to other statutory services such as drug and alcohol clinics will be excluded, as well as those in which participants are under 18 years or are from a specific population such as those with intellectual disabilities. This is because these services and populations are likely to experience different barriers and

facilitators which may not be applicable to the wider Black African community or generic mental health services (for full inclusion and exclusion criteria, see methods section).

To my knowledge there have been no previous reviews in this area and although the literature is not extensive, it is important to evaluate and synthesise the current evidence to inform services of factors to consider in their attempts to improve accessibility.

The review questions are: A) what is currently known about barriers and facilitators to statutory mental health services for Black Africans? B) What is the quality of the evidence?

Method

Search strategy

An electronic database search was conducted using PsycINFO (1806-Oct week 3 2014), Medline (to October 24, 2014), and Scopus (to 7th November 2014; see appendix A for full search strategies). The searches produced 2191 results. Duplicate articles were removed and the remaining articles were examined against inclusion and exclusion criteria (see below). Studies were initially excluded based on the title, where indicated, or abstract. In just under 100 cases, it was necessary to review the full text to decide whether the study met criteria (see Figure 1). The reference list of relevant papers was hand searched; however no further articles were found.

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Identification

  ┌─────────────────────┐      ┌─────────────────────┐
  │ 2191 records        │      │ 0 additional records│
  │ identified through  │      │ identified through  │
  │ database searches   │      │ other sources       │
  └─────────────────────┘      └─────────────────────┘

Screening

          ┌──────────────────────────────────┐
          │ 1832 records after duplicates    │
          │ removed                          │
          └──────────────────────────────────┘

          ┌───────────────┐      ┌─────────────────────┐
          │ 1832 records  │      │ 1406 records excluded│
          │ screened      │      │ based on title      │
          │               │      │                     │
          │               │      │ 329 records excluded│
          │               │      │ based on abstract   │
          └───────────────┘      └─────────────────────┘

Eligibility

          ┌───────────────┐      ┌─────────────────────┐
          │ 97 full text  │      │ 83 full text articles│
          │ articles      │      │ excluded based on   │
          │ assessed for  │      │ inclusion/exclusion │
          │ eligibility   │      │ criteria:           │
          │               │      │  -  20 on criterion 1│
          │               │      │  -  4 on criterion 2 │
          │               │      │  -  45 on criterion 3│
          │               │      │  -  1 on criterion 4 │
          │               │      │  -  6 on criterion 6 │
          │               │      │  -  7 on criterion 7 │
          └───────────────┘      └─────────────────────┘

Included

          ┌───────────────┐
          │ 14 studies    │
          │ included      │
          │ in review     │
          └───────────────┘
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Figure 1. Steps to the identification of relevant papers

Inclusion and exclusion criteria

The inclusion criteria for studies were:

1. The study must contain reference to barriers and/or facilitators to access

2. The study must relate to statutory mental health services

3. The study must include data from Black Africans

4. The study must be written in or translated into English

5. The study must be published in a peer reviewed journal

6. They study must be empirically based (e.g. not a review of previous literature)

The exclusion criteria for studies were:

7. Black Africans were involved in the study but findings did not separate barriers/facilitators for this population from other ethnicities (N.B. this includes studies where the participants were described as 'African American' as this term is used for any Black American regardless of whether they are of African or Caribbean origin).

8. The study focussed on student counselling, drug and alcohol services, physical health services or other health problems e.g. smoking cessation

9. The study focussed on participants who were under 18 years

10. The study looked at barriers to mental health services for particular populations e.g. service users with intellectual or physical disabilities

Analysis

A thematic synthesis was used to analyse data from the studies in the review. This method is a type of interpretative analysis which enables the concepts derived to be combined into a higher-order theoretical structure rather than using pre-decided groupings (Noblit & Hare, 1988), and is therefore suited to answering questions which cannot be addressed by meta-analysis. Thematic synthesis can be carried out on studies using both quantitative and qualitative methodologies (Dixon-Woods, Agarwal, Young, Jones, & Sutton, 2005; Lucas, Baird, Arai, Law & Roberts, 2007), therefore this type of analysis has been chosen to accommodate the variety of methodologies used in the studies under review.

A theory-driven approach to data extraction was taken (Braun & Clarke, 2008), so that only data relating to barriers and facilitators was included in the analysis. The definitions provided above were used to find all information in the results sections of the studies which could be interpreted as barriers or facilitators to accessing statutory mental health services. This enabled the focus to be on primary data presented (e.g. quotes from participants) as well as the researchers' interpretations of these findings.

The following steps were taken to analyse the studies, informed by Braun and Clarke (2008) and Thomas and Harden (2008). Firstly, the results sections of all studies were read and re-read, and all parts of the results sections which could be interpreted as a barrier to access were highlighted. Secondly, all highlighted parts of the text were then given an initial code according to their meaning. Thirdly, the codes were grouped according to similarities and differences, and new codes were created to describe each group. Fourthly, the groups were organised into a

hierarchical structure which provided a coherent conceptualisation of the data, and thematic maps were produced. All steps were repeated for facilitators.

The steps described above correspond to stages one and two described in the paper by Thomas and Harden (2008). As the data extracted from the studies was theory-driven (relating specifically to barriers and facilitators), it was considered that Thomas and Harden's stage three (generating analytical themes) was not necessary as the descriptive themes were close to the data and answered the research question.

It is stated by Lucas et al. (2007) that results from quantitative studies should be included from the initial stages of collating data for synthesis. In the current review, the same steps were followed in order to analyse results from quantitative studies. The difference was that less interpretation was necessary between the text and the initial coding, for example if questionnaire data found that stigma and logistical barriers were in place for members of Black African communities, 'stigma' and 'logistical barriers' would be included in the initial code list.

Quality rating scales

For studies using qualitative methods, the CASP-QRC (Critical Appraisal Skills Programme-Qualitative Rating Checklist; CASP, 2013) was used to provide quality ratings. The CASP-QRC contains 10 different criteria against which the studies were evaluated; with each criterion containing more specific prompts to aid appraisal (see Appendix B). Studies received a score of 1 (feature is present), 0.5 (feature is somewhat present) or 0 (feature is not present) on each criterion and a single mean quality score was calculated. In this case, the CASP-QRC was adapted to include the consideration of limitations.

Each study was also given a global rating of low, medium or high quality in addition to the numerical rating. Global ratings took into account both the numerical ratings from the CASP and further critique of each study described below. This was to ensure that all aspects of the study were taken into account rather than limiting the quality appraisal to only those aspects raised in the CASP. Studies were given a 'high' quality rating if they were deemed to be scientifically rigorous, replicable and transparent including an acknowledgement of limitations and reflection on possible sources of bias and how these were reduced.

For studies which involved quantitative methods, the QualSyst (Kmet, Lee, & Cook, 2011; see Appendix B) was used to aid appraisal of the papers. The QualSyst produces numerical ratings of quantitative studies, giving a score of 1 (yes), 0.5 (somewhat) or 0 (no) on each criterion. This allowed a single mean quality score to be calculated, although it should be noted that given the difference between criteria, the ratings are not directly comparable to those generated by the CASP-QRC. As with the qualitative studies, global ratings were generated by taking into account the numerical scores as well as further critique which is detailed below.

Results

Overview of articles

Fourteen articles were found which met inclusion and exclusion criteria, eight of which were qualitative, two were quantitative and four were mixed methods. Of the mixed methods studies, three were predominantly quantitative (e.g. questionnaires containing some open-ended questions) and one was evenly split between qualitative and quantitative methods (e.g. focus groups and questionnaires).

The studies were based in a range of countries including the UK (four studies), USA (three studies), South Africa (three studies), Portugal, the Netherlands, Ghana, Uganda, and Australia (one study each). The majority of studies were based in primary care mental health services (seven studies) and/or in the community (eleven studies) and therefore in most cases participants were services users or members of the general public. Two studies used staff and/or stakeholders as participants (see Table 1 for an overview of studies included in the review). In the following section, barriers and facilitators identified in the studies are summarised in turn. Of note the former by far outweighed the latter, which is at least in part a reflection of the much greater attention paid to barriers in research.

Barriers to accessing services

Four overarching themes (domains) were identified following a thematic analysis of the results of the studies. The domains represent barriers which were found to prevent Black Africans from accessing statutory mental health services and increase the likelihood that help would be sought elsewhere e.g. via traditional healers. The barriers were *different world views, inadequate statutory services, lack of knowledge and information,* and *stigma/shame*. Each domain has a number of constituent subthemes discuss below (see Figure 2 and Table 2).

Different world views

A finding that Black Africans have different world views to those generally held by statutory mental health services emerged in seven studies. This may act as a barrier because experiences described by services as 'mental health problems' are often understood in religious or spiritual terms by Black Africans (Brown et al.,

Table 1. Overview of studies included in the review

Authors	Year	Title	Type of study	Country	Setting	Sampling method	N	Ethnicity	Analysis	Quality rating
Ae-Ngibise, Cooper, Adiibokah, Akpalu, Lund, Doku, & Mhapp Research Programme Consortium	2010	'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana.	Qualitative	Ghana	Community, Services, Stakeholders	Purposive	122	Ghanaian (?)	Framework Approach	Medium 0.7
Brown, Casey, Bishop, Prytys, Whittinger & Weinman	2011	How Black African and White British women perceive depression and help-seeking: A pilot vignette study	Mixed Methods	UK	Community	Convenience	73	Black African	Chi squared, t-tests, Mann-Whitney U, general inductive approach	High 0.9
Drummond, Mizan, Brocx & Wright	2011	Barriers to accessing health care services for West African refugee women living in Western Australia.	Quantitative	Australia	Community	Personal Invitation (?)	51	Liberian, Sierra Leonean	Fischer's exact, point biserial correlations	Medium 0.6
Knipscheer & Kleber	2008	Help-seeking behavior of west African Migrants	Mixed Methods	Netherlands	Community, Healthcare services	Convenience	104, 29	Ghanaian	Descriptive statistics, fischer's exact, Chi squared, t-tests, Mann-Whitney U, ANOVA	High 0.85
Loewenthal, Mohamed, Mukhopadhyay, Ganesh, & Thomas	2012	Reducing the barriers to accessing psychological therapies for Bengali, Urdu, Tamil and Somali communities in the UK: some implications for training, policy and practice	Qualitative	UK	Community, NHS	Opportunistic	24, 6	Somali	Thematic Analysis	High 0.95
Lupuwana, Simbayi, & Elkonin	1999	Psychological services in the Black community of Port Elizabeth in South Africa: Assessment of awareness, attitudes, practices and needs	Mixed methods (predominantly quantitative)	South Africa	Community	Random Route Sampling	265	Black South African (Xhosan)	Descriptive statistics inc. frequencies, thematic content analysis	Medium-High 0.8

Authors	Year	Title	Methodology	Country	Setting	Sampling	N	Population	Analysis	Quality
Moleiro, Silva, Rodrigues, & Borges	2009	Health and mental health needs and experiences of minority clients in Portugal	Qualitative	Portugal	Community (?)	Convenience	21	Angolan, Cape Verdean, Mozambican, other African	Generic Qualitative Analysis	Medium 0.65
Nadeem, Lange, Edge, Fongwa, Belin, & Miranda	2007	Does stigma keep poor young immigrant and US-born black and Latina women from seeking mental health care?	Quantitative	US	Healthcare services, other community services	Unclear	273	Black African Born	Descriptive statistics, logistic regression	High 0.8
Petersen, Ssebunnya, Bhana, & Baillie	2011	Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda	Qualitative	South Africa, Uganda	Primary Care	Voluntary/ purposive?	15, 31(?)	South African, Ugandan	Framework Approach	Low-Medium 0.5
Piwowarczyk, Bishop, Yusuf, Mudymba & Raj	2014	Congolese and Somali beliefs about mental health services	Mixed Methods	US	Community	Convenience, snowballing	31, 296	Congolese, Somali	Grounded theory, descriptive statistics, frequencies	Medium 0.75
Ruane	2010	Obstacles to the utilisation of psychological resources in a South African township community	Qualitative	South Africa	Community, Healthcare services	Convenience (?)	12	Black South African	Unclear	Medium 0.75
Saechao, Sharrock, Reicherter, Livingston, Aylward, Whisnant, Koopman & Kohli.	2012	Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States.	Qualitative	US	Community, immigration centres	Convenience	5	Eritrean, Ethiopian, Sierra Leonean	Thematic Analysis	Medium 0.6
Shefer, Rose, Nellums, Thornicroft, Henderson, & Evans-Lacko	2013	'Our community is the worst': The influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London.	Qualitative	UK	Healthcare services, laypersons	Unclear	11, 13	Somali	Thematic Analysis, Content Analysis	Medium 0.65
Whittaker, Hardy, Lewis, & Buchan	2005	An exploration of psychological well-being with young Somali refugee and asylum-seeker women.	Qualitative	UK	Community	Unclear	5	Somali	IPA	High 0.95
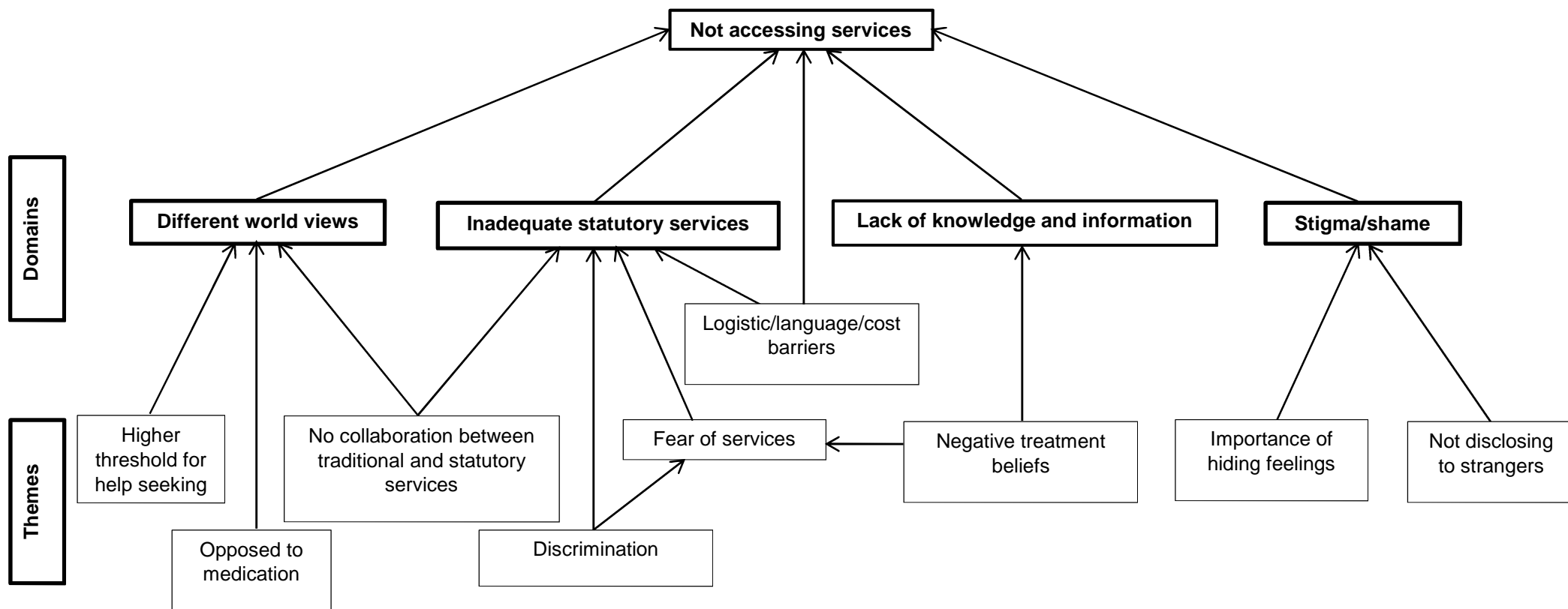
Figure 2. Thematic map of barriers to seeking statutory mental health services

Table 2. Barriers to seeking statutory mental health service by study

						First Author									
Barrier	**Ae-Ngibise**	**Brown**	**Drummond**	**Knipscheer**	**Loewenthal**	**Lupuwana**	**Moleiro**	**Nadeem**	**Petersen**	**Piwowarczyk**	**Ruane**	**Saechao**	**Shefer**	**Whittaker**	**Total**
Lack of knowledge/information		X	X	X	X	X				X	X	X	X	X	**10**
Stigma/shame		X		X	X	X		X		X	X		X	X	**9**
Different world views	X	X			X					X	X		X	X	**7**
Importance of hiding feelings					X				X	X	X	X		X	**6**
Inadequate Statutory Services	X					X			X		X		X	X	**6**
Logistical/language/cost barriers								X							**6**
Higher threshold for help seeking		X	X		X					X			X		**5**
Negative treatment beliefs		X	X			X							X	X	**5**
Fear of services			X	X	X					X	X				**5**
Opposed to medication	X	X	X							X					**4**
Not disclosing to strangers						X				X					**2**
Discrimination							X				X				**2**
No collaboration between traditional and statutory services	X										X				**2**

2011; Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014). This therefore makes it more likely that help will be sought from the church or traditional healers (Ae-Ngibise, et al., 2010).

Participants in the study by Ruane (2010) stated that psychologists do not understand the African world view which involves religious and magical beliefs. One participant in the Ae-Ngibise et al. (2010) study stated that services do not know the difference between demons and real madness, demonstrating the different explanatory models and beliefs held by some members of Black African communities.

Somalian participants disagreed on which word to use for mental health problems as there was no overarching term, rather there was a word meaning 'depression' and a different word for psychosis (Piwowarczyk et al., 2014), suggesting that Somalis categorise their experiences differently to western mental health systems.

Religious beliefs created barriers to mental health services for a number of reasons. Participants reported that it can be confusing if they are recommended different courses of action by their pastor and doctor (Piwowarzcyk et al., 2014), and disagreed with Western criticism of using religion to treat mental health problems (Shefer et al., 2013). Whittaker, Hardy, Lewis, and Buchan (2005) found that Muslim participants reported being seen as too Westernised and going against Islam by using mental health services, although another participant suggested that the Qur'an advocated the use of medicine.

Higher threshold for help seeking: In five studies, including two rated as high quality (Brown et al., 2011; Loewenthal, Mohamed, Mukhopadhyay, Ganesh, & Thomas, 2012), participants saw mental health problems such as anxiety and

depression as part of everyday life and therefore as not serious enough to seek help. For example, anxiety was described as 'a fleeting discomfort that passes away' (Loewenthal et al., 2012) and depression was believed by women to be less likely to strongly affect their lives (Brown et al., 2011). There was a separation of 'serious' mental health problems which were shown by extreme behaviours such as 'taking off your clothes' and anxiety and depression which were seen as a normal part of life (Piwowarczyk et al., 2014). Another study also found that depression was seen as normal and something to be 'brushed off' (Shefer et al., 2013).

Along with this belief came the tendency for participants to try to cope with problems alone (Brown et al., 2011; Drummond, Mizan, Brocx, & Wright, 2011) or use distraction, for example getting someone married so that planning the wedding would take their mind off things (Loewenthal et al., 2012).

Opposed to medication: Four studies concluded that negative attitudes towards medication prevented participants seeking help from statutory services. In the study by Brown et al. (2010; p. 370), one participant stated they "*do not believe in taking medication for depression*" and in Congolese and Somali communities it was reported that people were under pressure from others not to take prescribed medication (Piwowarczyk et al., 2014). There was also a view that conventional services only administer medication and then send people away (Ae-Ngibise et al., 2010). These beliefs made it less likely that statutory services would be accessed (Brown et al., 2010; Drummond et al., 2011).

Inadequate statutory services

Six studies found that statutory mental health services were seen as inadequate. This finding was highlighted in studies conducted in the UK, South

Africa, Uganda and Ghana. The main criticism was of staff who were seen as lacking

skills and knowledge, failing to develop therapeutic relationships with service users,

and as 'woefully inadequate' (Ruane, 2010; Ae-Ngibise et al., 2010). Lack of

resources was also raised as an issue, for example understaffing, lack of medication,

limited availability of interpreters and a general lack of services (Ae-Ngibise et al.,

2010; Lupuwana, Simbayi, & Elkonin, 1999; Petersen, Ssebunnya, Bhana, & Baillie,

2011; Ruane, 2010; Whittaker et al., 2005).

Fear of services: Five studies found that fear of treatment and lack of trust in

professionals were barriers to seeking help from statutory services. Participants in the

studies by Piwowarczyk et al. (2014) and Loewenthal et al. (2012) discussed a fear

that they would be 'locked up' or that social services would take their children away.

The latter study also found that interpreters were not trusted due to a fear that they

would gossip in the community, whereas Ruane (2010) found that participants were

reluctant to trust professionals who were not active in the community. Finally,

Drummond et al. (2011) and Knipscheer and Kleber (2008) both found that

participants feared being judged or not taken seriously by services.

Discrimination: Further to a lack of trust in services, participants in two

studies also noted concern about discrimination in the mental health system and a

fear that psychologists could not separate their own beliefs from those of society

(Moleiro, Silva, Rodrigues, & Borges, 2009; Ruane, 2010). This finding also derived

from a study conducted in South Africa where participants saw psychology as a

'white' profession and expressed concern about discrimination given the socio-

political context of apartheid.

