Addressing Inequalities in the Care of Black People with Psychosis: A Quantitative Study Evaluating the Impact of the ‘SEE ME’ Training on Mental Health Professionals

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DClinPsy Thesis (Volume 1), 2023

University College London

UCL Doctorate in Clinical Psychology

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.

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Overview

The presence of mental health disparities among racialised minorities has been consistently documented, notably affecting Black African and Caribbean origin communities. While quantitative data helps to evaluate these disparities, it is important to understand the underlying factors, and lived experiences through qualitative investigation. Furthermore, despite these extensively documented racial inequalities and existing National Health Service (NHS) training initiatives aimed at addressing them, limited robust evaluations evaluating their effectiveness exist.

Part one is a thematic synthesis, which comprehensively reviewed and synthesised the findings from twenty-six qualitative studies exploring the experiences of mental health services among Black service users in the UK. In parallel to quantitative research, the findings reveal persistent experiences of racial bias, discrimination, and racism in mental health services. Additionally, they highlight the value of actively involving patients in their treatment, facilitating open communication, and considering social and cultural factors.

Part two is a quantitative study that evaluated the impact of a training aimed at addressing racial inequalities, the 'SEE ME' training, on mental health professionals unconscious bias, cultural competence, clinical decision-making, mentalising capacity and commitment. Seventy mental health professionals working in Early Intervention Psychosis (EIP) services in inner London participated in the study. The 'SEE ME' training was found to be effective for improving cultural awareness and commitment to addressing inequalities, but it did not shift unconscious racial bias, self-reflection about the role of one's own ethnicity, feelings of discomfort discussing the inequalities Black people face, mentalising capacity, and the likelihood of recommending restrictive practices.

This empirical study was part of a wider service initiative within the North-East London NHS Foundation Trust (NEFLT) with a research team consisting of three other trainee clinical psychologists, Experts by Experience (EbEs), and two research supervisors who were involved in the co-production and implementation of the 'SEE ME' training. The three other trainee clinical psychologists DClinPsy empirical studies had the following aims:

- A.1. NHS mental health staff interviews: To understand staff perspectives on engaging with initiatives to address racial inequalities, specifically for Black service users with psychosis.
- A.2. Experts by experience interviews (Black service users with psychosis): To explore the perspectives of Black Experts by Experience on engaging with and being involved in co-production projects aimed at addressing racial inequalities within psychosis services.
- B.1. NHS mental health staff interviews within EIP services: to investigate the experience and impact of attending the ‘See Me’ training intervention on mental health professionals.

Part three of the thesis provides a critical appraisal of the conducted research, with reflections focussing on my rationale for selecting this project, the complexities of categorising ‘Black’ individuals in mental health research, the importance of co-production in the context of this project, my involvement in the ‘SEE ME’ training, and finally, challenges that came up whilst conducting the research.

Impact Statement

Despite extensive quantitative research unveiling the pervasive disparities that Black and Minority Ethnic (BME) individuals encounter, these inequalities persist with Black communities experiencing the most adverse mental health outcomes. Improving mental health service experiences necessitates a systemic transformation that includes service users' perspectives in planning and implementation. The qualitative data from this review is pivotal for reshaping and enhancing services. This was the first systematic review that thematically synthesised the research related to Black individual's experiences of mental health services in the UK. The findings from the review provide a comprehensive overview on the lived experiences of Black individuals within mental health services, shedding light on the pervasive issues of racial prejudice and discriminatory practices. Furthermore, they underscore the paramount significance of services recognising and actively addressing the broader social and cultural determinants that influence overall wellbeing and considering spirituality, community support, and a holistic approach that recognises individuals beyond their diagnosis. An essential element identified is the need for services to foster trust by offering transparent and clear information, promoting culturally responsive approaches that empower individuals and breaking the cycle of feeling disempowered and controlled by the system. Collectively, these insights emphasise the continued need for mental health services to intensify their efforts in addressing and alleviating racial disparities by providing culturally competent and trauma-informed approaches. Moreover, the findings highlight the importance of service user involvement and co-producing trainings and initiatives to enhance experiences of care and service provision.

The empirical paper is the first quantitative study that evaluates the impact of the 'SEE ME' training on mental health professionals, a training that was co-produced with Experts by Experience (EbEs) and experts by profession, to improve the care of Black people with psychosis in in Early Intervention in Psychosis (EIP) services. It involves the viewing of a co-produced film and engaging in reflecting tasks. A key finding from this study was that the 'SEE ME' training significantly improved mental health professionals' cultural awareness and commitment to addressing racial inequalities, however it did not change unconscious racial bias, self-reflection about the role of one’s own ethnicity, feelings of discomfort discussing the inequalities Black people face, mentalising capacity, and the likelihood of recommending restrictive practices.

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Acknowledgements

I would firstly like to thank my research supervisors, Dr Miriam Fornells-Ambrojo and Dr Chelsea Gardener. I am extremely appreciative for the opportunity to have been part of such an incredible and meaningful project. You have both been so supportive and I am immensely grateful to you both.