Lack of collaboration between statutory and traditional services: Two studies

found that the lack of collaboration with traditional healers was a barrier to mental

health services. The study by Ae-Ngibise et al. (2010) asked specifically about barriers to collaboration and found that conventional mental health services were concerned about the lack of a scientific basis for traditional and faith practices as well as highlighting fear about human rights abuses perpetrated by some healers. Ruane (2010) found that it was a problem for participants that psychology services did not collaborate with traditional healers and stated that this would prevent people who were used to seeking help from traditional healers from using mental health clinics.

Lack of knowledge and information

Lack of knowledge and information about mental health problems and services was a frequently cited barrier, appearing in ten of the fourteen studies. Ruane (2010) found that participants in a South African township reported a lack of knowledge about the signs and symptoms of mental health problems and no acknowledgement that therapy could be helpful in addressing certain issues. They also reported having little information about available services or what happens in therapy, for example the timeframe and how it might help. Similarly, in another South African study, Lupuwana et al. (1999) found that over half of respondents had not heard of a psychologist and did not know whether treatment would be successful.

Five studies found that participants were not aware of which services were available or how to access them (Drummond et al., 2007; Loewenthal et al., 2012; Lupuwana et al., 1999; Saechao et al., 2012; Whittaker et al., 2005). One participant expressed uncertainty about whether Somalis were welcome in services or whether they were just for the white community (Whittaker et al., 2005). Studies also frequently found that there was a lack of knowledge about the symptoms of mental

health problems and what could be treated in therapy (Brown et al., 2011; Loewenthal et al., 2012; Piwowarczyk et al., 2014; Shefer et al., 2013), as well as the view that 'you have to be mad' to consult mental health services (Knipscheer & Kleber, 2008).

Negative treatment beliefs: Five studies found that participants held negative beliefs about treatment and its efficacy. Participants in studies by Brown et al. (2011) and Shefer et al. (2013) believed that mental health problems were not amenable to treatment or that they were 'incurable'. A belief that talking does not help much was found by Whittaker et al. (2010), as well as in the study by Lupuwana et al. (1999) in which participants voiced uncertainty about whether treatment would be effective. Finally, Drummond et al. (2011) found that participants did not access services due to a belief that no one could help.

Stigma/shame

Stigma and shame were cited as barriers in nine of the fourteen studies. Many of the qualitative studies found that participants would not seek mental health services because they would be seen as 'mad', 'bad', or 'weak' (Knipscheer & Kleber, 2008; Piwowarczyk et al., 2014; Whittaker et al., 2005). It was also highlighted that often one's own community or culture was the source of the stigma and any sign of mental health problems or help seeking would lead to rejection by friends and family (Shefer et al., 2013; Whittaker et al., 2005).

In a study by Nadeem et al. (2007), logistic regression was used to show that Black African-born women in the US were more likely to report concerns about stigma than white US women, and that this left them reluctant to seek treatment. This was the only study to focus on one particular concept and look at whether it

constituted a barrier for particular populations including Black Africans. The study is useful as it showed that stigma affects behaviour rather than just the intention to seek services. However, it also found that logistical barriers such as lack of money, childcare and transportation were present in 60% of cases, whereas stigma was only found in 20% which suggests that there were other more important barriers for the population under study.

Importance of hiding feelings: Participants discussed a cultural response to emotions which involved hiding distress from others or even from themselves. For example, in one study a Somali participant reported that it was important for women not to cry, even following bereavement (Whittaker et al., 2005). Participants stated that people in their community were expected to be strong and 'deal with' difficult emotions (Piwowarczyk et al., 2014; Whittaker et al., 2005).

With regard to mental health problems, Piwowarczyk et al. (2014) found that there was a general denial of their existence in all but the most extreme cases. Similar findings were discussed by participants from a number of different African backgrounds and in studies which explored the experience of service users, staff, and lay members of the community.

Not disclosing to strangers: Two studies found that participants did not feel comfortable disclosing to strangers (Lupuwana et al., 1999; Piwowarczyk et al., 2014). This was raised by members of the Somali community and was seen as something shared by others in that culture in particular.

Logistical/language/cost barriers:

Logistical, language and cost barriers were found on six occasions (Loewenthal et al., 2012; Lupuwana et al., 1999; Nadeem et al., 2007; Ruane, 2010;

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Saechao et al., 2012). For example, lack of childcare, time and transportation were found to be barriers to seeking treatment for 60% of participants in a study by Nadeem et al. (2007). In countries where a fee is charged to access healthcare services, this was often found to be a barrier (e.g. South Africa; Lupuwana et al., 1999; Ruane, 2010). To a certain extent these barriers can be said to link to the inadequacies of services, for example through a lack of provision of interpreters etc; however they could also be linked to high levels of deprivation and/or personal circumstances.

Facilitators to accessing services

Only two of the fourteen studies specifically asked about facilitators to mental health services and only half of the studies contained discussion of factors which could be seen as facilitators as they increased the likelihood that statutory mental health services are accessed. The analysis indicated that factors that facilitated access to services clustered under three broad themes: *changes to services*, *increased information provision* and *positive treatment beliefs* (see Figure 3 and Table 3).

Changes to services

World views integrated into treatment: It was important to participants that their own explanatory models and values are integrated into treatment to ensure that services have a greater understanding of their clients (Loewenthal et al. 2012; Lupuwana et al., 1999).

Traditional and Statutory Service Collaboration: Continuing this theme, studies found that collaboration between traditional and statutory services would
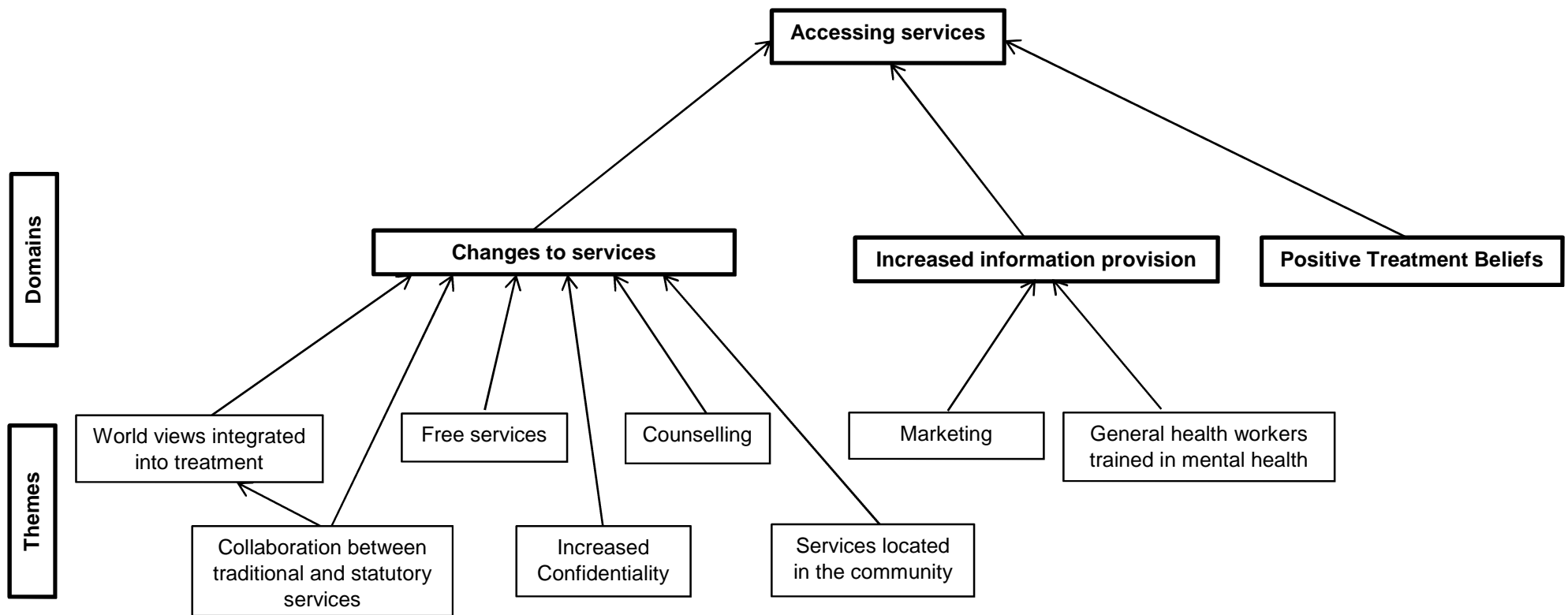
Figure 3. Thematic map of facilitators to accessing statutory mental health services

Table 3. Facilitators to seeking statutory mental health service by study

							First Author								
Facilitators	**Ae-Ngibise**	**Brown**	**Drummond**	**Knipscheer**	**Loewenthal**	**Lupuwana**	**Moleiro**	**Nadeem**	**Petersen**	**Piwowarczyk**	**Ruane**	**Saechao**	**Shefer**	**Whittaker**	**Total**
Services located in the community						X			X		X				3
Increased confidentiality					X	X								X	3
Positive treatment beliefs					X	X					X				3
Traditional/statutory collaboration	X										X				2
World views integrated into treatment					X	X									2
Counselling		X									X				2
Marketing						X									1
General health workers trained in mental health									X						1
Free services											X				1

encourage people to seek help from mental health services, for example Ruane (2010) found that participants wanted integration of traditional and Western practices to help solve their problems. In Ghana, Ae-Ngibise et al. (2010) suggested ways in which this collaboration could occur, including churches encouraging people to take their medication and monitoring their progress, healers giving advice to seek help from mental health services when nothing else was working and healers visiting people who had been admitted to psychiatric hospitals.

Locating services in the community: Three studies found that participants were more likely to consider accessing statutory mental health services if they were located in the local community. Lupuwana et al. (1999) found that respondents would be more likely to access services if they were launched in youth clubs, and would also consider attending a 'helping centre' in the community with a psychologist based there. In the Petersen et al. (2011) study it was suggested that 'village health teams' would be helpful. Finally, Ruane (2010) found that participants wanted psychologists to become a familiar face in the black community.

Increased confidentiality: Studies by Lupuwana et al. (1999) and Whittaker et al. (2005) found that participants would be more likely to attend services if their visits were kept secret from others in their community. Loewenthal et al. (2012) also found that participants wanted more professionally trained interpreters to reduce the chance that they were existing members of their community.

Counselling: Two studies found that participants were more likely to see counselling as acceptable and were more willing to seek counselling or alternative therapies rather than seeing their GP (Brown et al., 2011; Ruane, 2010).

Free services: Ruane (2010) found that participants would be more likely to access services if they were free.

Increased information

    Increased marketing: Respondents in the study by Lupuwana et al. (1999) wanted more marketing about psychology and mental health services, and also requested that psychologists clearly defined their responsibilities for the community so that even those who are illiterate could understand.

    General health staff trained in mental health: From the perspective of staff interviewed by Petersen et al. (2011), training general health staff in mental health was found to be particularly useful for identifying the mental health needs of patients. It also helped staff to be more aware that people have emotional problems and to address issues around stigma.

Positive treatment beliefs:

    Positive beliefs about treatment were found to facilitate access to mental health services in three studies. Loewenthal et al. (2012) found that some participants had a belief that talking treatments can be helpful, and Lupuwana et al. (1999) found that those who had visited a psychologist before would consider doing so again. Ruane (2010) found that it was important that services were seen as valuable or useful to the community.

Quality of the studies reviewed

Qualitative and mixed method studies

    Eight qualitative and three mixed methods studies were appraised using the CASP-QRC. Where studies used mixed methods only the qualitative aspects of the study were evaluated using this tool. Of the eleven studies, three were found to be of

high quality, one of medium to high quality, six of medium quality and one of low to medium quality (see Table 1).

High quality studies: Three studies were given a subjective high quality rating, two of which achieved a score of 0.95 (Loewenthal et al., 2012; Whittaker et al., 2005) and one of 0.9 (Brown et al., 2011).

Whittaker et al. (2005) studied how young Somali women living in the UK understand psychological wellbeing. The women were recruited from a voluntary sector training and community centre and data was collected using focus groups and interviews.

The study received a high quality rating because all but one of the ten CASP-QRC criteria were met fully and also because of the lengths taken by the researchers to ensure that the results were credible. These were explicitly listed in the paper and included a third focus group which was held to check the emergent themes, extensive quotations used in the results section, and disparities within themes being discussed. Triangulation was carried out between group and individual data, and four informants including two Somali mental health workers were consulted. Finally, reverse validity checks were performed and the transcripts and themes were independently assessed.

The paper also explicitly stated that the researchers had taken into account their relationship to the study and participants and acknowledged the potential bias this introduced into the analysis. In order to prevent this, a research journal was maintained throughout the process and the preconceptions of the researchers were acknowledged in the paper.

A number of limitations were stated including difficulty generalising the results due to the small sample size and uncertainty around whether refugees

attending the community centre have the same characteristics as those who do not. It was also noted that, at times, the women were unsure exactly what the researchers were asking.

A high quality rating was also achieved by Loewenthal et al.'s study (2012), which fully met all appraisal criteria of the CASP-QRC, except they did not explicitly state whether the study had received ethical approval. Nonetheless they considered all other aspects of the research carefully including justification of methods and analysis and consideration of bias and attempts to reduce this.

The study used focus groups including vignettes to look at how mental health problems are conceptualised and experienced, and the implications of this for access to mental health services. The study took place in community and NHS settings and included Somali participants as well as members of the Bengali, Urdu and Tamil communities. Where applicable, methods and results for each ethnic group were clearly separated and this review therefore only focuses on aspects relevant to the Somali participants.

Recruitment of 14 female and ten male Somali participants to two gender specific focus groups was done through opportunistic sampling, in which participants were verbally invited to attend by staff of community groups or responded to posters in community centres. It was reported that this recruitment method was seen as culturally appropriate. Researchers were matched on ethnicity to the focus groups, which were carried out in the appropriate language.

The main strengths of this research included the use of respondent validation interviews in which three males and three females who were not involved in the original focus groups were consulted to check whether the themes emerging from the focus groups had been correctly understood and captured. The paper also considered

the impact of the researchers on the study (known as reflexivity), which is a potential for the introduction of bias. In order to reduce this possibility, frequent group supervision was held for the researchers to discuss their own assumptions and how this may affect the focus groups and the analysis. Diaries were also kept in which researchers reflected on different aspects of the process and their role within the construction of research knowledge.

Limitations of the study acknowledged in the paper include the possibility that due to the setting, those who were more active within the community and those who were religious were likely to have been overrepresented in the focus groups. In addition, due to time constraints, the interviews were not back-translated to ensure they were an accurate representation of the original data.

The perceptions of depression in Black African compared to White British women and reasons why women experiencing depression may not consult their GPs, was studied by Brown et al. (2011). This study received a rating of 0.9 on the CASP-QRC, scoring highly in all areas apart from the researchers' relationship to the participants and research (reflexivity) which was not considered. It received a high subjective rating due to the general scientific rigour in which the paper was written making the study clear and replicable, and the choice of recruitment setting, local libraries, which are visited by a large proportion of the population.

The main limitations of this study were that data on country of origin was not collected and therefore people from many different cultures and levels of acculturation may have been included. There is also a possibility that the sample was unrepresentative, containing a greater proportion of more educated participants given that they were recruited from a library.

Finally, the study by Lupuwana et al. (1999) received a medium to high subjective rating, scoring 0.8 on the CASP-QRC. This study looked at awareness of and attitudes towards psychology in the black community of a South African township as well as identifying needs for psychology services. The study was mainly quantitative, using a questionnaire method; however a number of questions were open and therefore required qualitative analysis. The subjective appraisal given to this study was medium to high as the sampling method contained a random sampling procedure unlike any other study in the review; however certain areas showed only moderate scientific rigour (e.g. the description of the qualitative analysis).

Researchers administered the questionnaire verbally and the findings were reported comprehensively in the paper; however there was no consideration of reflexivity or the effect of answering a somewhat sensitive questionnaire verbally to a researcher, which may have produced social desirability effects. The results may have been more favourable towards psychology due to the wording of the questionnaire which focussed on whether participants would see a psychologist given a number of listed life events (e.g. marital problems, bereavement etc). However it did not ask about emotional experiences (e.g. feeling low or worried). It may therefore have been more acceptable for participants to say they would see a psychologist in response to life events than if they were experiencing difficult thoughts and emotions.

Medium quality studies: Six studies were judged as being of medium quality. These studies mainly showed flaws in replicability due to a lack of information provided regarding recruitment methods, data collection and analysis. Notably, only one of these studies considered reflexivity.

The concept and experience of mental health problems, treatments and barriers to care in the Congolese and Somali communities in the US was studied by Piwowarczyk et al. (2014). They recruited participants using convenience and snowball sampling from churches, community groups and businesses attended by members of the Congolese and Somali communities. Although these methods of sampling can be criticised for their potential for bias and lack of randomisation, in research such as this where the experiences of a particular hard to reach client group are under study, they are seen as acceptable. A weakness of this study is that the data was not audiotaped and analysis was performed on 'extensive notes' taken during the focus groups. The fact that this is a potential source of bias was not considered.

A study by Saechao et al. (2012) scored 0.6 on the CASP-QRC and a medium subjective rating. This study aimed to identify sources of stress and barriers to mental health services in first generation immigrants from countries such as Eritrea and Ethiopia in the US. The paper gave a clear and detailed account of the qualitative analysis used and checked for credibility by having a second independent coder; however the recruitment process was unclear and confusing. The authors also proposed a conceptual model of how life stressors and barriers to treatment affect the utilisation of mental health services but the model did not take into account service characteristics and facilitators and therefore has somewhat limited utility.

A rating of 0.65 on the CASP-QRC was achieved by Shefer et al. (2013), although the study, which aimed to explore cultural beliefs regarding mental health in three ethnic communities, was let down by an unclear recruitment strategy, lack of detail about how the data was analysed and lack of reflexivity. The study involved a number of focus groups, two of which solely contained Somali participants; one group of service users and one group of lay people. This was a strength of the study

as the data are more likely to be balanced rather than over-representing the views of one particular group.

In a study conducted in Portugal, Moleiro et al. (2009) explored representations of health and illness among ethnic minority clients in order to understand how this affects their use of services. It was unclear to what extent the participants had any experience of using mental health services as the recruitment method involved masters' students recruiting 'acquaintances' as part of an assignment. This also raised ethical issues around anonymity and confidentiality and means that results may have been biased by social desirability.

The strengths of this study include the data being analysed by four independent coders which increases the credibility of results by reducing the risk of bias in the interpretation. A table was also produced to show which barriers were found across all, more than half, or less than half of the interviews, although this was not separated by ethnicity and is therefore of limited utility to this review. Due to the lack of differentiation between nationalities in the results section, very few barriers were cited as specifically affecting the eleven Black Africans who took part in the study. Therefore only a very small amount of data was taken from the study for this review.

In a South African township, Ruane (2010) conducted focus groups with members of the local community, undergraduates, clients of the township mental health clinic and their family members in order to investigate their beliefs and attitudes towards mental health and psychology. This study had a number of notable strengths and weaknesses and was therefore given a medium subjective quality rating.

The researcher in this study paid particular attention to reflexivity and discussed the impact of participants being interviewed by a white psychologist at the start of the focus group. The results provided extensive evidence of negative beliefs about psychologists and therefore suggest that participants felt they did not feel under pressure to give desirable responses. The themes from the data were checked back with participants which increases the credibility of the results. However this study did not provide sufficient detail of the recruitment method or consideration of ethical issues, nor was information given about the analysis. The latter was the major shortcoming of an otherwise useful study.

A study conducted in Ghana by Ae-Ngibise et al. (2010) took a different approach to looking at barriers by exploring reasons why traditional and faith healers are so frequently chosen over statutory services. The study used data from seven focus groups and 81 interviews with health professionals at national, regional and district level, service users, traditional and faith healers, and members of other professions including police officers, teachers and academics. The study had an exceptionally large N for a qualitative study and this is reflected in a comprehensive results section. Unfortunately there was little detail given about the analysis, no credibility or reflexivity considerations and no acknowledgement of limitations. This study was therefore given a medium quality rating.

Low quality studies: Finally, there was one low to medium quality study conducted by Petersen et al. (2011) in Uganda and South Africa. This study focussed on the views of staff from two programmes in the respective countries in which mental health care has been integrated into primary care services. This article largely consisted of jargon with no definitions provided (e.g. 'task shifting') and gave insufficient information about the aims, recruitment strategy, data collection and data

analysis. There was also no information given on reflexivity or credibility checks or acknowledgement of limitations. Although this study provides a different perspective on barriers to mental health service use, unfortunately little effort was made to enable the reader to understand the programmes and generalise the findings to other areas.

Quantitative studies

High quality studies: Service utilisation, delay before consultation and preconceptions about help-seeking were studied by Knipscheer and Kleber (2008) through questionnaires administered to Ghanaian immigrants in the Netherlands. A non-clinical community sample and mental health service users and were recruited through convenience and snowball sampling methods. A strength of this study was that all questionnaires were rigorously tested through focus groups and a pilot study with members of the Ghanaian community and mental health professionals who work with this population to ensure that they were culturally valid.

It is not clear how the questionnaires were administered which is important as verbal administration may lead to social desirability effects whilst self-report questionnaires may exclude those with low levels of literacy. Overall the results were inconsistent with other literature in this area and suggested that participants experienced shame, stigma and mistrust around using traditional healers. This may be due to broad inclusion criteria in which participants were required to have only one parent born in Ghana to take part in the study.

In a study about the effects of stigma on help-seeking, women including African-born immigrants were recruited from health settings and surveyed about depression symptoms, endorsement of stigma-related concerns and use of mental health services (Nadeem et al., 2007). The large n (913 African Immigrants) was a

strength of this study; however it was difficult to draw conclusion about the direction of the effects as the data was correlational. Questions relating to stigma and other barriers were limited in number and may therefore have missed out important aspects of the experience of stigma and its impact on help seeking.

Medium quality studies: In another survey-based study, Drummond et al. (2011) compared pathways and barriers to services including mental health care in West African and Australian women in Perth. The questionnaires were culturally adapted based on feedback from members of a West African community group; however the surveys were then administered by these women which raises concerns about whether the participants could speak freely without social desirability affecting their responses.

The survey featured closed-questions, asking the participants to choose where they would seek help for different problems including stress; however this may have produced different results than if the women were not limited to set options. As in the study above by Knipscheer and Kleber (2008), it was found that the women were more likely to seek help from services than traditional or faith healers, which was explained by the lack of a language barrier for English speaking West African refugees.

Discussion

This systematic review aimed to establish what is currently known about barriers and facilitators to members of Black African communities accessing statutory mental health services. Across the fourteen studies included in the review this question has mainly been answered using qualitative methods to find beliefs

about and understandings of mental health problems, as well as attitudes towards help seeking and services. A small number of studies used quantitative or mixed methods including questionnaires or surveys with closed and open questions.

Authors have highlighted the importance of using evidence from qualitative studies in systematic reviews to answer questions which cannot be addressed using an RCT (e.g. Dixon-Woods, et al., 2006; Whittemore, Chase & Mandle, 2001). The evidence in this review therefore makes a valuable contribution to current knowledge.

The studies rated using the CASP-QRC and the Qualsyst were mostly appraised as of high or medium standard with only one study rated as of low to medium quality. In evaluating the qualitative studies, emphasis was placed on credibility and reflexivity checks as well as replicability and scientific rigour in order to identify sources of bias which may have affected the results. All barriers found in the low to medium quality study were also found in medium and high quality studies and are therefore seen as valid.

The articles highlighted a number of barriers and facilitators, many of which appeared in multiple studies conducted in a variety of settings and with different populations. The evidence base regarding barriers to accessing services was greater and more robust than that regarding facilitators. No study focussed exclusively on facilitators and only a small number included facilitators explicitly or implicitly in their results. Research focussed on barriers aims to find the cause of low access rates to services; however the recommendations and implications for services are based on the assumption that removing barriers will increase access. Although this may seem reasonable, it offers an over simplistic view of barriers and the ease of their removal,

whilst ignoring facilitators which may increase access despite the presence of barriers.

Barriers to accessing services

Barriers to seeking mental health services fell into four main domains: different world views, inadequate statutory services, lack of knowledge and information, and stigma/shame. In studies which found different world views to be a barrier, participants discussed explanatory models and beliefs which are different to and possibly incompatible with western understandings of mental health problems. This supports previous research which has found that West Africans are more likely to endorse social or supernatural rather than biological explanations of schizophrenia (McCabe & Priebe, 2004). In this review beliefs about the cause of mental health problems were closely linked to ideas about where to seek help, for example from the local pastor or traditional healers. This is consistent with research findings that beliefs about where to seek help are closely in line with a person's understanding of the problem (Furnham & Anthony, 2010).

The results also suggest that there is a notable difference in how problems such as anxiety and depression are experienced, in that they are seen as temporary states which are not serious enough to warrant help seeking. This is markedly different from Western mental health services, many of which are set up specifically to provide treatment for anxiety and depression. In certain cultures (e.g. Somali) words used to describe mental health problems do not correspond with Western categories and diagnoses, suggesting that some Black African communities do not recognise particular problems for which mental health services are set up.

The inadequacy of statutory mental health services in a number of countries poses a particular barrier for Black Africans. Lack of collaboration between mental health services and traditional and faith healers again demonstrates a lack of recognition of typical African world views. A fear of services is also likely to have come, at least in part, from the poor standard of care provided as well as a lack of information relating to treatment and services in general.

Stigma is a frequently cited barrier to mental health care and is the focus of mental health campaigns such as 'Time to Change' in the UK. Stigma/shame was the third most frequently cited barrier and was found in high and medium quality studies. Although this review did not aim to look at differences between ethnicities and cultures, it is noted that Somali participants in particular stated that stigma played a large role in their community's attitudes towards mental health and help seeking.

Facilitators to accessing services

The three high quality studies reported data on facilitators to accessing mental health services. However, robust conclusions cannot be drawn from this review due to the small number of studies which included this data (each facilitator was found in three or fewer studies).

The facilitators found in this review primarily involved changes to services which are needed to increase access, including increased confidentiality, locating services in the community, and integrating different world views and cultural values into treatment. It was also highlighted that increased marketing and information would increase access as well as training general health staff in mental health. The latter was studied in South Africa and Uganda as a way to increase knowledge and reduce stigma. It may also provide a new pathway into mental health services in

countries in which services are not accessed through a general practitioner or equivalent.

One major limitation of the findings relating to facilitators is that many of those cited were raised by participants as suggestions for increasing access to services in the future. In general, studies have not focussed on facilitators which have already been shown to increase access to services, and the facilitators cited above may not prove to be such in practice.

Methodological issues

Thematic synthesis was used to analyse the findings of studies included in the review. This allowed results from both quantitative and qualitative studies to be synthesised (Dixon-Woods et al., 2005; Lucas et al., 2007), and enabled facilitators to be identified in studies in which they were not explicitly explored.

Nonetheless there were a number of limitations to using this type of analysis. Firstly, a mixture of primary data (quotations) and researchers' interpretations of primary data were included in the analysis, which means that the latter was subject to two levels of interpretation following synthesis in this review. This raises the possibility that the final themes derived here may have somewhat departed from the original data they are based upon. This may have been confounded by the fact that due to time constraints, it was not possible for a second researcher to check the themes derived.

Secondly, despite Dixon-Woods et al.'s (2005) assertion that both quantitative and qualitative data can be included in thematic syntheses, few papers include a description of how quantitative data should be treated (e.g. Thomas & Harden, 2008). It is also the case that two of the three quantitative studies included in

this review used questionnaire data in which certain items where endorsed more than others. However this meant that the barriers and facilitators found to be significant were limited to those included in the questionnaires.

A large amount of potentially useful information was lost due to the exclusion of studies involving African Americans. However, this was unavoidable as the term does not distinguish between those of African and Caribbean origin. It should also be noted that studies which include multiple generations of Black Africans in host countries may be studying people with different levels of acculturation or even of different cultures. Someone who is born and grew up in Africa may have very different experiences and understandings of the world compared to someone born in the UK, for example, of Black African parents.

A further limitation of this review is that the majority of studies used qualitative methodologies and varied as to whether they were set in host nations or countries of origin. It may therefore be difficult to transfer the findings to Black African populations in general. However, the combined N for the studies was large and many of the same barriers were found across studies in different countries suggesting that they are likely to generalise across countries and health care systems.

Implications

The findings of this review suggest that mental health services in a number of countries are contributing to the barriers experienced by Black Africans. In particular, the provision of accessible information to local communities should be addressed with utmost importance in order to reach those who need help but do not know what is available or where to look.

Further training and support are necessary to encourage services to integrate African world views into treatment, for example by teaching staff how to work with explanatory models which differ from those that services use most frequently (e.g. the medical model). Further resources are needed to promote collaboration between statutory services and traditional/faith healers.

Many of the barriers highlighted in this review suggest that there are more fundamental reasons why mental health services are not accessed by Black African communities. For example, stigma continues to be a major barrier to accessing mental health services. Black Africans also hold different understandings of mental health problems which do not closely correspond to Western diagnostic categories, and problems can be experienced as less serious and not requiring treatment. Traditional healers and faith leaders are often sought in times of difficulty and services may have to accept that they may never be first choice for some members of the Black African community, if they are accessed at all.

Future research

Much of the research in this area is still in the exploratory phase and the majority of the evidence comes from qualitative studies. The literature on barriers would benefit from studies which can be designed to find out whether there is a causal link between specific barriers and the number of referrals to services. This is being done in the area of stigma (e.g. Golberstein, Eisenberg, & Gollust, 2008; Nadeem et al, 2007) but this review did not find any other research concerning specific barriers and facilitators and their measurable effects on help seeking. Further study is needed to provide information that can be used by services to increase

referral rates. This review has also made some preliminary conceptual links between barriers which could be supported by a path analysis.

Compared to the literature on barriers, research on facilitators is in the very early stages and has not been focussed on to the same extent. It is vital that this area is understood as many of the barriers found in this review are considerable and difficult to address. Research should focus on factors which allow barriers to be overcome. This would make services accessible despite barriers rather than focussing on removing barriers all together. For example, studies involving participants who have accessed services despite coming up against a number of barriers would provide vital information that could be used by services now.

Conclusion

There are many substantial barriers which make it less likely that Black Africans will access statutory mental health services in the UK and around the world. There are a number of proactive steps which services can take in order to reduce some of these barriers; however the majority demand more creative and far reaching strategies to enable members of Black African communities to overcome them in order to access mental health services.

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Part 2: Empirical Paper

Pathways, Barriers and Facilitators to Psychological

Therapy for Members of Black African Communities

in the UK

Abstract

Aims: This study aimed to explore the pathways taken by members of Black African communities in the UK to NHS Improving Access to Psychological Therapies (IAPT) services. In particular, factors which made it more difficult to access services (barriers) were discussed as well as factors which made it easier (facilitators).

Method: Semi-structured interviews were conducted with ten members of Black African communities in the UK who had accessed psychological therapy at IAPT services. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA) in order to extract relevant themes and domains.

Results: The barriers to accessing services fell into five domains: *Stigma, Lack of knowledge and information, Reluctance to disclose, Different world views,* and *Negative experience of services.* Facilitators to accessing services fell into the following domains: *Others encouraging help-seeking, Value of information and awareness,* and *Recognising the need for help.* The pathways described by participants were diverse in their length, and contained a variety of triggers for help seeking and sources of support. All pathways involved seeking support from a General Practitioner (GP).

Conclusion: The pathways taken by members of Black African communities in the UK include significant barriers to accessing psychological therapy services. However, a number of facilitators including the central role of GPs and internet research can enable help seeking despite the presence of these barriers.

Introduction

The level of immigration to the UK is a highly controversial and politically charged topic. Many discussions around immigration focus on the concern about a 'strain on resources' especially in the National Health Service (NHS); however in mental health services there is evidence that Black and Minority Ethnic (BME) communities are significantly underutilising the resources available.

Mental health and psychological therapy have recently been subject to a major new government initiative with the introduction of Improving Access to Psychological Therapy (IAPT) services in England (Department of Health [DOH], 2008). These provide short term, evidence based psychological therapies for those experiencing common mental health problems such as depression and anxiety. Based in primary care, IAPT services are mainly accessed via General Practitioners (GPs) or self-referral.

The 'equity of access' principle is one of the foundations of IAPT services and states that treatment should be equally accessible to all adults experiencing depression and/or anxiety regardless of age, gender or ethnicity. Conversely, local and national data suggest that IAPT services are not accessed at the level expected by people from a number of different ethnic backgrounds relative to the population. These data use the '16+1' ethnicity categories (Office for National Statistics [ONS], 2001) to compare the ethnic make-up of the population as recorded in the 2011 census with those who access IAPT services (Health and Social Care Information Centre [HSCIC], 2014; ONS, 2011; see Figure 1). Black Africans, the focus of this study, have among the lowest levels of IAPT service use, with an access rate of only 57.4% compared to their population in England (see Figure 2).
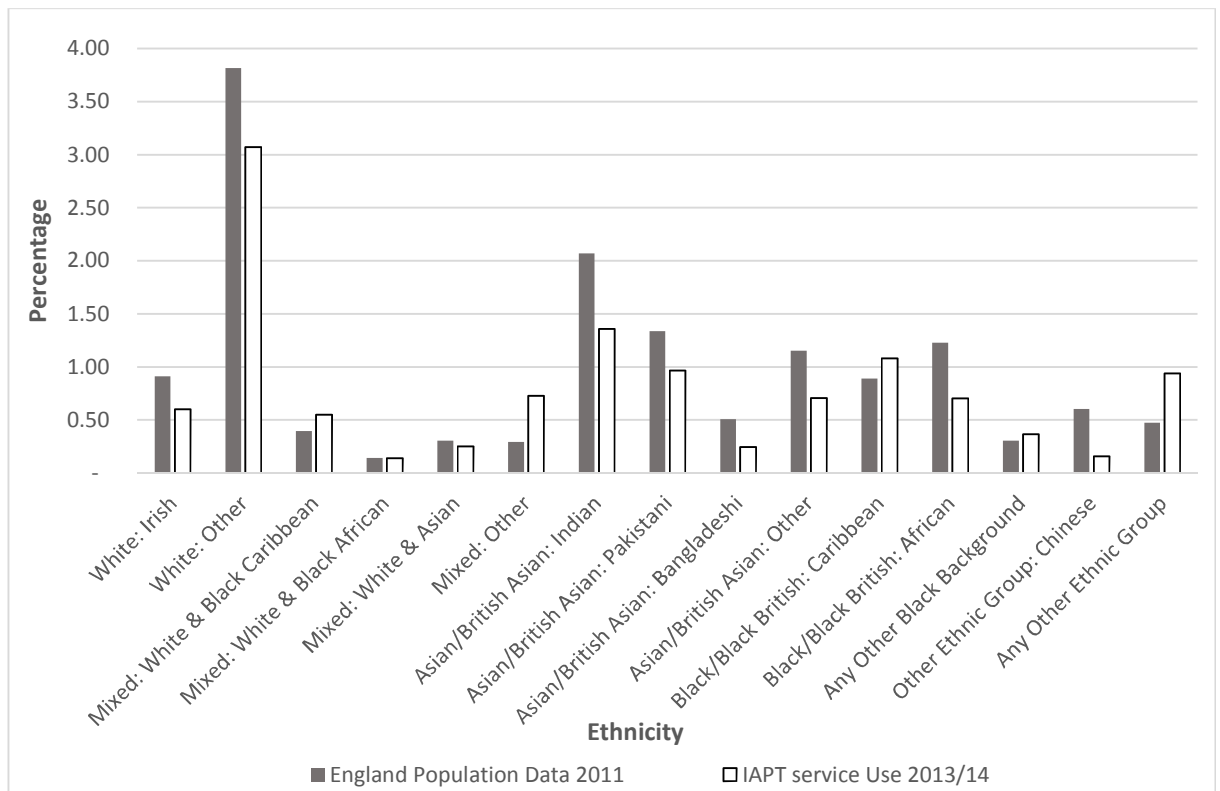
Notes. White British figures: 63.8% (population), 61.6% (IAPT service users); Adapted from Health and Social Care Information Centre (2014; IAPT service use data); ONS (2011; England population data).

Figure 1. Black and Minority Ethnic access to IAPT services in 2013/14 compared with their

rates in the population

This could be compared to the rate for members of Black Caribbean communities,

who, although often not differentiated from Black Africans in studies, access IAPT

services at a rate of 121.4% compared to their population.

One possible explanation for underuse of IAPT services among members of

Black African communities could be that they experience lower rates of mental

health problems. However, the Adult Psychiatric Morbidity Survey (McManus,

Meltzer, Brugha, Bebbington & Jenkins, 2009) suggests that rates of common mental

health problems are at least as high in this population as others, and therefore does

not support this hypothesis.
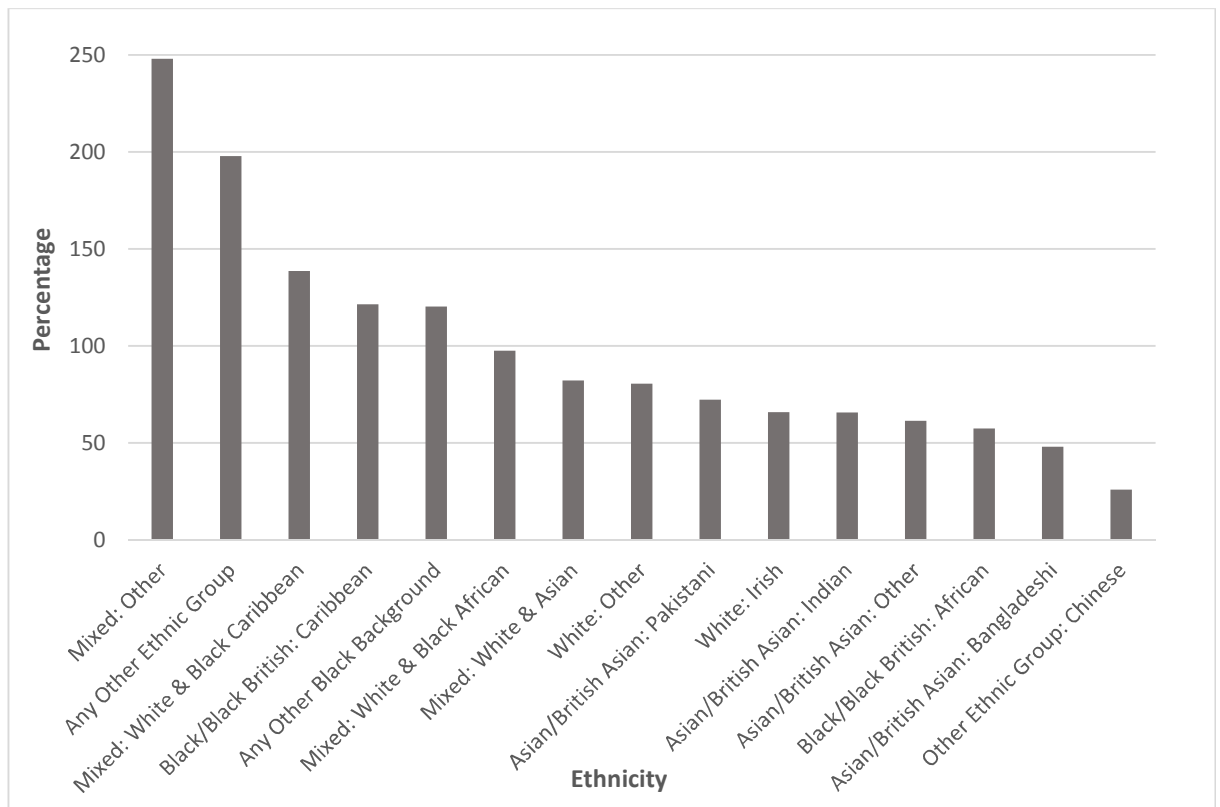
Notes. White British figure: 96.5%; Adapted from Health and Social Care Information Centre (2014); ONS (2011).

Figure 2. Level of access to IAPT services by BME groups as a percentage of their rate in the general population

Studies have also shown that members of Black African communities are more likely to be compulsorily admitted to psychiatric hospitals under the Mental Health Act (Bhui et al., 2003; Cole, Leavey, King, Johnson-Sabine, & Hoar, 1995; Commander, Cochrane, Sashidharan, Akilu, & Wildsmith, 1999). This again suggests that a lower rate of mental illness cannot be used to explain the reduction in access to psychological therapy, but instead suggests that Black Africans are accessing services at the point of crisis rather than in the early stages of mental health problems. Research into pathways to IAPT services including factors preventing and enabling their access is therefore vital for understanding these findings and increasing access to under-utilised sources of care.

Barriers to accessing mental health care

A barrier to mental health care is any obstacle or circumstance arising from the healthcare system, the prospective patient or the wider community which makes it less likely that care will be obtained. Barriers to accessing mental health services have been studied in a number of BME groups, although studies infrequently focus on Black Africans. In a qualitative interview study, Cinnirella and Loewenthal (1999) looked at the views of women from different religious and ethnic backgrounds including Pakistani Muslim, Orthodox Jewish, and African-Caribbean Christian. They found that frequently cited barriers to accessing mental health care included community stigma, fear of being misunderstood, and the belief that prayer can help. A study conducted in the US found that although African American women often used counselling as a coping strategy, they nonetheless perceived a number of barriers including stigma and lack of awareness of mental illness (Ward & Heidrich, 2009).

A number of studies have focussed specifically on barriers to accessing psychological therapy. Using focus groups with over 200 participants in total, Thompson, Bazile and Akbar (2004) found that barriers to psychotherapy for African Americans were stigma, lack of knowledge, lack of trust, and a perception of therapists as having a lack of cultural understanding. The potential role of religion as a barrier to psychological therapy was highlighted by Mayers, Leavey, Vallianatou and Barker (2007) who noted, for example, the worry that secular care may weaken one's faith. However, those participants who had completed psychological therapy felt the experience had in fact strengthened their faith.

Studies focussing specifically on members of Black African communities have found that the difference in world views held by these populations compared to

mental health service providers was a significant barrier to access. For example, Somali participants stated that they found it difficult to understand western conceptualisations of mental health problems (Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014), and a study in Ghana found that spiritual or religious models were used to understand emotional distress (Ae-Ngibise et al., 2010). This led to increased access of faith-based or spiritual sources of care (Ae-Ngibise et al., 2010). With regard to access to psychological therapy in particular, Ruane (2010) found that Black South Africans perceived psychologists as not understanding the African world view.