To my ‘THESISters’, Alaina, Lori, and Michaela, I couldn't have asked for a more incredible and supportive team to work alongside. We have been through so much together and sharing this experience with you has been truly special. I’m grateful to have you all as lifelong friends!

Ellie, I feel fortunate to have been friends with you before the doctorate, and I’m even more thankful for our shared journey that brought us closer. You have been the most incredible DClin friend, and I can’t thank you enough. Chris, I'm immensely grateful to you for all your support, for motivating me, and for always keeping me well-fed. You have been my rock.

To my family, Mama, Baba, Mohammed, Mustafa, Aya, and all my close friends. I can't express how grateful I am for your support, not just during this process but throughout my life.

Finally, I would like to thank the Experts by Experience who co-produced the ‘SEE ME’ film, it was a pleasure to work alongside you, thank you so much for sharing your stories with us.

Part 1: Systematic Literature Review

Black Service Users' Experiences of Mental Health Services in the UK: A Thematic Synthesis of the Qualitative Literature.

Abstract

Aim: The existence of mental health inequalities for ethnic minorities in the UK have been widely and consistently documented, with Black service users encountering the highest disparities, and experiencing poor treatment and outcomes. This review aimed to systematically synthesise the qualitative studies exploring Black service users' experiences of mental health services in the UK.

Method: A systematic literature search was conducted on PsycINFO, Medline, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, and Global Health. Twenty-six studies met eligibility criteria and were included in this review. The studies were assessed for methodological quality using the Critical Appraisal Skills Programme ([CASP]; 2018) and analysed using a thematic synthesis approach.

Results: Four overarching analytical themes were revealed comprising of 14 descriptive themes; '*racial bias and discrimination in mental health services', 'power, control and fear', 'building positive relationships and experiences', and 'cultural responsivity and competence'*. These findings highlight the persistent experiences of racial biases, discriminatory practices, and racism Black service users encounter with the mental health systems. Furthermore, they underscore the importance of involving service users in their care, information sharing, addressing power and control within the system, and considering sociocultural factors.

Conclusions: This review offers a comprehensive overview of Black service users experiences of mental health services in the UK. It is critical that mental health services identify and address racial biases and discriminatory practices and empower individuals through culturally responsive and trauma-informed approaches to deliver effective mental health support and improve experiences for Black populations. Additionally, the integration of service user involvement and co-production initiatives and training is recommended.

1. Introduction

The pervasive existence of health inequalities amongst Black and Minority Ethnic (BME) groups in the UK have been widely and consistently documented overtime (Bagley, 1971; Cochrane & Bal, 1989; Kiev, 1965; Nazroo et al., 2020; Van Os et al., 1996). Individuals from BME communities are disproportionately represented in mental health services and experience inferior mental health care, treatment, and outcomes compared to their White counterparts (Bhui et al., 2003; Bignall et al., 2019; Cabinet Office, 2017; Care Quality Commission, 2011; Commander et al., 1997; Keating et al., 2002; Morgan et al., 2005; Raleigh et al., 2007). Black Caribbean and Black African origin individuals are considered to experience the highest disparities (Department of Health, 2018).

Black service users experience higher rates of restrictive practices compared to their White Counterparts including higher rates of compulsory detention under the UK Mental Health Act (Barnett et al., 2019; Halvorsrud et al., 2018; Weich et al., 2017), prolonged compulsory hospitalisations and re-admissions (Ajnakina et al., 2017), and a significantly increased likelihood of being prescribed anti-psychotic injections (Das-Munshi et al., 2018). Comparably, higher rates of police involvement have been documented for Black individuals prior to psychiatric admissions (Ajnakina et al., 2017; Grey et al., 2013), higher rates of contact with the criminal justice system (Halvorsrud et al., 2018), forensic services and medium secure units, and increased likelihood of being restrained or secluded (Keating et al., 2002; Tarbuck et al., 1999).

Additionally, Black African, and Caribbean communities within the UK face limited engagement with mainstream mental health services, are known for accessing care via adverse pathways, and encounter inferior experiences and outcomes (Devonport et al., 2023; Morgan et al., 2006). Inequitable access to mental health services, along with delayed and non-engagement has consistently been identified amongst Black individuals. This prolonged delay often results in untreated conditions, ultimately leading to more severe and chronic presentations upon contact with services (Morgan et al., 2006). Moreover, higher rates of severe mental health problems have been reported in Black individuals, particularly psychosis-related diagnoses such as schizophrenia (Cooper et al., 2008; Fearon et al., 2006; Kirkbride et al., 2008; Nazroo et al., 2020; Sharpley et al., 2001). These disparities in mental health are also compounded by significant inequality related to access and acceptability of psychological support (Department of Health, 2003a; Grey et al., 2013).

Disparities have been consistently established and research has aimed to elucidate the complexities underlying their endurance. Within-communities research focusing on Black individuals' mental health disparities and poorer outcomes has revealed significant insight into the complex interplay of factors that are associated to impacting emotional well-being (Devonport et al., 2023; Keating et al., 2002; Keating & Robertson, 2004; Mantovani et al., 2017). These studies not only examine the prevalence of mental health disparities, but also explore the underlying social, cultural, and systemic determinants that contribute to them. Such research has accentuated the detrimental effects of racism, socioeconomic inequalities, lack of cultural competence in mental health services, barriers towards help-seeking including associated stereotypes and stigma, and the importance of hearing and working collaboratively with communities. This suggests that establishing connections with communities and gaining insights into their experiences are beneficial for enhancing the development of support provisions within these populations.