Lack of information and knowledge about mental health problems and services has been named a barrier to accessing mental health care for members of Black African communities (Drummond, Mizan, Brocx, & Wright, 2011; Loewenthal, Mohamed, Mukhopadhyay, Ganesh, & Thomas, 2012; Lupuwana, Simbayi, & Elkonin, 1999; Saechao et al., 2012; Shefer et al., 2013; Whittaker, Hardy, Lewis, & Buchan, 2005). This included lack of knowledge about what can be treated in therapy (Brown et al., 2011; Loewenthal et al., 2012; Piwowarczyk et al., 2014) and a belief that mental health problems are incurable (Shefer et al., 2013).

Stigma around mental health problems is a highly researched area and has been found to play a prominent role in preventing access to services (Knipscheer & Kleber, 2008; Nadeem et al., 2007; Piwowarczyk et al., 2014; Whittaker et al., 2005). It can impact negatively on help seeking as importance is placed on hiding one's distress rather than disclosing to others (Piwowarczyk et al., 2014; Whittaker et al., 2005).

Facilitators to accessing mental health care

Factors which make it easier for mental health services to be accessed or enable barriers to be overcome (facilitators) are less frequently studied. A systematic review by Gulliver, Griffiths and Christensen (2010) found only three studies out of 22 included facilitators to mental health help seeking in young people. The primary facilitators highlighted in studies are social or family support and previous positive experiences of services (Ayalon & Alvidrez, 2007; Gulliver, Griffiths & Christensen, 2010; Hines-Martin, Brown-Piper, Kim, & Malone, 2003). Furthermore, acknowledging the need for help has been found to be an important facilitator to accessing mental health care (Ayalon & Alvidrez, 2007).

Studies involving Black African participants suggest that integrating African world views into treatment and collaboration with traditional and faith healers may increase service use (Ae-Ngibise et al., 2010; Ruane, 2010). In addition, increased information and understanding for both staff and the general population may help to increase access (Petersen, Ssebunnya, Bhana, & Baillie, 2011). It should be noted that in the majority of these studies, participants were asked what they thought would make services more accessible; however their responses have not been empirically tested. Only a small number of studies in this area have focused on factors which have been personally experienced by participants as making services easier to access (Ayalon & Alvidrez, 2007; Hines-Martin et al., 2003).

Pathways to accessing mental health care

Pathways to mental health care have been defined as "the sequence of contacts with individuals and organisations prompted by the distressed person's efforts, and those of his or her significant others, to seek help as well as the help that

is supplied in response of these efforts" (Rogler & Cortes, 1993, p. 555). However, the majority of research into pathways to psychiatric care has involved using hospital service data to document referrals and formal routes into inpatient care (Morgan et al., 2005a; 2005b). The predominant finding from these studies is that Black Africans and Black Caribbeans (often studied together) are more likely to access services following compulsory detention under the Mental Health Act (Bhui et al., 2003; Cole et al., 1995; Commander et al., 1999; Morgan et al., 2005a; 2005b). Some studies also suggest that the police/judicial system are more likely to be involved in Black African and Caribbean pathways (Morgan et al., 2005b) although there is some dispute over this finding (Cole et al., 1995; Moodley & Perkins, 1991).

Previous studies in this area have rarely discussed other forms of help seeking outside contact with statutory services. In a cross-cultural study, Gater et al. (1991) found that traditional healers were often accessed for support, especially in areas where service provision was low, although this led to longer delays before formal treatment was accessed. The use of traditional healers in African countries such as Ghana has also been reported to be widespread (Ae-Ngibise et al., 2010).

An influential model of pathways to care was produced by Goldberg and Huxley (1980) involving the stages at which a person may present with distress and access services. Although this provides a useful framework for statutory services, it does not include informal help-seeking in the community. Moodley and Perkins (1991) provided a critique of Goldberg and Huxley's model, stating that it does not take into account those who enter services through the legal system or those who go directly to psychiatric services (e.g. through an emergency clinic). They presented an alternative framework which takes into account third sector organisations as well as

friends and relatives, although it did not include other sources of help in the community e.g. traditional healers.

Kleinman's health care systems model (1980) includes three sectors which encompass a much broader range of help than the frameworks discussed above. The 'popular' sector involves any help seeking which the person receives without payment and without consultation of traditional healers or formal health services. The 'folk' sector includes traditional practitioners and healers who are not recognised as part of statutory services, and the 'professional' sector includes all care provided as part of formally recognised health services (e.g. the NHS; see Helman, 1994 for further discussion). Morgan, Mallett, Hutchinson and Leff (2004) have built on this model to include factors operating at different levels which influence help seeking, for example beliefs about mental illness.

The majority of studies on pathways to mental health care have used quantitative methodologies, and have focussed on formal agencies involved prior to admission to inpatient care (e.g. GPs, police/judicial system). Morgan et al. (2004) suggest that this way of studying pathways to mental health care, whilst not without value, is one-dimensional, and pathways should be seen as social phenomena and therefore studied using narrative approaches.

Very few studies have looked at help seeking from what Kleinman (1980) terms the 'folk' and 'popular' sectors, for example friends and family, faith leaders, or traditional healers. These have therefore not been taken into account in the current understanding of pathways to care despite their potential importance in someone's attempt to address their distress. Another major gap in the literature concerns pathways to psychological therapy in particular. Finally, the study of pathways to care has rarely been integrated with that of barriers and facilitators to access despite

the opportunity this provides to study how the latter operate in context and interact to influence help seeking behaviour.

Aims of this research

This study aimed to explore experiences of Black African service users who had successfully accessed NHS IAPT services, in order to find out which barriers and facilitators were encountered in their pathways to accessing psychological therapy. Individual pathways were studied including help seeking from formal and informal sources of support using the participants' own narrative. There was a specific focus on factors experienced by participants as making services difficult to access (barriers) and factors which facilitated access (facilitators).

The research questions to be addressed in this study were therefore:

1) What pathways were taken by members of Black African communities who have accessed psychological therapies in IAPT services?

   a.) What sources of help did they seek out and access prior to psychological therapy?

   b.) What barriers did they encounter and what facilitators enabled them to access services?

Methods

Setting

Participants were recruited from two NHS IAPT services in London. The inclusion criterion was that participants had to be registered as Black African on the computer system. In the two services, local differences meant that ethnicity was

recorded prior to assessment or subsequent to the client's first contact. Therefore those contacted may have been on the waiting list, in therapy, discharged after completing therapy or disengaged from the service. In one of the sites, participants had given their consent to be contacted about research.

Participants

Clinicians sent letters to 108 Black African service users providing information about the study and asking them to contact the researcher if they were interested in taking part (See Appendix C). The researcher then provided further information about the study and arranged to meet with those who agreed to be interviewed. Participants were paid £15 for their time and asked if they would like to receive a summary sheet of the findings.

Twenty-five responses were received and 12 interviews were arranged on a first come, first served basis. The 13 individuals who were not interviewed were thanked for taking time to respond to the letter and were offered a summary sheet of the study findings. Of the 12 interviews which took place, one participant withdrew their data after the interview and one audio recording was not usable due to technical difficulties.

Of the ten participants who provided data, nine were sub-Saharan African and one was North African (see Table 1 for demographics). Participant 7 was included as he identified as 'African' and repeatedly noted similarities between Morocco and other African countries. All but two participants were first generation African (where this was not the case, the parents' country of origin has been included in the table). Their level of education varied from a basic level obtained in Africa to master's level

Table 1. Participant demographics

Participant	Country of origin (parents' country of origin)	Gender	Age category
1	Nigeria	M	50-59
2	Nigeria	F	50-59
3	Nigeria	M	50-59
4	UK (Ghana)	M	30-39
5	Angola	F	<20
6	Somalia	M	40-49
7	Morocco	M	40-49
8	Cameroon	F	50-59
9	UK (Somalia)	M	20-29
10	Zimbabwe	F	50-59

university education obtained in Africa or the UK and employment similarly ranged from being unemployed to working in senior managerial positions. Around half the sample cited Christianity as their religion; however a number of participants stated that they were not religious or no longer attended church. The majority of participants were seeking help for common mental health problems such as depression, anxiety and PTSD.

Ethical considerations

The study received ethical approval from the London Brent Research Ethics Committee (see Appendix D). Participants were given the information sheet to read and all aspects were discussed (see Appendix E). Written consent was sought and participants were told verbally and in writing that they could withdraw at any time up to two weeks following their interview and did not have to provide a reason (see Appendix F). Participants were also reassured that all data were anonymous and care would be taken to ensure that all quotes used in the paper were not identifiable.

Interview schedule

The semi-structured interview schedule was designed to allow participants to tell the story of their journey from noticing they were experiencing emotional distress to seeking help from an IAPT service (see appendix G). This method was chosen to allow differences between participants' stories and experiences to be highlighted, as it was anticipated that a more structured approach would ignore the individual nature of help seeking for mental health difficulties.

The initial questions were intended to find background information about the participant such as where they grew up and the role religion plays in their lives. This also aimed to allow the participant to feel more comfortable in the interview. In the main part of the interview, questions were asked regarding participants' pathways to psychological therapy. Interventions from the researcher aimed to focus on each participant's particular help-seeking pathway including the people and places they sought help from prior to their referral to the IAPT psychological therapy service. The researcher also aimed to ascertain the chronological order of help seeking and the reasons behind the participant's decision to seek help from certain places at certain times. On the whole, participants were enabled to tell their story with minimal interruption from the researcher, with the exception of clarifying questions. In particular, barriers and facilitators were discussed, including questions such as 'what stopped you from attending X sooner?' and 'what helped you to seek help from X at that time when you had not done so before?'.

Analysis

Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) was chosen to find themes in the data as it enables an in-depth understanding of how participants make sense of their experiences and personal world.

The following steps were taken to analyse the data. First, the interviews were tape recorded and transcribed. The transcriptions were read and reread, with the researcher annotating anything which seemed interesting or significant in the data in the right margin. This included making associations, preliminary interpretations and getting a sense of the person. Particular attention was paid to aspects of the data which related to the research question. Following this, the whole transcript was read again and emerging themes were noted in the left margin (see Appendix H). These emerging themes were sorted into categories and combined with themes from other transcripts, creating superordinate themes (domains). The process was iterative in that the themes were frequently checked against the original transcript to ensure they accurately represented the data.

This process was repeated with each transcript, with themes from previous transcripts used to orientate analysis of subsequent data. Repeated patterns in the data were noted, as well as new issues and themes which arose. When all transcripts were analysed, a final table of themes was produced and checked back against the original data.

Themes were dropped if they did not fit with the emerging structure and/or did not have much supporting evidence. The weight and importance of issues to participants was taken into account rather than frequency when deciding on themes. For that reason, some only appeared in one transcript but were retained as themes as they were particularly relevant in that participant's narrative.

Credibility checks

To ensure the credibility of results, one transcript was analysed independently by the principal researcher and one other researcher. Any disagreements were discussed and a consensus was reached. Emergent themes and domains were also reviewed and revised with the main research supervisor. Participants who gave their consent were contacted after the interview process to review the themes and check whether they fitted with their own experiences.

Researcher's perspective

As a white British female middle class researcher, I often had a very different background and cultural upbringing to the participants in the study. Being mindful of my position as someone from the outside studying experiences in a cultural group, I adopted an open stance in the interviews. I acknowledged the discrepancy in cultural background between myself and participants at the start of every interview and highlighted the possibility of misunderstandings. The participants were invited to explain their experiences further if they thought I had not understood, and were also told that I would ask further questions if I felt I needed more explanation.

Results

The barriers and facilitators to accessing IAPT services found in the thematic analysis are discussed below and thematic maps are provided to show how themes and domains interrelate. Pathways are then presented to demonstrate how barriers and facilitators operated in context and their effects on help seeking in the real life experiences of participants. Quotes are used throughout to support the conclusions

which have been drawn. English was a second language for the majority of participants; therefore, quotes have been edited for readability where appropriate.

Barriers to accessing IAPT services

A number of barriers to accessing IAPT services were evident in participants' accounts (see Figure 3 and Table 2). These fell into the following domains: S*tigma/shame*, *Lack of knowledge and information*, R*eluctance to disclose, Negative experiences of services,* and *Different world views.* Each will be discussed below including their constituent themes and the links between them.

Stigma/shame:

Stigma and shame around mental health problems and help seeking were frequently discussed by participants. For some, this directly resulted in delayed help seeking:

"…I thought about [accessing counselling] but I would never do it because I just felt what if someone in my lecture hall saw me, I'd be ashamed." (P9)

Participants also discussed stigma and shame within African communities more generally as a barrier to help seeking:

"…probably they feel shame…if you're like an African … if you told your friend you're going to psychology he's gonna look at you different like that guy he's mental, they look at you they start laughing…" (P7)

Stigma was notable in the transcripts with regard to its impact on two of the other domains: *Lack of knowledge and information*, and *Reluctance to disclose*. Firstly, it was stated that stigma prevents members of Black African communities from seeking information about mental health problems and services:
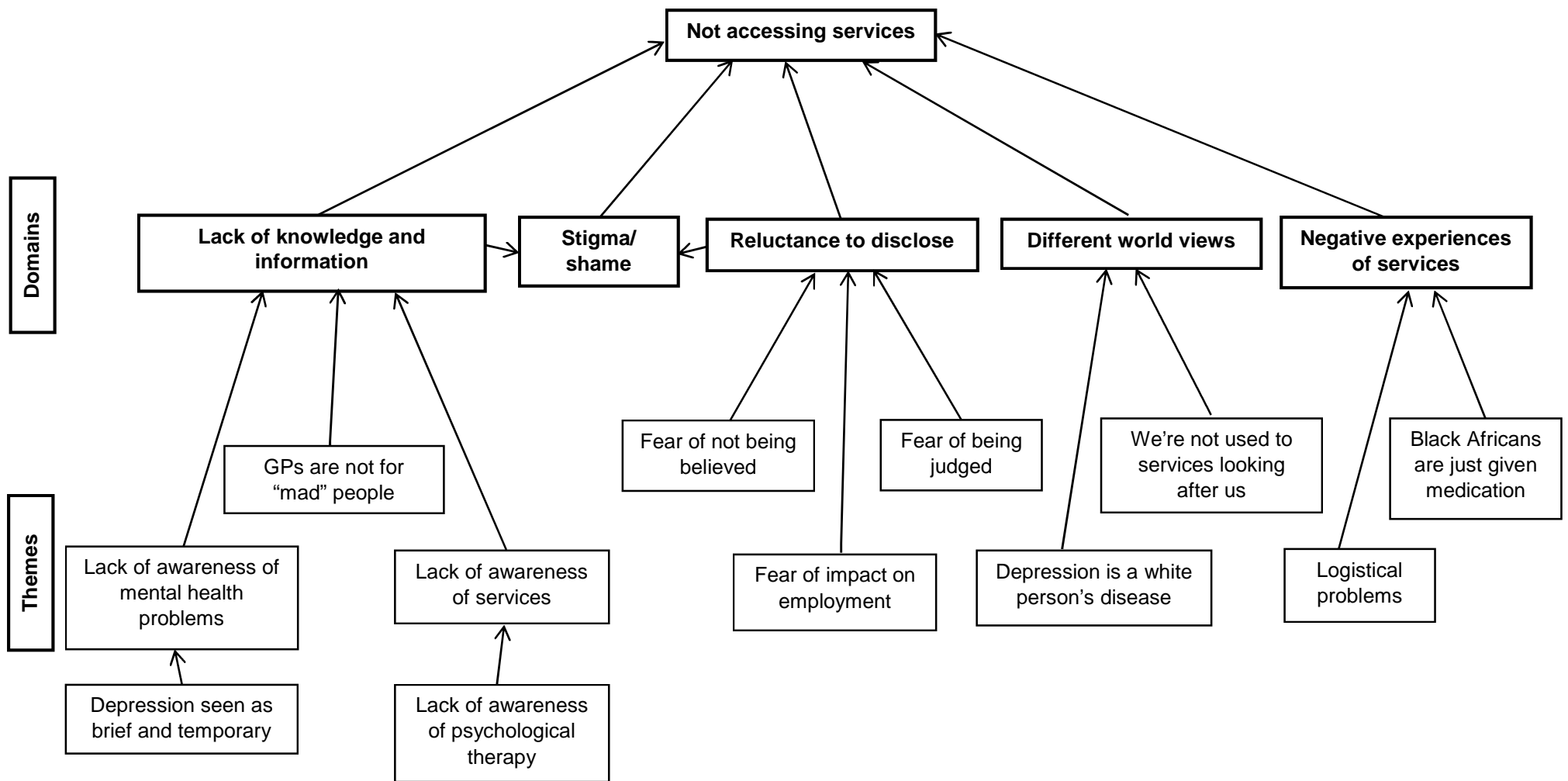
Figure 3. Thematic map of barriers to accessing NHS IAPT services

Table 2. References to barriers by participants (P)

Barrier	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Stigma/shame	X	X		X	X			X	X	X
Lack of knowledge and information	X	X	X	X	X	X			X	X
Lack of awareness of mental health problems	X		X	X	X	X			X	X
Depression seen as brief and temporary		X								
Lack of awareness of services	X	X	X		X					X
Lack of awareness of psychological therapy	X	X	X			X				
GPs are not for "mad" people	X	X	X			X				
Reluctance to disclose	X	X	X			X		X		
Fear of not being believed		X						X		
Fear of being judged						X				
Fear of impact on employment	X									
Different world views			X	X		X				
Depression is a white person's disease			X			X				
We're not used to services looking after us			X							
Negative experiences of services	X	X				X			X	X
Logistical problems	X	X				X			X	X
Black Africans are just given medication		X								

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"…even when the information's out, people don't read it, they just [say] 'oh oh it's that crazy mental health people,' they would just literally automatically just go 'no, not looking at that.'" (P9)

Therefore prevailing myths around mental health problems are not dispelled:

"…I think they're not really aware of depression, they just think that depression's when you want to just kill yourself…" (P6)

Stigma also prevented participants from disclosing their experiences to others, particularly due to a fear of being shunned by the community. There was a perception that a person with mental health problems brings shame to others as well as a general fear around "madness":

"…behind closed doors I am dying and bawling I'm just very unhappy… so that's a face I put on all the time you know, a clown, so that they can't they can't say I'm mad" (P2)

"…they won't allow you to come to their house because they think you might just… do something funny… in society and thereby you give them shame…" (P1)

"…they'll be afraid 'oh no we'd better not say this because she's mad' they're avoiding you" (P2)

Lack of knowledge and information

The majority of participants discussed a lack of knowledge and understanding about mental health problems, services, psychological therapy and the role of GPs.

Lack of awareness of mental health problems: Participants were frequently unable to understand or make sense of their distress. In some cases, participants felt

that they had a problem or that something was not right, although they could not give it a label:

> *"…I always knew that I had some sort of problem but like, I never sort of like done the research on [it] or anything…" (P6)*

> *"I didn't know what it was, I was just plain crazy, that's what I thought" (P9)*

In other cases, participants had not related their experiences to 'mental health':

> *"… I didn't really understand it…I dunno how to explain it but it was just an ongoing thing that I had to deal with…" (P4)*

> *"I didn't know they were panic attacks, I just didn't understand what was happening" (P10)*

> *Depression seen as brief and temporary:* One participant described in detail how Black African communities' understanding of depression differs from the definition used by mental health services in the UK:

> *"…we think depression is just being…sad, being unhappy, which will probably disappear in a couple of hours…" (P2)*

This had implications for the understanding of mental health problems, as any experience which was more severe or prolonged was seen as 'madness' and therefore stigmatised:

> *"…we never ever ever think depression is that deep…we just say once it goes beyond that then we call it madness…" (P2)*

> *"…it's not actually called depression…it's called madness 'oh she's gone mad'…" (P2)*

Lack of awareness of services: Many of the participants were not aware of IAPT services prior to being referred there. This was also highlighted more generally as a barrier for members of Black African communities:

> *"…I didn't know [services] exist, I don't even know what they do…" (P1)*

> *"…something like that a lot of Black people don't even know…" (P3)*

This meant that often, participants had not sought a referral to psychology services but were seeking help more generally.

Lack of awareness of psychological therapy: Following on from a lack of awareness of services, participants discussed not knowing about the role of psychologists or psychological therapy in particular. They highlighted a belief that psychologists only help 'mad' people:

> *"…really I always had in mind that consulting with [a] psychologist was for crazy people…" (P6)*

> *"…seeing somebody means that you're going doolally…" (P2)*

There was also a lack of awareness that psychologists are not limited to seeing those with mental health problems, but could provide support for a range of difficulties including those relating to physical health.

GPs are not for "mad" people: A consistent finding was that participants were not aware that GPs could be consulted about mental health problems, and where GPs featured in pathways they were often consulted for physical health problems, sleep difficulties, and pain:

> *"…I used to think you know GPs is not for what we call mad people…" (P2)*

> *"No I didn't tell him I think I have depression… I just told him that I have issues with sleeping…" (P6)*

Reluctance to disclose

As mentioned above, stigma was one reason why participants chose not to disclose their difficulties to others. Participants also spoke about other factors influencing their decision not to share their experiences, including feeling ashamed of what they were going through, others not being able to understand, and not feeling able to express themselves:

"It's not a thing I would broadcast because I'm not happy with it..." (P3)

"...I could never express myself well enough to explain to people how I felt..." (P6)

Fear of not being believed: Another factor preventing participants from disclosing what they were going through was a fear that they would not be believed. In one case, there was a general fear that Africans would not be believed by white people:

"...they are thinking that maybe if they tell like a white person you will not believe [them]..." (P8)

Another participant met with disbelief when she attempted to disclose to family members, which discouraged further discussion:

"...he would ring me back and say what do you mean you're depressed? You can't be depressed..." (P2)

Fear of being judged: One participant noted that fear of being judged specifically prevented her from disclosing to her GP:

"...I always had like this worry that he might judge me for having depression..." (P6)

Fear of impact on employment: A major barrier for one participant was the fear that disclosing his experiences of post-traumatic stress disorder to his GP would be passed on his employers:

> *"…my initial concern was if I have to tell my GP that will affect my employment because everything you tell your GP they have to write down…" (P1)*

Negative experiences of services

Logistical problems: Participants described a number of logistical barriers to accessing services which impacted on pathways through increasing the delay between help seeking and response, or prevented help seeking all together:

> *"I tried to consult [services] but they never got back to me so then I left it …" (P6)*

In some cases, participants noticed the impact of funding cuts on services:

> *"…I don't know whether it's because of the heavy demands on the service or because of the cuts [but] the delays in accessing support services actually doesn't help…" (P10)*

Black Africans are just given medication: A concern for one participant when considering whether to seek help for mental health problems was a perception that they would be given medication rather than a choice of treatment or support:

> *"…when it comes to black people all they want to do is dope them up, they don't…want to listen to why it's happening…" (P2)*

> *"…you just want to talk to someone…but they start prescribing…" (P2)*

Different world views

Depression is a white person's disease: Along with the perception that depression is brief and temporary (discussed above), there was also a belief that Africans do not experience depression:

"...they say that only white people have this type of disease..." (P6)

"...depression is not a word there in Africa we don't understand it there..." (P3)

We're not used to services looking after us: Participants stated that depending on services was not something that was comfortable, particularly for African men:

"...most African men don't like to depend upon [others] we're just here to do our job..." (P3)

"...the African community as well, you know, seem to think that they can deal with it themselves either through church or just through keeping it within the family..." (P4)

"...I feel less of a man if I'm receiving help..." (P3)

It was explained that this was partly because services do not exist in Africa:

"...they don't have [services] in Africa so we are not used to it...that's why they don't access it here because we are not used to that at all..." (P3)

Facilitators to accessing IAPT services

Participants discussed factors which enabled or encouraged them to seek help from IAPT services. These could be categorised into three domains: *Others encouraging help seeking*, *Value of information and awareness*, and *Recognising the need for help* (see Figure 4 and Table 3 below).
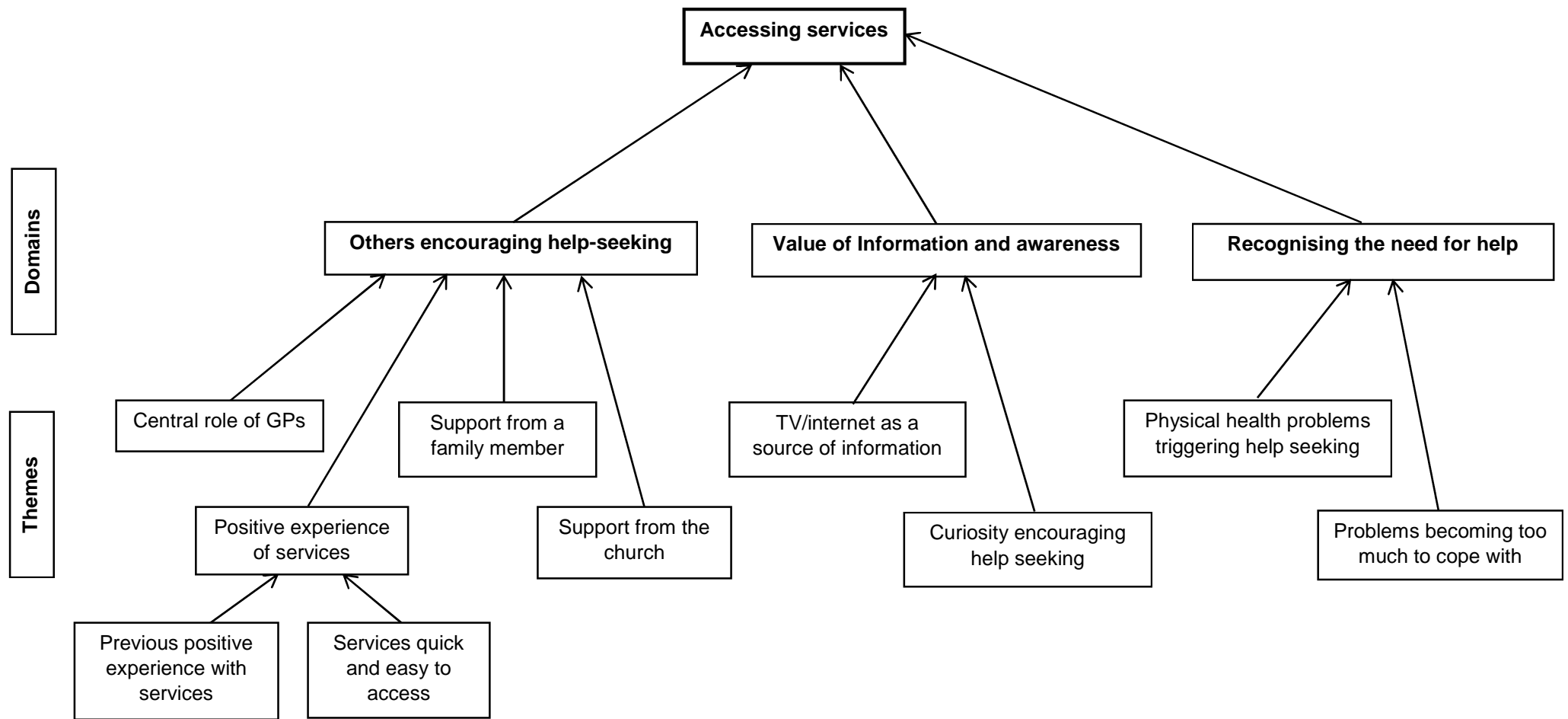
Figure 4. Thematic map of facilitators to accessing NHS IAPT services

Table 3. References to facilitators by participants (P)

Facilitator	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Others encouraging help seeking	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Support from a family member	X			X	X	X				
Support from the church	X									
Positive experience of services		X	X	X		X	X	X	X	X
Previous positive experience with services								X	X	X
Services quick and easy to access		X	X	X		X	X		X	
Central role of GPs	X	X	X		X	X	X	X	X	X
Value of information and awareness	**X**		**X**			**X**	**X**	**X**	**X**	
TV/Internet as source of information						X	X	X	X	
Curiosity encouraging help seeking	X		X			X			X	
Problems triggering help seeking	**X**	**X**	**X**		**X**	**X**	**X**	**X**	**X**	**X**
Other problems triggering help seeking	X		X		X	X			X	X
Problems becoming too much to cope with	X	X					X	X		X

Others encouraging help seeking

Central role of GPs: The most commonly cited facilitator was the central role of GPs in recognising mental health problems and making referrals to IAPT services. Participants frequently attended GP appointments without being aware that what they were experiencing was mental health related and with little knowledge of services. It was the GP who recognised a need for psychological support:

> "...I went to my doctor and...he said I have to go [to counselling] because I went to his office I was just crying..." (P8)

> "...I think I slammed the door or I don't know I don't even I can't even remember and he just said to me I have to see these people [psychology services]..." (P1)

In all but one pathway, GPs made the referral to IAPT services or provided participants with contact details. In the one exception, the participant had a GP in his family who was able to recognise his experiences and signpost him to the appropriate service.

A number of participants highlighted positive experiences of visiting their GPs, and how important this was for them:

> "...he just looked at me and he chatted to me, he use[d] you know...I suppose what he learnt being a doctor to talk to me... and I remember he used to always phone me as well, the doctor, to say 'how you doing', to see if I was okay"(P2)

Positive experience of services: A number of participants found *services quick and easy to access* if they had to telephone the service to make an appointment:

> "...I was surprised at how quick and easy it was to...get things moving..." (P4)

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"…yeah [an appointment] was easy to get, it was just a call to them…" (P6)

Others stated that services making contact with them following referral from the GP was helpful as they would not have made first contact.

Some participants discussed *positive previous experiences of services,* particularly counselling in GP surgeries or third sector services. This meant that they were aware that support was available and had previously experienced talking therapy as helpful:

"Yeah I know that I could see [a counsellor] because when I was [experiencing difficulties previously] I was seeing a counsellor…" (P8)

"[After seeing a student counsellor] I felt more knowledgeable, I could understand…I guess…just after that I stopped thinking I'm crazy and I realised it would probably go away…" (P9)

Support from a family member: Some participants disclosed their difficulties to particular members of their family who supported them in seeking help, either through encouragement or by accompanying them to attend their GP or psychology services:

"…first time I'm coming here [services] my brother bring me…" (P5)

"… [my aunty] told me to consult with psychologist…" (P6)

This occurred particularly when a member of the family had expertise in mental health or services or when that family member was a participant's main support in this country.

Support from the church: One participant found the church particularly helpful in encouraging him to seek help from his GP:

"…the pastor…said 'well just talk to your GP, I mean your GP will know the best thing to do'…" (P1)

Recognising the need for help

Problems becoming too much to cope with: Participants described reaching a point when they could no longer cope with their experiences and sought help as a last resort:

"…but I never ever ever thought of going to the GP until that day when I thought, you know, I almost killed myself and I said no something has to give…something has to happen…" (P2)

Participants described wanting to change or to get better because their difficulties were impacting negatively on their life:

"…I wanted to get better so I can go back to uni or at least get out of the house more…" (P9)

Others described experiencing stressors which continued to accumulate until they could no longer be managed and they felt they needed support.

"I said, hang on this is too much for me I need to see somebody…" (P7)

Some reached a point where they felt that they could not go on without speaking to someone about what they were going through. Two participants held positive beliefs about talking which encouraged them to seek help:

"I need to talk with somebody, I need to get things from my chest otherwise like a volcano a bomb in my chest you understand that bomb I need to get out…" (P7)

"…I felt if I don't tell somebody then then I will just do damage to myself…" (P8)

Other problems triggering help seeking: Problems including sleep or pain were often cited as triggers for making GP appointments. In some cases this was because participants chose not to disclose mental health problems, or because they

thought that they could only go to their GP for physical health problems. The main reason for help seeking was difficulties sleeping:

"…so initially I went to doctor [xxx] and said 'look doctor I couldn't sleep for the past three days now'…" (P1)

"…just because of my sleeping problems otherwise I think I still wouldn't get any help…" (P6)

Value of information and awareness

TV/Internet as source of information: Some participants cited television and film as providing information about the role of psychologists and GPs. This enabled one participant to seek help from her GP:

"…sometimes when I'm watching the TV they used to say you can tell your doctor…anything that is worrying you…" (P8)

Two of the younger participants discussed using the internet to learn about their experiences and the services that were available:

"I'm a person that always does research on the internet, like I always search the reason… why am I feeling like this…why it's happening to me…" (P6)

Curiosity encouraging help-seeking: A drive to understand what they were experiencing and to see what services had to offer was important in some participants' decisions to attend IAPT services. Generally this played a role after the participant had been referred by their GP:

"…I am curious but I don't know what they offer so I went …" (P1)

Pathways to accessing IAPT services

Participants were asked to describe the steps taken from first experiencing mental health problems or emotional distress to accessing IAPT services. Frequently, participants did not have a clear narrative of their pathways and sometimes found it difficult to remember when and in which order they had sought help. In some cases, mental health problems did not have a discrete onset and participants may have experienced multiple episodes of mental health problems with unique pathways to IAPT services in each episode. The pathways described by participants predominantly featured significant lengths of time between the onset of mental health problems and initial help seeking, ranging between months and years which made them more difficult to recall.

The main commonality in the pathways was that all participants had sought help from a GP. In eight of the ten pathways, the GP was the first person from whom help was sought, although participants often asked for help with sleep or physical problems rather than discussing mental health or requesting psychological therapy. Pathways also frequently contained multiple GP appointments, with the referral to IAPT rarely being made in the first contact.

Differences between pathways greatly exceeded similarities, with participants describing a variety of mental health problems, triggers for help seeking, and sources of support. In particular, the length of time between the onset of participants' difficulties and initial help seeking varied greatly. Sources of support included individual family members, third sector or student counselling services, the internet and the church.

There was no typical pathway and a number of different barriers and facilitators acted in each. To demonstrate the diversity of pathways discussed by

participants, four have been displayed and discussed below (see Figure 5-8). Some details have been changed to preserve confidentiality.

Figure 5 shows one participant's pathway to IAPT. She experienced adverse events in her childhood which she described carrying around like a "burden". A previous experience of counselling had been perceived as helpful and she held positive beliefs about talking. She had also learned from television what can be disclosed to GPs:

> *"…sometimes when I'm watching the TV they used to say you can tell your doctor… anything that is worrying you…"*

She therefore sought help from her GP when stressors became too much for her to deal with alone and she reached a point of crisis:

> *"everything was just inside me so…there were so many times I wanted to kill myself because I said there's no point me living, but when I look at my son and the grandchildren I just said [no], so I went to see my doctor"*

Nonetheless, it was high blood pressure that was initially picked up by the GP; however when this did not respond to medication, further treatment options were offered including antidepressants and counselling. Antidepressants were chosen initially; however due to her condition worsening, the GP again suggested counselling through the NHS IAPT service:

> *"I needed help…because I wasn't sleeping at night, I was having hot flushes, I would get up in the morning I'll be shaking so I just I said to him I said ok I said I will go [to see a counsellor]".*

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┌─────────────────────────────────┐
│      Adverse childhood events     │
└─────────────────────────────────┘
                ▼
┌─────────────────────────────────┐
│       Cumulative life stressors   │
└─────────────────────────────────┘
                ▼
┌──────────────────────────────────────────────┐
│ Facilitator: Reached point of crisis – wanted to end life │
└──────────────────────────────────────────────┘
                ▼
┌──────────────────────────────────────────────────────────────┐
│ Facilitator: Learnt from television that anything worrying can be discussed with a GP │
└──────────────────────────────────────────────────────────────┘
                ▼
┌─────────────────────────────────┐
│         Made GP appointment       │
└─────────────────────────────────┘
                ▼
┌──────────────────────────────────────────────────────┐
│ Problem perceived to be high blood pressure – medication prescribed │
└──────────────────────────────────────────────────────┘
                ▼
┌─────────────────────────────────┐
│       Further GP appointments     │
└─────────────────────────────────┘
                ▼
┌──────────────────────────────────────────────┐
│ Given choice of treatment – chose antidepressants │
└──────────────────────────────────────────────┘
                ▼
┌─────────────────────────────────┐
│     Facilitator: Condition worsened │
└─────────────────────────────────┘
                ▼
┌──────────────────────────────────────────────┐
│ Facilitator: GP told her to see an IAPT counsellor │
└──────────────────────────────────────────────┘
                ▼
┌──────────────────────────────────────────────┐
│    IAPT counsellor appointment attended         │
└──────────────────────────────────────────────┘
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Figure 5. Pathway 1

In Pathway 2 (see Figure 6), another participant discussed attempts to disclose to family members when she first noticed that she was experiencing difficulties. Internet research had enabled her to understand that her symptoms were similar to those of depression; however their response prevented further disclosure:

> *"when I first told my [family members] that I had depression…they told me*
> *'do you even know the meaning of depression?'… and they said that they*
> *have this code, like it's a bit racist but… they say that only white people have*
> *the have this type of disease…since then I never told my family anything"*

Nonetheless, a family member with experience in mental health recognised what she was going through and encouraged help seeking. Unfortunately certain barriers prevented her from seeking treatment, as internet research had shown that consulting with a psychologist incurred a cost and she was concerned that it would not help. She also perceived psychologists as only seeing "crazy people":

> *"[a family member] told me that I had issues with depression… [and] I*
> *should consult with [a] psychologist but… I always had in mind that*
> *consulting with psychologist was for crazy people… like people that are not*
> *good in the head"*

Again, further internet research enabled her to learn that psychologists could be consulted for problems such as anxiety and depression. Following difficulties sleeping, the participant attended a GP appointment but did not disclose more than this due to a fear of being judged:

> *"I always had like this worry that he might judge me for having depression…*
> *[so] I didn't tell him I think I have depression, I just told him that I have*
> *issues with sleeping".*

Felt like she had "some sort of problem" from teens

Disclosed to family members

Barrier: Family members did not believe her and said that depression was only experienced by white people

Facilitator: Depression recognised by family member, help seeking from psychologist was encouraged

Barrier: Believed that seeing a psychologist is for "crazy" people and feared that treatment would not work

Barrier: Internet research showed that there is a charge for consulting a psychologist

Facilitator: Internet research showed that psychologists see people for depression and anxiety

Experienced a panic attack but thought it was a physical health problem

Attended GP appointment

Facilitator: GP encouraged her to contact IAPT service

Barrier: Service did not return her call

Facilitator: Sleep problems

Attended GP appointment

Barrier: Did not disclose depression to GP due to fear of being judged

GP prescribed sleeping tablets

Continued sleep problems

Attended GP appointment

Facilitator: GP encouraged her to contact IAPT services

Telephoned IAPT and was given an appointment

Figure 6. Pathway 2

Further experiences of anxiety including a panic attack which she believed to be a physical problem encouraged further help seeking from the GP. When she learnt that the GP was not the one who would be giving her therapy for depression, this made her feel more able to discuss her experiences. The GP encouraged help seeking from the IAPT service; however further barriers prevented this:

> *"he just told me to consult a psychologist and I tried to consult one but they never got back to me so then I left it"*

It was not until further encouragement from the GP a few months later that she was able to access the service.

Figure 7 shows a pathway involving frequent GP contact from a few days following a traumatic event. However, various barriers and different forms of help seeking delayed access to the IAPT service. Initially, the participant was told that she could be referred, but that the waiting list was very long and therefore she decided to seek help elsewhere:

> *"…the doctor said 'oh we can refer you but there's a long waiting list' so… I was aware of one of the local black organisations offered counselling services for families so I gave them a call…"*

After attending counselling sessions which the participant reported finding unhelpful, she returned to her GP and was given medication to help with sleeping difficulties:

> *"Then we went for these counselling sessions…but I don't think it was adequate because…my sleeping problems still continued so [I] went back to the doctor again and this time I did get some sleeping tablets…"*

When she received a referral to the NHS psychology service, she began

sessions but then had to be placed back on the waiting list due to being

misdiagnosed:

> *"…when I came to the second [session] this is when I… realised that the*
> *diagnosis was wrong so then she said ok so that means we have to refer you*
> *to speak to the right person right so I'm still waiting…".*

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┌─────────────────────────────────────────────────────┐
│                  Traumatic event                      │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│  Facilitator: Concerned about impact of trauma on child│
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│                Made GP appointment                     │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│      Barrier: Told that IAPT had long waiting list     │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│       Contacted third sector counselling service      │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│ Counselling was experienced as unhelpful as trauma symptoms continued│
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│                Made GP appointment                     │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│               Sleeping tablets prescribed              │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│  Sleeping tablets experienced as unhelpful due to side effects│
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│                Made GP appointments                    │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│              GP referred to IAPT service               │
└─────────────────────────────────────────────────────┘
                          ↓
┌─────────────────────────────────────────────────────┐
│    Misdiagnosed and placed back on the waiting list    │
└─────────────────────────────────────────────────────┘
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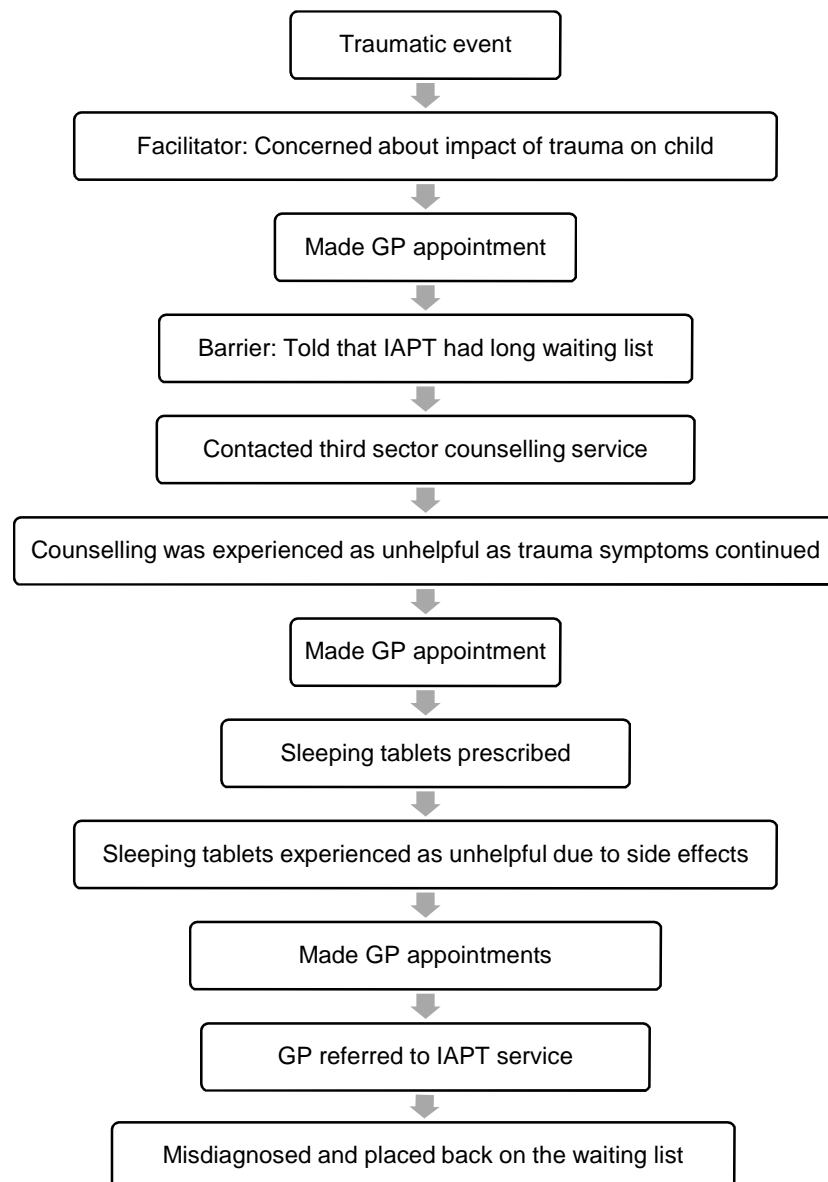
Figure 4. Pathway 3

In Pathway 4 (Figure 8), the participant spoke about a strong fear of discussing mental health problems with his GP as he did not want it to impact negatively on his employment:

"…my initial concern was if I have to tell my GP that will affect my employment because everything you tell your GP they have to write down…".

He also felt that he could not disclose to members of his community due to a fear of being ostracised. This was directly linked to the stigma around "madness":

"…you know in Africa if you talk to yourself they call you like a mad person so people will be 'oh that guy is mad you know he might do something to you so you better step stay away' so you try to hide it…"

However, as his mental health problems became more difficult to cope with, he found that he could disclose to a counsellor attached to the church:

"every Sunday people with a problem…distress or anxiety or whatever…can get some like 15 minutes or half an hour counselling, so I've been you know, because we are same community we are same church, we are same African, so I can confide in them"

Pathway 4 was the only one involving help seeking from a church. In this case, the barrier preventing the participant from accessing his GP was not present for this alternative source of support. The church counsellor and pastor then acted as a facilitator by encouraging him to attend his GP despite doubts about what would be put on his record:

"well [the] pastor said okay talk to your GP because you might need some antidepressant[s]…"
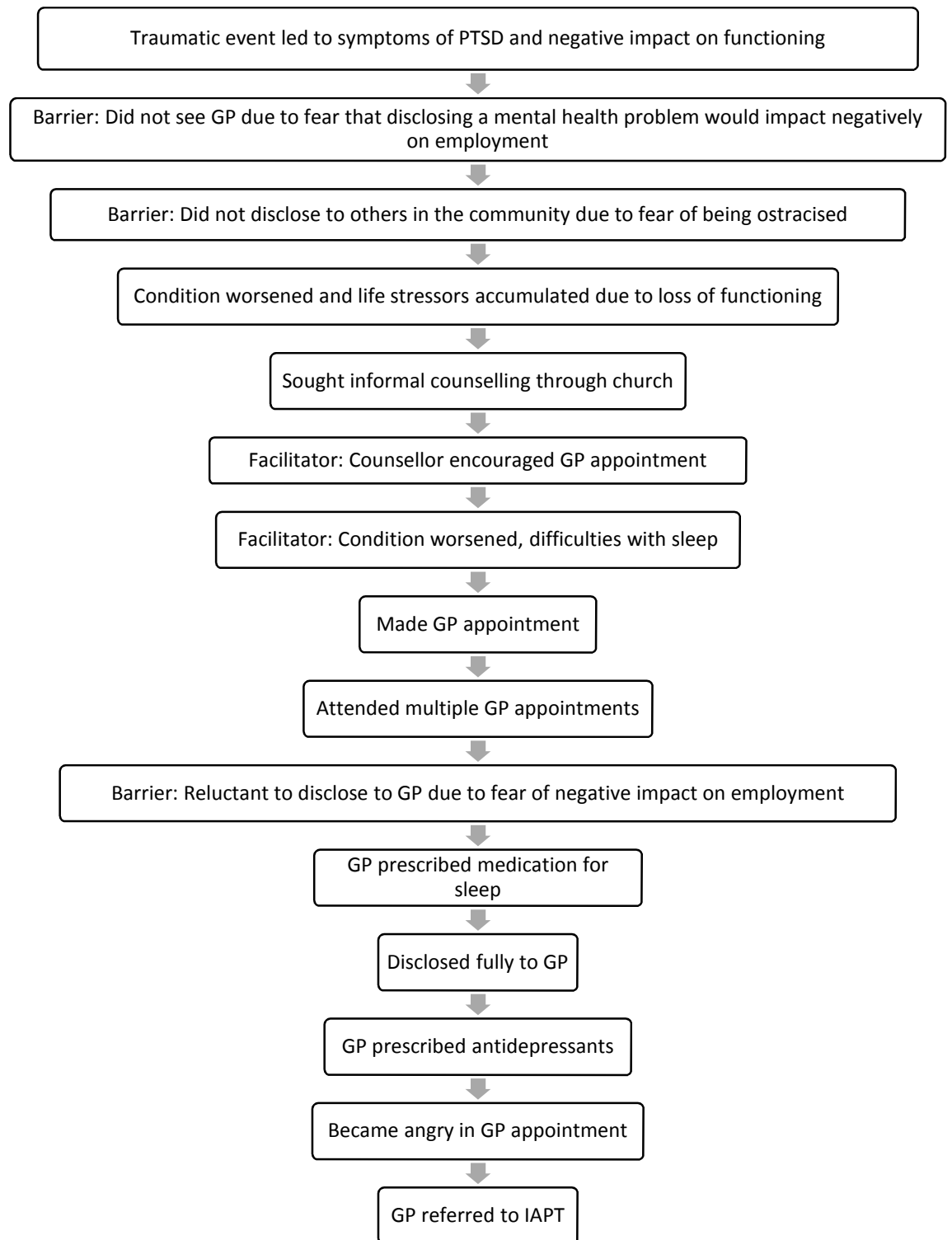
Figure 5. Pathway 4

This, along with his condition worsening and difficulties sleeping meant that help was sought from his GP. However, fear of what was put in his records continued to be a barrier:

> *"I started open up slowly...I didn't tell [the GP] everything...I couldn't do it because I was trying to hide, I don't want him to put something in my file..."*

Over a number of appointments, the participant did disclose all his experiences to the GP, and was prescribed antidepressants, until eventually, following becoming angry in an appointment, his GP told him he needed to see a psychologist and referred him to IAPT.

The pathways described here demonstrate how barriers and facilitators operate and interact to influence decisions about help seeking. As shown in these pathways, barriers and facilitators often coexist, operating simultaneously or even contradicting one another. For example, Pathways 2 and 4 show that despite the existence of barriers preventing disclosure to others, help seeking from the GP was triggered in both cases following the sharing of their difficulties with a member of the community and a family member, respectively.

In some cases, barriers were removed by facilitators, for example the lack of information about the role of a psychologist which was preventing consultation in Pathway 2 was corrected by the participant gaining information from the internet. In other cases, facilitators enabled help seeking despite the presence of barriers, for example in Pathway 4, a GP appointment was made following encouragement from others despite fear of what would be put in his medical records.

Discussion

Key findings

Barriers and facilitators to accessing IAPT services were apparent throughout the pathways described by participants. The barriers described fell into five domains: S*tigma/shame, Lack of knowledge and information, Reluctance to disclose, Different world views,* and *Negative experiences of services.* All of these are consistent with previous literature conducted with members of Black African communities both in the UK and in their countries of origin (e.g. Ruane, 2010; Whittaker et al., 2005).

An interplay between barriers was highlighted in the interviews, in particular between *Stigma/shame, Reluctance to disclose* and *Lack of knowledge and information*. Participants described stigma and shame related to their experience of mental health problems which led to a fear of being shunned by the community if these were disclosed. Participants also stated that stigma is likely to prevent members of the Black African community from seeking information about mental health problems, meaning that unhelpful beliefs remained without being challenged.

The narratives involved a number of facilitators to accessing services: *Others encouraging help seeking, Value of information and awareness,* and *Recognising the need for help.* In particular, GPs were crucial in recognising mental health problems and referring to IAPT services. Often, the triggers for seeking help from the GP were physical health or sleep problems. During such consultations, participants often chose not to disclose mental health problems, or were not aware that their experiences were something that could be raised in a GP appointment. Very few participants specifically requested psychological therapy. Nonetheless, in the present

study the respective GPs recognised when psychological therapy may be helpful and made referrals to IAPT services.

The role of significant others and the recognition of the need for support have been identified as facilitators to help seeking in previous studies (Ayalon & Alvidrez, 2007; Hines-Martin et al., 2003). In the present study, recognition of the need for help pertained to both mental and physical health problems. Increased information and advertising about mental health problems and services, for example therapists featuring in television programmes and films, and self-diagnosis tools on the internet enabled participants to gain an understanding of their experiences and the types of support that might be available.

Pathways to accessing IAPT services were described in detail by participants. One key similarity between participants' experiences was contact with a GP, which occurred in all pathways. In most cases, the GP was the last contact prior to accessing IAPT services and generally the referrer. This is understandable given that the vast majority of IAPT referrals come from GPs. It is also consistent with studies suggesting general practice is not underutilised by many BME groups including Black Africans (McMunn, Mwanje, Paine, & Pozniak, 1998; Morris, Sutton, & Gravelle, 2005).

An unexpected finding was that only one of the ten participants sought help from a religious source, as well as the lack of reported contact with traditional healers. The use of traditional and faith healers is widespread in many African countries (Ae-Ngibise et al., 2010) although there is little evidence of how widespread their use is in the UK. Of note, in a study conducted in the Netherlands, Knipscheer and Kleber (2010) suggested that Ghanaian migrants may experience more shame and mistrust around accessing traditional healers than formal mental

health care. This raises the possibility that participants chose not to disclose contact with traditional healers in the interviews, or that they are simply not accessed at the same rate in non-African countries.

Of the pathway models presented in the literature, the present findings fit more closely with Kleinman's health care systems model (1980), than with Goldberg and Huxley's (1980) or Moodley and Perkins' (1991) models, both of which fail to recognise help seeking outside of formal or informal services. Kleinman's model takes into account help seeking in popular, folk and professional sectors, which were reflected to a greater or lesser extent in the current study. A number of pathways described help seeking in the popular sector, including attempts to discuss difficulties with family members or to conduct research on the internet. Help seeking from the folk sector (non-statutory services) was less frequently accessed, although some participants attended third sector counselling services. Services in the professional sector (NHS services), especially GPs, were highly accessed and often triggered referrals and access to other support within this sector. Generally, participants moved from seeking help in the popular and folk sectors to the professional sectors although this was not universal. It is possible that this was an artefact of the data as all participants were recruited through the professional sector and help seeking subsequent to accessing IAPT services was not discussed.

Studied in this way, the pathways were also able to show how barriers and facilitators to accessing IAPT services interact to influence decisions about help seeking. In certain cases, facilitators acted by removing a barrier which enabled help seeking (for example, gaining information removed the barrier of having incorrect information). In other cases facilitators enabled help seeking despite the continued presence of barriers.

Methodological issues

When conducting research aiming to study a population which underutilises mental health services, careful thought must be given as to how and from where participants are recruited. One option is to recruit participants from the relevant services, whilst another is to attempt to reach participants who have experienced mental health problems but have not accessed services. In this study, the former option was chosen, as it was considered that this would facilitate recruitment, whilst finding participants who had not accessed services would raise a number of difficulties. For example, it was thought that stigma around mental health problems would prevent potential participants from wanting to find out more information about the study or be associated with it. The chosen recruitment strategy also enabled a greater focus on facilitators than would have been possible with populations who had not accessed services.

Nonetheless, it should be acknowledged that this choice of recruitment strategy presents a number of challenges. Firstly, participants in this study are likely to be atypical as they succeeded in accessing services which are underutilised by the Black African population as a whole. This means that facilitators may have been in place for them which are absent for those who do not access services. Secondly, recruiting participants from the professional sector (Kleinman, 1980) has also potentially limited contact with those in whose pathways the popular and folk sectors feature more prominently.

IPA was used to analyse the data generated in this study as it has a specific emphasis on the inner experiences, thoughts and feelings of participants. Given the individual nature of pathways into psychology services and the central role of thoughts and feelings in the data (e.g. fear of being judged as a barrier to accessing

services), analysis based in a phenomenological epistemological framework was well suited to this research. IPA also focusses on generating rich data from small samples, as it is stated that this richness gets lost when samples become too large (Smith, et al, 2009), and was therefore useful given the sample size obtained here.

Other approaches such as narrative analysis may offer valuable insights into pathways to psychology services, given their emphasis on studying the stories told by participants about their experiences and the chronology of events. However narrative approaches arise from a different epistemological position, closer to social constructionism, and therefore it was decided that in the present study, these two different forms of analysis would not be combined.

Another challenge was posed by the decision to include all who self-defined as Black African, regardless of generation or the culture they identified with. This was taken in line with data showing that those who define themselves as Black African on the NHS '16+1' system underutilise IAPT services. However, some participants discussed their own reservations with the '16+1' ethnicity categories, particularly that they do not adequately capture the feeling of belonging to more than one culture.

Pathways from younger participants involved factors such as internet research which were not mentioned in other pathways. Participants who were second generation immigrants drew distinctions between themselves and older generations who were described as being more "old school". This raises the likely possibility that 'Black African' encompasses multiple groups and sub-groups encountering different barriers and facilitators to accessing mental health services.

Strengths and limitations

In this study, rich data was collected related to the unique experiences of members of Black African communities who had accessed IAPT services. This enabled facilitators to be studied from the perspective of those who had experienced them first hand, rather than information being gained through suggestions and speculation about what might be helpful.

Studying narrative accounts of pathways to mental health services allowed the full range of participants' sources of support to be captured, which is not possible when studying service referral data. It also allowed barriers and facilitators to be examined in context, showing the interactions between them. For example, in some cases facilitators can be seen as on a continuum with barriers (e.g. lack of information and knowledge/value of information and knowledge), whereas in other cases facilitators can be seen to exist alongside barriers, enabling the latter to be overcome (e.g. reluctance to disclose/recognition of need for help).

The limitations of this study include the assumption that participants had discrete pathways into services with a defined starting point, and would be able to recall and articulate these. A number of participants could not recall a point at which they first experienced emotional distress, and for some, the onset was a number of years ago or there had been multiple episodes of mental health difficulties and help seeking. This meant that it was often difficult to recall the exact sequence of help seeking including why decisions were made and why help was sought at a particular time.

As mentioned above, this is likely to have been a population whose experiences were not necessarily typical of members of Black African communities who generally underutilise IAPT services. It is possible that different barriers operate

for those who have not accessed services, or that the facilitators identified here are not available. For example, given the crucial role of GPs in recognising mental health problems and encouraging accesses to psychology services, it may be that for those who do not access services, GPs have not recognised mental health problems or have referred to alternative sources of support.

Given the small sample size, it should also be noted that the demographics of participants are unlikely to be representative of the general IAPT population, for example 60% of the sample were male and 50% were in the 50-59 age bracket.

During the interviews, a number of participants brought up the theme of racial differences and discrimination. For example, some expressed a belief that depression is only experienced by white people. Others felt that if they disclosed their problems to white people they would not be believed. Although potential differences in culture between myself as a white British researcher and participants were highlighted at the start of each interview, it was clearly difficult for some participants to discuss racial differences when they were negative towards white people. This may well have prevented participants from raising further relevant issues.

Implications

A major implication of the findings of this study is the important role that GPs can play in increasing the utilisation of IAPT services by underserved populations. Given that barriers to disclosure often continue to operate in GP appointments, increased information about the role of GPs in mental health care may be useful. Unfortunately, time constraints currently placed on GPs are well publicised and may exacerbate a reluctance to disclose issues which patients find

difficult to understand and see as outside the GP's role. Time constraints may also preclude the sufficient exploration of patients' difficulties and treatment options. Nonetheless, non-judgemental conversations initiated by the GP about anxiety or low mood may also enable mental health related experiences to be discussed more easily.

One of the concerns raised in the pathways was the fear that information told to a GP could affect employment. Despite legislation to prevent discrimination, its impact on finding and keeping employment for those with mental health problems has been well documented in the literature (e.g. Thornicroft et al., 2009). Given the value placed on working to provide for one's family in Black African communities, it is likely that this barrier is more widespread than indicated here, and further efforts should be made to ensure that legislation is adhered to.

Currently, IAPT services are run on a borough-by-borough basis by NHS or private providers. This means that there is no standardised publicity, and the quality and even existence of websites varies by service. Given the popularity of the internet and its widespread use, particularly by younger generations, it is crucial that IAPT services have easily accessible websites providing information about common mental health problems and how to self-refer in a form designed to encourage underserved groups to seek help.

Anti-stigma campaigns such as Time to Change are receiving publicity from mainstream avenues such as television, social media, and internet music streaming services. However, despite campaigns focussed specifically on reducing stigma in BME communities, it remains one of the major barriers to accessing mental health care. It is also important that information is delivered in a way which can be accepted by members of Black African communities, as this may enable the reduction of one of the major barriers to accessing services.

Future research

Rather than following the assumption that 'Black African' encompasses a discrete group, research into the characteristics of those who do and do not access IAPT services would be helpful. For example there may be systematic differences in generation, age, gender or religiosity which may impact on whether services are utilised.

Whilst the barriers found here are well documented, for example stigma, facilitators are an under researched area which may prove vital to achieving equity of access to mental health services. As seen here, facilitators can enable services to be accessed *despite* the presence of barriers, making this line of research enquiry potentially far more valuable. Future studies focussing on the impact of facilitators such as increased provision of information on referral rates or proxies such as the intention to seek help may provide useful information for services.

Conclusion

Studying individual narrative accounts of pathways into psychological therapy has provided insight into the diversity of experiences which result in access to IAPT services. Barriers found here mirror those found in previous literature, and facilitators have been shown in a context which can enable them to be utilised to increase access to services.

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Part 3: Critical Appraisal

Introduction

This research project generated a number of reflections which are detailed in this critical appraisal. Issues concerning the background of the study such as those around culture and ethnicity are discussed, and explanations are provided for particular methodological choices including the choice of recruitment strategy. A number of assumptions which were highlighted by the research are outlined, and reflections on the process of conducting the research, particularly the interviews themselves, are provided.

My background in IAPT services

I have previously worked in the IAPT services from which participants were recruited. This meant that I was aware of the inequity of access and the importance of finding ways to address this. Having contacts in the services allowed the research to be set up with few difficulties and staff in the services were supportive. This meant that the process of recruitment once R&D approval had been granted was, on the whole, straight forward.

I was also able to take into consideration how staff perceived research, which unfortunately was often as a hindrance to the existing pressures they managed, and ensure that the research process was as unintrusive as possible.

Assumptions about ethnicity

Ethnicity can be defined as 'the fact or state of belonging to a social group that has a common national or cultural tradition' (Oxford Dictionaries Online, n.d.). Both the systematic literature review and the empirical paper are based on the assumption that the term 'Black African' encompasses one discrete ethnic

group whose members have something in common which means that the barriers and facilitators they experience will be similar to those faced by others of this ethnicity.

The justification for focusing on this broad ethnic group in the empirical study was based on data provided by IAPT services in which service users are categorised by ethnicity. In the services concerned, ethnicity is selected by the service user when completing the initial paperwork. Although it is described as 'self-defined', service users must choose one of a set number of options which make up the '16+1' ethnic categories used in the UK census since 2001 (Office for National Statistics, 2001). This allows one discrete choice, for example in the 'Black or Black British' category, either 'Caribbean', 'African' or 'Any other Black Ethnic Background' can be selected.

One difficulty with this categorisation is that there is no way to distinguish between first and second generation Black Africans (e.g. those born in sub-Saharan Africa, now living in the UK, and those born and living in the UK with parents from sub-Saharan Africa). Two participants in the empirical study were born in the UK of African parentage, and both stated that they identified with both their African background and as being British. One participant questioned my assumption that I was from a different cultural background, stated at the start of each interview. He argued that we were likely to have a number of shared experiences and similar world views as we had both grown up in the UK. This system of ethnicity categorisation therefore does not appear to capture the way that people see themselves and the groups they identify with.

It was also clear from the interviews that participants, all of whom were recorded as Black African, could have very different backgrounds and world views. However it should be noted that the participant from Morocco, who identified as

being 'African', emphasised similarities between Morocco and Sub-Saharan African countries, feeling that people from both backgrounds faced similar barriers.

Despite these limitations, the decision to focus on this population was taken for a number of reasons. Firstly, the issue was discussed with a service user consultant from Ghana in the early stages of planning, who, on the basis of his experience as a peer mentor for members of Black communities experiencing mental health problems, stated that 'Black African' is a term which encompasses a group of people who identify with each other and face many of the same difficulties. Choosing this population also increased the ease of recruitment as it did not limit the potential pool of participants more than necessary (unlike, for example, focusing solely on individuals of Nigerian or Ghanaian heritage). I also made the decision not to limit recruitment by immigration history in order to preserve the richness of data, and because services do not routinely record this information meaning that many potential participants would have been screened out.

In the literature review, a focus on Black Africans was again chosen based on studies showing underuse of services in a number of countries. Yet the '16+1' ethnic categorisation system is not universal and other countries such as the US define ethnicities differently. This meant that a number of studies were excluded from the literature review where the term 'African American' was used to describe participants, without distinction between those of African or Caribbean backgrounds. This is a strong reminder of the socially constructed nature of ethnicity.

Recruitment challenges

A major challenge for this research was finding a recruitment strategy which enabled an 'underserved' population to be reached. One option considered in the

early stages of planning this project was studying attitudes towards mental health problems and barriers to accessing services among members of Black African communities without the stipulation that they had accessed services themselves. However, given that the basic premise of the research was that Black Africans do not seek help, I judged it unlikely people would be willing to discuss mental health problems with me. In essence, my concerns were that many of the same barriers which prevent people from accessing services would also prevent them from agreeing to take part in this research. Furthermore, as in previous studies, barriers would likely have been the main focus of interviews.

I therefore chose to recruit participants who had already accessed services. This posed a potential problem in that the barriers they faced in accessing services had either been overcome or were not present. Nonetheless, it provided the opportunity to learn about factors that facilitated access to mental health services. This emphasis on facilitators as well as barriers enabled the study to provide a different perspective from much of the previous literature and, potentially, more useful implications for services.

The limitation of this recruitment strategy was that participants' experiences may not be indicative of the wider Black African population. However, the resulting need to exercise precaution in generalising results seems acceptable, particularly as this is not the aim of qualitative research in general.

Personal reflections on the interviews

In the interviews, participants shared very difficult personal experiences which many of them had not disclosed other than in psychological therapy. Given the nature of the study and interview questions, this should not have been unexpected;

however at times I felt unprepared for the resulting emotions I experienced. A number of participants' stories were highly emotive and involved difficult topics such as childhood abuse, racially-motivated physical attacks, and experiences of being in a war zone.

During one interview, I experienced strong feelings of powerlessness and, looking back on the transcript, I can see times when I stepped out of the role of researcher and into the role of therapist, encouraging the participant to seek help. The recognition that as a researcher, my role was not to provide support but to treat experiences as data to be analysed was, at times, difficult to uphold.

As a clinical psychologist, I hold the general belief that therapy can generate positive change and ameliorate distress. However, conducting these interviews led me to the realisation that this hope is just as much a help for me as it is for the client, as it may enable me to deal with the difficult, distressing and traumatic issues clients bring. As a researcher, when this expectation of positive change is removed, I found the emotions that were evoked overwhelming, especially the immediate feeling of powerlessness.

Despite the differences between a therapy session and a research interview, many of the same processes occur. For example, transference has been said to be part of any social relationship (Andersen, & Berk, 1998). However, as a researcher there are fewer opportunities to discuss the emotional impact of interviews as the supervision provided is different to that available to a clinician. This is understandable given that, in most research settings, contact with participants occurs on one occasion and the content of the interaction is likely to be governed by the nature of the research. Nonetheless a lesson which I will take into future research of

this nature is that many of the self-care and support strategies I currently use as a therapist are also highly relevant when I am in the role of a researcher.

One assumption implicit in research into barriers to accessing care is that people experiencing mental health problems would access care if those barriers were not present. Despite coming across clients during training who resisted change, appeared ambivalent about or declined the help they had been referred for, I had not considered that this can extend to cultural groups rather than just individuals. One participant stated that Africans don't like to depend on help from others as value is placed on independence and working to provide for one's family. It was a personal affront to him that help was being offered. This is in contrast with British culture in which the welfare state is based on the assumption that people want help from others if they cannot help themselves.

In a slightly different form, this issue was raised in the literature review. A number of studies found that participants preferred to seek help from traditional and faith healers and talk to friends and family rather than statutory mental health services. However, after some consideration, I decided that labelling these sources of help as barriers was making a value judgement, as it assumes services are what 'should' be sought when someone experiences mental health problems. In reality, services do not always provide the best care or the most therapeutic experience, and the emphasis should be on providing information and making services as acceptable as possible to allow people informed choice whether they want to access services or not. If all other 'barriers' are removed there is nothing to say that personal choice cannot be a legitimate reason why someone may not access services.

Discrimination

A theme repeated throughout the interviews was racial discrimination, although this was not experienced as a barrier to accessing services and therefore was not discussed in the results section. Racial discrimination is something that I rarely experience as someone from a white British background, and, although I am aware that it is widespread, I have rarely heard first-hand accounts. Participants in this study discussed not just racially motivated physical attacks, but frequent examples of how 'the system', by which they were referring to public services such as the job centre, the criminal justice system and local government, treated them differently to someone from a middle class, white British background. A concept relevant here is 'White privilege', which has been described by McIntosh (1992) as the phenomenon whereby white people see others as disadvantaged but do not see themselves as advantaged. It is the situation whereby access is given to privileges such as status, jobs, housing, money and freedom, but this is unnoticed by those who benefit. Never had my white privilege been more starkly revealed as during these interviews.

Examples of the perceived racial discrimination which highlighted my white privilege include the experience of not being offered a job, being convicted of a speeding offence, being wrongly raided by the police, and not being given adequate support following a racially motivated physical attack. These experiences can have broad psychological effects such as making people feel powerless, worthless, and like outsiders who are not welcome. Given this context, it is unsurprising that people experiencing mental health problems do not feel like the support they need can be provided by services which they view as part of 'the system'. In the current political climate, those who claim that all the country's problems are caused by immigrants

and those on benefits should take a close look at how our country is causing significant problems for these groups.

Interview location

One important lesson I learnt early on in the data collection process was the importance of meeting participants in a place in which they felt comfortable. Initially, I had planned to hold interviews at services from which the participants were recruited. However this was not possible in one of the two services due to pressure on rooms. I then invited participants to interviews at UCL, but quickly learnt from participants that this was not convenient and a location nearer to where they lived would be more acceptable.

Another important consideration, which I had not realised prior to arranging the interviews, was that service users are often referred to IAPT services because of difficulties using public transport, for example following a trauma. Having worked in an IAPT service and knowing that a significant number of referrals concern difficulties such as post traumatic stress disorder (PTSD) or panic attacks where public transport is avoided, this is something which potentially could have been foreseen.

Nevertheless, I was able to find a community location (an integrated church and community centre) with which I had retained links since working in the IAPT service in that borough. I found that they were not only supportive of my research, but willing to provide a room to interview participants free of charge, in exchange for a sharing of expertise to inform their work in the community around mental health. This community location was not in a prominent position on a high street and none

of the participants were aware of it, but all were willing to be interviewed at the community centre as it was close to places with which they were familiar.

Another reason why this location may have been more acceptable for participants was that it was situated on a quiet street where it was unlikely that they would be seen. It was also not a place which was associated with mental health. It therefore offered privacy to participants, some of whom stated that they had not disclosed to others that they were attending the interview. This is an important lesson for future research aiming to recruit underserved populations, especially when the topic under study is one which is frequently stigmatised.

Pathways

An assumption I made in studying pathways from the perspective of the participant rather than service data is that participants have a clear narrative in their mind about when and where help was sought prior to accessing services. During the interviews, it became clear that this was not the case, and frequently participants could not remember what had triggered a particular decision to seek help or where they had learnt about services. This is understandable given that the start of the pathway was conceptualised as the point at which the participant or someone else recognised that they were experiencing distress and might need help. Therefore, by their very nature, pathways into services occur at a time when participants are experiencing distress, and thinking back to this time can be difficult for a number of reasons.

For example, decisions about help seeking occur during a time when experiences can be confusing and difficult to make sense of. Common mental health problems such as anxiety and depression can be characterised by strong emotions
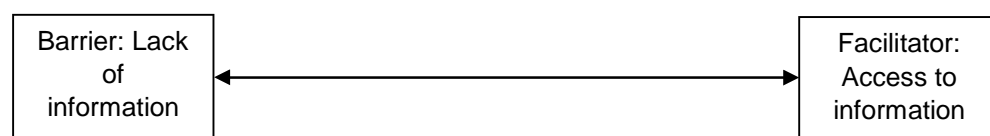
such as shame which make that time difficult to revisit. Certain problems, for example PTSD, are also accompanied by difficulties encoding memories with a time and place (Brewin, Joseph, Dalgleish, 1996), and research has shown that experiences of some mental health problems can lead to post-traumatic stress symptoms (Shaw, McFarlane & Bookless, 1997), suggesting that the memories themselves may have been affected.

Some participants described experiencing mental health problems for many years which meant that pathways could not be discussed in their entirety due to time constraints and that there were difficulties remembering events which happened many years ago. Other participants discussed feeling as if they had always had difficulties, which meant that they did not perceive their pathways as having a discrete onset. These challenges suggest that it is unrealistic to expect participants to have a clear narrative in their mind of their pathways to help, and those described in the empirical paper should be seen as approximations of participants' experiences.

Barriers and facilitators

Crucial differences between barriers and facilitators must be highlighted and elaborated here. Barriers and facilitators can be defined as factors which make it more difficult or easy to access services, respectively. In their definition, there is a symmetry which suggests that barriers and facilitators could be opposites e.g. if lack of information is a barrier, having information would be a facilitator (see Figure 1).

However, the thematic maps produced following analysis of the interview data show that only some facilitators could be seen as the inverse of particular barriers. In other cases, facilitators could be seen as coexisting with barriers, enabling access to services despite their presence (see Figure 2).

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┌──────────────┐                                    ┌──────────────┐
│ Barrier: Lack│                                    │ Facilitator: │
│      of      │◄──────────────────────────────────►│  Access to   │
│  information │                                    │  information │
└──────────────┘                                    └──────────────┘
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Figure 61. Facilitators as the inverse of barriers

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                        │ Barrier: reluctance to │
                        │      disclose      │
                        └────────────────────┘

        ◄───────────────────────────────────────────────

                        ┌────────────────────┐
                        │ Facilitator: Problem │
                        │  too much to cope  │
                        │        with        │
                        └────────────────────┘

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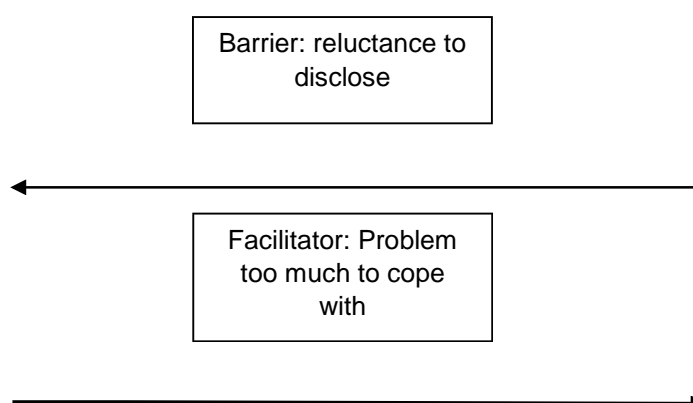
Figure 2. Facilitators as coexisting with barriers

Another difference between barriers and facilitators emerged during analysis. The nature of barriers is that they can be thought of as currently acting on a large scale to prevent particular communities from accessing services. The evidence for this is the discrepancy between the size of the population of Black Africans and the numbers attending IAPT services. Therefore, to study barriers, participants can be asked about their own unique journey to services, as well as factors which they see as preventing access to services for their communities in general.

Conversely, facilitators are not currently in place on a large scale across Black African communities. This means that although the facilitators personally experienced by participants can be taken into account, factors which participants highlighted as having potential use for increasing access to services in the future can

be seen as suggestions to be tested, rather than statements of that which is currently happening.

Summary

Both the systematic review of the literature and the empirical research raised a number of difficulties and assumptions which have been discussed here. When conducting any research, it is necessary to make choices about the way that research will be carried out and be mindful of the assumptions underpinning it. All decisions come with benefits and constraints and this is something which must be acknowledged rather than ignored. As a clinician who engages in research, it is important to reflect on how these different roles can influence, complement and impede one another, and impact on the participants who agree to take part. In research, the focus is often on what the findings can add to scientific knowledge and how this can impact on the populations concerned. However, what is less frequently highlighted is the profound impact of research on those who carry it out.

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Appendices

Appendix A: Search strategies

PsychINFO search strategy

1. exp african cultural groups/
2. "black*".ab,ti.
3. "africa*".ab,ti.
4. 1 or 2 or 3
5. exp Treatment Barriers/
6. exp help seeking behavior/
7. exp health care utilization/
8. exp Mental Health Services/
9. exp Mental Health/
10. exp mental health programs/
11. exp Mental Disorders/
12. exp psychotherapy/
13. exp Cognitive Techniques/
14. exp Relaxation Therapy/
15. exp psychiatry/
16. exp Counseling/
17. 5 or 6 or 7
18. 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16
19. 4 and 17 and 18
20. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("mental health treatment" or "mental health care" or "mental health service*")).ab,ti.
21. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("psychiatr* treatment" or "psychiatr* care" or "psychiatr* service*" or "psychiatr* help")).ab,ti.

22. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("psycholog* treatment" or "psycholog* therapy" or "psycholog* care" or "psycholog* service*" or "psycholog* help")).ab,ti.

23. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("talking therapy" or "talking cure")).ab,ti.

24. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("counsel*ing" or psychotherap*)).ab,ti.

25. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 (CBT or "cognitive behavio*r* therapy")).ab,ti.

26. 20 or 21 or 22 or 23 or 24 or 25

27. 4 and 26

28. 19 or 27

29. limit 28 to (english language and "300 adulthood " and ("0110 peer-reviewed journal"))

Medline Search Strategy

1. exp african continental ancestry group/

2. "black*".ab,ti.

3. "africa*".ab,ti.

4. 1 or 2 or 3

5. exp Health Services Accessibility/

6. exp patient acceptance of healthcare/

7. exp Healthcare disparities/

8. exp psychotherapy/

9. exp mental health services/

10. exp mental disorders/

11. exp mental health/

12. exp Relaxation Therapy/

13. exp psychiatry/

14. exp Counseling/

15. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("mental health treatment" or "mental health care" or "mental health service*")).ab,ti.

16. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("psychiatr* treatment" or "psychiatr* care" or "psychiatr* service*" or "psychiatr* help")).ab,ti.

17. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("psycholog* treatment" or "psycholog* therapy" or "psycholog* care" or "psycholog* service*" or "psycholog* help")).ab,ti.

18. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("talking therapy" or "talking cure")).ab,ti.

19. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 ("counsel*ing" or psychotherap*)).ab,ti.

20. ((barrier* or facilitator* or obstacle* or enabler* or access* or participation*) adj6 (CBT or "cognitive behavio*r* therapy")).ab,ti.

21. 15 or 16 or 17 or 18 or 19 or 20

22. 4 and 21

23. 5 or 6 or 7

24. 8 or 9 or 10 or 11 or 12 or 13 or 14

25. 4 and 23 and 24

26. 22 or 25

27. limit 26 to ("all adult (19 plus years)" and english and journal article)

Scopus Search Strategy

1.   (TITLE-ABS-KEY (**black*** OR **africa***)
AND
2.   TITLE-ABS
KEY (**barrier*** OR **obstacle*** OR **facilitator*** OR **enabler*** OR **access**
OR **participation**)
AND

3.	TITLE-ABS-KEY (**"mental health services"** OR **"mental health care"** OR **"mental health treatment"** OR **"psychotherapy"** OR **"psycholog* therapy"** OR **"psycholog* treatment"** OR **"psycholog* help"** OR **"psycholog* service*"** OR **"psycholog* care"** OR **"talking therapy"** OR **"talking cure"** OR **"psychiatr* treatment"** OR **"psychiatr* care"** OR **"psychiatr* service*"** OR **"psychiatr* help"** OR **cbt** OR **"cognitive behavio*r* therapy"**))
AND
4.

DOCTYPE (**ar**) AND SUBJAREA (**mult** OR **agri** OR **bioc** OR **immu** OR **neur** OR **phar** OR **mult** OR **medi** OR **nurs** OR **vete** OR **dent** OR **heal** OR **mult** OR **arts** OR **busi** OR **deci** OR **econ** OR **psyc** OR **soci**)

Appendix B: Quality rating tools

CASP-QRC

	Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist	Yes	Somewhat	No
1	**Was there a clear statement of the aims of the research?**			
1.1	What was the goal of the research?			
1.2	Why it was thought important?			
1.3	Is it relevant?			
2	**Is a qualitative methodology appropriate?**			
2.1	If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants			
2.2	Is qualitative research the right methodology for addressing the research goal?			
3	**Was the research design appropriate to address the aims of the research?**			
3.1	If the researcher has justified the research design			
4	**Was the recruitment strategy appropriate to the aims of the research?**			
4.1	If the researcher has explained how the participants were selected			
4.2	If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study			
4.3	If there are any discussions around recruitment (e.g. why some people chose not to take part)			
5	**Was the data collected in a way that addressed the research issue?**			
5.1	If the setting for data collection was justified			
5.2	If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)			
5.3	If the researcher has justified the methods chosen			
5.4	If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?			
5.5	If methods were modified during the study. If so, has the researcher explained how and why?			
5.6	If the form of data is clear (e.g. tape recordings, video material, notes etc)			
5.7	If the researcher has discussed saturation of data			
6	**Has the relationship between researcher and participants been adequately considered?**			
6.1	If the researcher critically examined their own role, potential bias and influence during (a) Formulation of the research questions (b) Data collection, including sample recruitment and choice of location			
6.2	How the researcher responded to events during the study and whether they considered the implications of any changes in the research design			
7	**Have ethical issues been taken into consideration?**			
7.1	If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained			
7.2	If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)			
7.3	If approval has been sought from the ethics committee			
8	**Was the data analysis sufficiently rigorous?**			

8.1	If there is an in-depth description of the analysis process			
8.2	If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?			
8.3	Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process			
8.4	If sufficient data are presented to support the findings			
8.5	To what extent contradictory data are taken into account			
8.6	Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation			
9	**Is there a clear statement of findings?**			
9.1	If the findings are explicit			
9.2	If there is adequate discussion of the evidence both for and against the researchers arguments			
9.3	If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)			
9.4	If the findings are discussed in relation to the original research question			
9.5	Limitations are acknowledged			
10	**How valuable is the research?**			
10.1	If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?			
10.2	If they identify new areas where research is necessary			
10.3	If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used			

Qualsyst

	QualSyst Quality checklist for Quantitative Studies	Yes	Somewhat	No	N/A
1	**Question or objective sufficiently described**				
2	**Study design evident and appropriate**				
3	**Method of subject/comparison group selection or source of information/input variables described and appropriate?**				
4	**Subject (and comparison group, if applicable) characteristics sufficiently described?**				
5	**If interventional and random allocation was possible, was it described?**				
6	**If interventional and blinding of investigators was possible, was it reported?**				
7	**If interventional and blinding of subjects was possible, was it reported?**				
8	**Outcome and exposure measures well defined and robust to measurement bias? Means of assessment reported?**				
9	**Was a sample size calculation reported?**				
10	**Analytic methods described/justified and appropriate? (e.g., testing of parametric assumptions)**				
11	**Some estimate of variance is reported for the main results?**				
12	**Controlled for confounding?**				
13	**Results reported in sufficient detail?**				
14	**Conclusion supported by results?**				

Note. Items 5, 6 and 7 apply to randomised controlled trials only and were not used in this review.

Appendix C: Sample recruitment letter

South London and Maudsley **NHS**
NHS Foundation Trust

Southwark Psychological Therapies Service
Maudsley Hospital
Denmark Hill
London
SE5 8AZ

Invitation to take part in important research

Dear

I would like to invite you to take part in some important research happening at Southwark Psychological Therapies Service. **This is being carried out by Liz Anthony, a trainee clinical psychologist at University College London (UCL).**

The research is about the experiences of members of the Black African community who have had psychological therapy. It focusses on the journey into psychological therapy services from the time when emotional distress was first experienced, including places in the community where people go to get help, and what makes it more difficult or easier to access services.

The study involves one interview lasting about 1 hour, where you will be asked to talk about your own experiences of getting or seeking help (please see attached sheet for more information). You will be paid £10 for your time and your travel expenses will be covered up to a value of £5.

All information from the interviews will be stored securely and all personally identifiable information removed. ALL INFORMATION YOU PROVIDE WILL BE ANOYMOUS.

This research will be written up as part of a Doctorate in Clinical Psychology at UCL, and is being supervised by Dr Katrina Scior and Prof Adrian Furnham.

The following sheet provides further information about the project and details about how to get involved.

Please consider this invitation carefully.

Yours Sincerely,

Consultant Clinical Psychologist & Head of Service
Southwark Psychological Therapies Service

Pathways to Psychological Therapy for Black Africans (Student Study)
Recruitment letter- SLAM
V 3 – 11/06/2014

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Background Information Sheet:

What is the study about?

NHS psychological therapy services are based on the principle of improving access for people of any age, gender and ethnicity. However data suggest that certain ethnic groups, such as members of the Black African community, are not accessing psychological therapy as much as expected, given the size of their population in this country.

This study can be helpful as the findings may be able to improve access for members of the Black African community to talking therapies, by helping us to know more about what is stopping people at the moment. This may mean that it will be easier for people to get help when they are going through difficult experiences.

Do I have to take part?

It is up to you whether you want to join the study. If you decide to take part, you can leave at any time, without giving a reason. This would not affect any care you are receiving.

What are the risks of taking part?

For most people, the time in their life when they were stressed or experiencing difficulties was very distressing, and talking about it can bring back the same feelings. You don't have to answer any questions you're not comfortable with and you can withdraw at any time.

What are the benefits of taking part?

There may be no direct benefits for you of taking part, although some people do find it useful to talk about their experiences. The indirect benefits of the study include helping services to have a better understanding of how members of the Black African community get help for emotional distress, and things which make it more difficult or easier for this to happen. This may help more people to access psychological therapy who are experiencing problems.

- -

If you would like to find out more about this study or are interested in taking part, please return this slip in the freepost envelope provided. Alternatively, you can email Liz Anthony to register your interest at **elizabeth.anthony.12@ucl.ac.uk**

Name:

Phone:

Can messages be left on this phone?   Y/N

Email:

Appendix D: Letter of ethical approval

NHS
Health Research Authority

NRES Committee London - Brent

80 London Road
Skipton House
London
SE1 6LH

Telephone: 020 7972 2554

02 June 2014

Dr Katrina Scior
Academic director/senior lecturer
University College London
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
WC1E 6BT

Dear Dr Scior

Study title:	Pathways, Barriers and Facilitators to Accessing Psychological Therapy in Black African Communities in the UK
REC reference:	14/LO/0763
IRAS project ID:	148648

The Research Ethics Committee reviewed the above application at the meeting held on 19 May 2014. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager ███████ nrescommittee.london-brent@nhs.net .

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. .

Conditions of the favourable opinion

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

1. Please forward the standard crisis leaflet.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>
Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

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

Sponsors are not required to notify the Committee of approvals from host organisations.

<u>Registration of Clinical Trials</u>
All clinical trials (defined as the first four categories on question 2 of the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

<u>If a sponsor wishes to contest the need</u> for registration they should contact ████████
████████████████████████, the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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

Ethical review of research sites

NHS Sites
The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Ethical issues raised by the Committee in private discussion, together with responses given by the Liz Anthony when invited into the meeting.

Recruitment arrangements and access to health information, and fair participant selection

The Chair confirmed the two different sites Southwark Psychological Therapies Service & Homerton University and if the researchers had consent at both sites. *Miss Anthony said they would send information letters to current and previous patients with a freepost envelope and wait for a response if interested. Both localities would be sent information by somebody else from the care team.*

Miss Anthony explained that 4sight was the service user group and participants would be identified through Improving Access to Psychological Therapies (IAPT) services at Southwark Psychological Therapies.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

The Chair asked if participants had accessed the session previously might they be unstable also how the participants' depression would be defined. *Miss Anthony said that they would not necessarily be more unwell if they had previously used the service, and that the service was for people with depression and anxiety; anyone in tier 2 treatment, or those with psychosis etc. would automatically be excluded from the study.*

Informed consent process and the adequacy and completeness of participant information

The Committee were content with the information and consent forms provided and complimented the researcher on the flow chart

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering letter on headed paper	Letter from Elizabeth Anthony	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		
Interview schedules or topic guides for participants	V1	17 December 2013
Letters of invitation to participant	2 (SLAM)	02 April 2014
Letters of invitation to participant	2 (HUH)	02 April 2014
Other [Project Flow Chart]	V1	24 March 2014
Other [Academic Supervisor 2]	V1- Adrian Furnham	24 March 2014
Other [Student CV]	V1- Elizabeth Anthony	24 March 2014
Participant consent form [HUH]	2	02 April 2014
Participant consent form [SLAM]	2	02 April 2014
Participant information sheet (PIS) [HUH]	2	02 April 2014
Participant information sheet (PIS) [SLAM]	2	02 April 2014
REC Application Form	148648/598685/1/347	23 April 2014
Referee's report or other scientific critique report	Reviewer- ▮▮▮▮▮	20 January 2014
Research protocol or project proposal	3	02 April 2014
Summary CV for Chief Investigator (CI)	V1- Katrina Scior	24 March 2014

Membership of the Committee
The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

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

After ethical review
Reporting requirements

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

- *Notifying substantial amendments*
- *Adding new sites and investigators*
- *Notification of serious breaches of the protocol*
- *Progress and safety reports*
- *Notifying the end of the study*

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback
You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

14/LO/0763	Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

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

Yours sincerely
PP

Chair
E-mail: nrescommittee.london-brent@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

                     "After ethical review – guidance for researchers"

Copy to: Homerton University Hosp. NHS Foundation Trust

Appendix E: Participant information sheet

≜UCL   South London and Maudsley **NHS**
                                                  NHS Foundation Trust

Pathways to Psychological Therapy for members of the Black African Community (Student Study)

Participant Information Sheet

I would like to invite you to take part in this research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. This should take about 15 minutes. You can talk to others about the study if you wish. Please ask me if there is anything that is not clear.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Part 1:

What is the study about?

NHS psychological therapy services are based on the principle of improving access for people of any age, gender and ethnicity. However data suggest that certain ethnic groups such as members of the Black African community are not accessing psychological therapy as much as expected, given the size of their population in this country.

This research aims to study the experiences of members of the Black African community who have been to psychological therapy services to find out how they get there, including who they talk to, other places they go for help, what makes it more easy or more difficult to access services. This study can be helpful as the findings may be able to improve access for members of the Black African community to talking therapies, by helping us to know more about what is stopping people at the moment. This may mean that it will be easier for people to get help when they are going through difficult experiences.

The study involves an interview lasting about 1 hour, where participants will be asked to talk about their own experiences of seeking help for emotional distress.

Why is the study happening?

The purpose of the study is to find out what happens when people of Black African ethnicity start to experience emotional distress, including how it is understood, where people go to for help, how they find out about what services and what is involved in their decision to go for psychological therapy.

This study is being completed as part of a doctorate in clinical psychology and is funded by University College London.

Pathways to Psychological Therapy for Black Africans (Student Study)
Participant Information Sheet - SLAM
V 2 – 02/04/2014
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Why have I been contacted?

Letters were sent to people who have had at least one session of psychological therapy at **Southwark Psychological Therapies Service (SPTS),** whose ethnicity is recorded as Black African, and who have agreed to be contacted about research. Around 10-12 other people will be interviewed as well.

Do I have to take part?

It is up to you whether you decide to join the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of any care you are receiving.

What will happen if I do take part?

You will take part in an interview which will ask you in-depth questions about your journey from when you started to experience emotional distress until your contact with **SPTS.** You will be asked about who you talked to about your problems in your family or community, where you went for help, and how you came to get therapy at **SPTS.** I will try to let you talk and not interrupt you, however there may be things which I will need to know more detail about so I can really understand your experiences.

The interview will last for around 1 hour, and will be tape recorded. It will be arranged at a time which is convenient for you and will be in a private room so no one else can hear what you say. After that, you do not have to do anything else.

Will I be paid?

You will be paid £10 for being in the study, and up to £5 to cover your travel expenses **(please remember to bring a valid receipt, as unfortunately travel expenses can't be paid without one).**

What are the risks of taking part?

For most people, the time in their life when they were stressed or experiencing difficulties can be very distressing, and talking about this can bring back the same feelings. This means that you might find it difficult to discuss, especially if you haven't talked about it before. However, I will try to keep any distress you may feel to a minimum. You don't have to answer any questions you're not comfortable with and you can withdraw at any time without giving me a reason. **If you lose capacity during the study, all information you have provided will be destroyed.**

In order to make sure you're safe, I may need to break confidentiality, for example if you talk about wanting to hurt yourself. I will discuss this with you if possible, and in most cases information will only be passed on to the GP.

Pathways to Psychological Therapy for Black Africans (Student Study)
Participant Information Sheet - SLAM
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What are the benefits of taking part?

There may be no direct benefits for you of taking part, although some people do find it useful to talk about their experiences. The indirect benefits of the study include helping services to have a better understanding of how members of the Black African community get help for emotional distress, and things which make it more difficult or easier for this to happen. This may help more people to access psychological therapy who are experiencing problems.

Will it be confidential?

Yes, all the information you give will be confidential and anonymised. No one should be able to tell who you are from the final report.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2:

What will happen if I want to leave the study?

You can leave at any time during the interview, and you can ask for your interview not to be used any time in the next two weeks. If you don't want your interview to be used, the recording and any other information you provided will be destroyed.

What if there is a problem?

You can ask as many questions as you need before deciding whether to take part and can leave at any time if you do not wish to carry on. However, if you are unhappy with this research or wish to make a complaint, there is a complaints leaflet provided which tells you who to contact. Insurance and indemnity arrangements are also in place.

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. Please ask me if you would like more information on this. In the unlikely event that you are harmed by taking part in this study, compensation may be available.

If you suspect that the harm is the result of the Sponsor's (University College London) or the hospital's negligence then you may be able to claim compensation. After discussing with me, please make the claim in writing to Dr Katrina Scior who is the Chief Investigator for the study and is based at the Research Department of Clinical, Health and Educational Psychology, University College London. The Chief Investigator will then pass the claim to the Sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

Pathways to Psychological Therapy for Black Africans (Student Study)
Participant Information Sheet - SLAM
V 2 – 02/04/2014

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How will my information be kept confidential?

The interview will be tape recorded and stored on a password-protected university computer which only I can access. **A back-up copy will be stored on a secure memory stick which only I can access.** The information you gave in the screening phone call, and any sheets you sign today will be kept in a locked filing cabinet, only accessible to the member of staff supervising this project at UCL. Once the study has been completed, all the information you provide including the interview and contact details will be destroyed.

Some original quotes from the interviews will be included in the write up of the study. Care will be taken to ensure these are completely anonymous so you cannot be recognised.

Will my GP be involved?

Under most circumstances, I will not inform your GP that you are involved or give any details about the information you provide. The only time when your GP may be contacted is if you tell me you want to hurt yourself or someone else, or are in danger from someone else. In this situation I may have to talk with other professionals such as your GP or the police to make sure you are safe. Where possible, this will be discussed with you first. There is also crisis **leaflet** available.

What will happen to the results of the study?

All participants are invited check the findings from the interviews to see whether they fit with their own experiences. This will involve talking to me in a few months' time about whether the findings make sense with the information you gave in the interview.

If you would like to know the results of the study, there will be a summary sheet available for all those who take part. This will be sent to you when the study has been written up. If you would like to receive a summary sheet, or be involved in checking the findings, you can let me know **by ticking the box** on the consent form.

The study will be written up as part of a Doctorate in Clinical Psychology thesis. This will be 'restricted access' and not available to the general public. The results may also be published in a scientific journal. This means it can be accessed by anyone, although it will mainly be read by people who work and research in the area of psychology and mental health.

Who has reviewed the study?

This study was reviewed by the research department of clinical, educational and health psychology at University College London. All aspects of the study have been looked at by independent group of people, called a Research Ethics Committee, to protect your interests. It has been reviewed and given favourable opinion by London Brent Research Ethics Committee.

Pathways to Psychological Therapy for Black Africans (Student Study)
Participant Information Sheet - SLAM
V 2 – 02/04/2014

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Contact details:

If you would like to go away and think about whether you would like to take part, or if you have decided to take part and may like to talk about the study following your interview, here are my contact details:

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Appendix F: Consent form

UCL   South London and Maudsley **NHS**
                                    NHS Foundation Trust

Participant Consent Form

Participant Identification Number: ....   Please
                                                                                  initial

1. I confirm that I have read and understood the information sheet dated...................
(Version............) for the above study. I have had the opportunity to think about the   ☐
information, and my questions have been answered

2. I understand that my participation is voluntary and that I am free to withdraw at any
time without giving any reason, without my medical care or legal rights being affected.   ☐
**If I lose capacity during the study, I understand that the information I have provided
will be destroyed.**

3. I understand that I can request the withdrawal of the information I provide up to   ☐
two weeks following this interview (date.....................................)

4. I understand that this interview will be tape recorded and will be stored securely on
a password protected university computer, **and on a secure memory stick,** accessible   ☐
only to the student researcher

5. **I understand that my GP or other professionals may be notified if there is a   ☐
concern about my safety and wellbeing, or the safety and wellbeing of others**

6. **I understand that relevant sections of my medical notes and data collected during
the study may be looked at by individuals from University College London, from   ☐
regulatory authorities or from the NHS Trust, where it is relevant to my taking part in
this research. I give permission for these individuals to have access to my records.**

7. I agree to take part in this study   ☐

Name of participant: Date: Signature:

....

Name of researcher: Date: Signature:

....

I would like to receive a summary sheet of the findings of this study   ☐

I would like to be involved in checking the findings of this study   ☐

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Appendix G: Interview schedule

Pathways to Psychological Therapy Interview

Thank you for coming today and agreeing to take part in this interview.

The first part of this interview is about how you came to have psychological therapy, as well as the obstacles which made it harder for you to get help and how you overcame these.

1. About you

Would it be ok if I ask you some questions so I can find out a bit more about you?

Prompts:
How old are you?
Which country were you born in?
Have you lived in this country all your life?
When did you/ your family move to the UK?
Why did you/your family move to the UK?
What's your marital status?
What is your highest educational qualification?
Do you have children?
What do you do for a living?
Are you religious?

2. Recognising the need for help

"Can you tell me about the time when you or someone else first noticed that you might be distressed or be experiencing some difficulties?"

Prompts:

How long ago was it?

What were the first signs you noticed?

How did you understand what you were experiencing?

What did you think had caused what you were experiencing?

Did anybody else notice?

How did your family/people close to you react?

N.B. If the distress was recognised by someone other than the participant, wording of the questions will be changed accordingly (e.g. "what were the first signs they noticed?")

3. Coping mechanisms

"What did you do first to try to cope with what you were experiencing?

Prompts:

What did you find helpful at the time?

What did you find wasn't so helpful?

How did others around you respond? Family, colleagues, friends

4. First steps to seeking help

"Did you look for or receive any help from others?"

"Who did you go to?"

Prompts:

Who did you talk to?

Was it easy for you to go and talk to them?

What did you say to them?

What did they say to you?

Was that helpful?

Did you do any research into the help available?

What did you find?

Did you try to get help from anywhere but were unsuccessful?

5. Informal sources of help

"Did you get help from anywhere in your community before you had psychological therapy?"

Prompts:
Who did you go to?
What did you say to them?
Were you passed on anywhere?

6. Decision to seek help from services

"Can you tell me about how you or someone else made the decision to seek help from services?"

"What was the first thing you did after you had decided you might need more formal help or support?"

Prompts:
What prompted this? (Or: How did this come about?)
Did this follow a particular event?
Did anyone help you to make this decision?
Did you agree with them?

7. Accessing psychological therapy

"How did you come into contact with the psychological therapy service?"

Prompts:
How did you find out about them?

How did you get a referral?

What happened after you were referred?

Did you experience obstacles to getting the help you needed? If so, what were they?

What stopped you from attending X sooner?

What helped you to overcome those obstacles?

What helped you to seek help from X at that time when you had not done so before?

How did you find the whole process of seeking help?

8. Reflection

"Based on your experience, what would your advice be to others in your community who were experiencing mental health problems?"

"What would you say to them about seeking help from informal sources and from services?"

Appendix H: Example of analysis

Codes	Speaker	Transcript	Notes
Depression as white person's disease		say that only white people have the have this type of disease (mmhmm) well not disease but you know (yep, no I understand) this type of mental healthiness (yeah) and since then I I never told my family anything just (OK) my auntie she actually was was the only able to recognise what actually had and um what I'm actually going through (mmm) yeah	- Depression as white person's disease - Not disclosing to family - Aunty recognising because she had studied psychology
	I	So depression is very much seen as a white persons problem (yeah and people from Africa don't don't get it	
Africans not getting depression	P	They don't really because it's it's it's rare for for isn't well in my family it's rare for someone to have depression mainly you see in the news mainly is why people why people are the ones that come up with this craze of *inaudible* (mmhmm) themselves and doing all this so they always stereotype us as a white peoples (mmhmm) mental health (mmhmm) thing	- people in Africa don't get depressed - White people's disease
	I	Umm okay so what point was it so you said you mentioned it when you were about 14 (mmm) to your auntie but but it was it a bit later that she started to recognise it in you or?	
	p	This wasn't the same Auntie that recognised (okay) it was a different auntie (ah okay) yeah umm yeah	
	I	When you say auntie do you mean auntie (auntie) in the sense of your mothers (yeah) sister or something like that?	
Being judged for having depression	P	My mums the one that recognised (mmhmm) was my mums sister and the one that judged me for having it was my step dads err sister (ok ok)	- Family judging her for saying she had depression
	I	Umm and e w where was the first place that you so your auntie kinda knew did she tell you where to get help or where did you try to get help from (umm) the first time?	
Family encouraging psychology referral Cost as barrier Didn't think psychology would work	P	The the first time she told me to consult with psychologist (mmhmm) I didn't know how to consul I tried to look online but umm it was hard because they were charging me a lot (mmhmm) and I was not really thinking to like erm I was always thinking what about if I don't really what about if really like er it doesn't disappear or (mmhmm) I I stay the same so I was not I was not really fussed about paying (mmhmm) a lot of psychologists (mmhmm) because they do cost money	- Not knowing how to access services - Cost as barrier - Auntie telling her to see psychologist - Didn't think it would work
	I	Did you know what I psychologist was?	
Internet for information	P	Ermm well erm I had to research because there's different types of psychologists (mm) actually ermm theres the clinical ones (mmhmm) the ones that actually deal with depression and anxiety (mmhmm) and there's the therapist (mmhmm) that umm well actually have erm I have a appointment with a therapist on the 3rd of March s so I'm no well I'm I'm now I'm trying umm I'm seeing like different types of psychologist 9mmhmm) out there on the market but before I thought that psychologist was ok mental health depression (mmhmm) the ones yeah deal with people with mental health (mmhmm) that was it *laughs*	- Internet research to access information - Knew what it was before but not in detail
	I	So sure and I guess you said that you were looking on the internet and everything everyone was charging	
Cost as barrier	P	Yeah at the time when I was looking there was charging me a lot (mmhmm) so I just kind of gave up in consulting	- Cost as barrier
Fear of being judged	I	And you didn't know that you could get it for free on the NHS (No) at that time?	- Fear that GP would judge
	P	That's why I tried I went to my doctors and see what he could do that (mmhmm) maybe he could he was the one that was going to deal with my the depression at the time I was well I still am I still think that he'll probably be err he'll probably judge me for having (ok) depression but I just realised	

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		that he's not the one that deals with this type of issues (mmhmm) yeah	
	I	So you went to your doctor because you thought that he might be able to help but he also might judge you (yeah I always had this um) now you've learnt actually its someone else that helps	
Fear of being judged	P	I always had like this worry that he might judge me (mhmm) for having depression but then I when but then he told me that he's not the one that deals with this type so I was just felt better *laughs* (mmhmm) yeah	- Fear that GP would judge
	I	Umm ok so what was it then that made you go to your GP why did you decide to go to your GP at that time?	
Not disclosing to GP	P	Er it was just because of my sleeping (ok) problems that was it otherwise I wouldn't go *laughs* (ok)	- Sleeping problems reason for contacting GP
	I	So did you go to ask him for help with your sleep and then or did you say I think I've got depression or how did it happen?	
GP referral to psychologist	P	No I didn't tell him I think I have depression *laughs* (mmm) I just told him that I have er umm issues with sleeping (mm) and he told me to ye he just gave me some sleeping pills but then months later I went back and that's when he umm self I mean he referred me to a psychologists and that's when I decided to this time (mmhmm) yeah	- Not discussing mental health with GP - GP referral to psychologist
	I	Wh where those two appointments were they quite recently or were they?	
	P	Yeah they were quite recent about a few weeks ago (OK) yeah	
	I	So between 14 and 19 apart from your internet research and maybe talking to your auntie did you try to get help in any other way or did you try to help yourself any other way?	
	P	Mm not really *laughs*	- Not seeking help previously
	I	How did you cope with how you were feeling?	
Coping mechanism – just deal with it	P	Ermm ok there were times that I would just say ok lets just out I will just deal with it (mmhmm) what happens happens and there was times when I didn't want to deal with the issue and there was a time when I tried to kill myself but it didn't really happen because erm er I was just to scared to do it (mmhmm) so I just told myself ok whatever happens happens I'll deal with it (mmhmm) ermm d'ya know I'm actually glad that nothing happened to me (mmm) umm and yeah I I'm glad to be here as well (mmhmm) so yeah	- Positive self-talk
	I	Ok so on the way there wasn't anywhere else that you kind of went you kind of thought I'm just gona try and deal with it myself and whatever happens happens (yeah) mm and eventually you decided that because you couldn't sleep very well you would go to your GP	
Sleeping problems as facilitator	P	Yeah just because of my sleeping problems otherwise I think otherwise I still wouldn't get any any help any help because I had that mentality of consulting psychology was just for crazy people (mmhmm) but now I know that its not just for that (mmhmm) its other issues as well	- Believing myths about psychologists - Getting help because of something else
Not knowing that GP could help with MH Not disclosing Worried about being judged	I	And is it right that the first time you went to your GP and told him about your sleeping problems that you didn't tell him about the depression just because he would judge you?	
	P	Yeah I didn't I know that when I talk I don't even mention that to people not even to my GP (mmhmm) like about and my family about only maybe 2 people know that i have it like its something that I try not to talk about (mmhmm) because it's a very er like is er m like it's a topic like that I don't really like to mention about (mmhmm) it sometimes it makes me it makes me emotional so (mmhmm) so it's something that I don't wanna touch like touch the touch about touch the conversation about it but umm yeah like yeah my only issue is people will people will judge me (mmhmm) but now I	- Not disclosing; not knowing that she could disclose - Not disclosing as would become emotional if she did

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