Government policies have been introduced in the UK to address the mental health disparities that exist amongst BME communities and working with marginalised groups, such as the Delivering Race Equality in Mental Health Care (Department of Health, 2005), Inside Outside (Department of Health, 2003b), and the NHS Long Term Plan (NHS England, 2019); however, these inequalities have prevailed. Targeted actions for these populations include local gathering and monitoring of data on ethnicity and culture, creating mechanisms for local user groups to interact with commissioners and providers, utilising specific outcomes that are effective for communities and individuals, and assessing and monitoring service delivery effectiveness (Bignall et al., 2019). A thematic synthesis exploring mental health UK policies published between 1999 and 2020 highlighted how the absence of data pertaining to the ethnicity of individuals accessing mental health service users remains an ongoing challenge (Hussain et al., 2022). Policy recommendations outlining the need to encompass data collection on service users' ethnicity, advance community engagement, enhance cultural awareness of the needs of BME communities among healthcare professionals, and recruit BME mental health staff remained consistent. Hussain and colleagues concluded that performance measurement indicators for policy implementation and monitoring have been inadequate (Hussain et al., 2022). Neglecting the specific needs of individuals from BME backgrounds can result in policies reinforcing bias, discrimination, and deeper divisions (Hui et al., 2020). By recognising these inequalities within communities and the distinct factors that influence them, this facilitates opportunities for increased awareness, policy changes, and targeted interventions aimed at addressing the mental health disparities among Black populations.

Given that Black communities are less likely to access or seek mental health support, it is unsurprising that the research related to these racial groups experiences of services is frequently underrepresented (Devonport et al., 2023; Dyer & Gilbert, 2019). A recent systematic review conducted by Devonport and colleagues (2023) shed light on the significant disparities in mental health outcomes among Black African and Black Caribbean populations in the UK, when compared to their White counterparts. The review also highlighted how sociocultural factors, such as racism, unemployment, housing, cultural beliefs, and stigma influenced access to and experiences of mental health services within Black communities. Moreover, Black populations sought support from community leaders, particularly faith-based communities, emphasising the need for collaborative mental health initiatives between healthcare services and community organisations. This review not only exposes the challenges faced by these populations but also highlights the need for action and culturally appropriate interventions and services to address these disparities. This review employed quantitative and qualitative methodology; however, a thematic synthesis of the qualitative data was not presented.

Despite research emphasising how statistics constitutes an integral component of the overall picture, specifically in unveiling substantial disparities, it is also crucial to understand the differences, underlying causes, and experiences at play by researching qualitatively. Qualitative research provides extensive insight into individual’s experiences via open ended questions (Groleau et al., 2006), that are not easily suitable to experimental or quantification methods. It is extremely valuable to understand lived experience, to help improve service provision and influence the direction of research. Although there have been studies on this topic, to date no systematic review has thematically synthesised the research related to Black individual’s lived experiences of mental health services. Therefore, the current review aims to systematically examine and synthesise qualitative studies, through the research question: What are Black service users’ experiences of mental health services in the UK?

Aims:

1) To synthesise existing qualitative literature on the experiences of individuals identifying as Black British, Black African, and/or Black Caribbean within the context of mental health services in the UK.
2) To critically evaluate the methodological quality of literature in this area.
3) To identify limitations and gaps within the current body of research to guide future research.
4) To identify clinical implications for improving Black communities’ experiences of mental health services.

2. Method

The systematic review methodology was carried out following the principles of the Cochrane guidelines (Higgins & Green, 2011) and the review process was shaped by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009; Page et al., 2021).

2.1. Researcher Background and Epistemological Positions

It is vital for researchers to recognise their epistemological and theoretical positions and assumptions, to understand the lens through which qualitative analysis might be shaped, thereby enhancing the analysis's validity (Caelli et al., 2003). The author of this review is a Black woman of Sudanese heritage currently employed by the NHS as a Trainee Clinical Psychologist. The author is completing this research as part of attaining her Doctorate in Clinical Psychology. Living in an inner city and working in the NHS with diverse populations, the author is mindful of the impact that racism, privilege, social exclusion, lack of familial support, and poverty has on emotional wellbeing. Whilst working in the NHS she has been particularly aware of the systemic racial inequalities that exist and are perpetuated by the mental health system. Through the author’s personal and professional experiences, it was important to focus the research on the Black communities’ experiences of the mental health system. The author considered their values and assumptions, allowing her to understand how her positioning might influence her connection with the data and the interpretation of the results.

The approach employed for this review was thematic synthesis (Thomas & Harden, 2008), which adopts a critical realist viewpoint. Critical realism acknowledges the existence of both objective reality and the subjectivity of human experiences (Fletcher, 2017). It recognises the limitations of direct observation, that our perception of the world is shaped by our experiences, beliefs, and interpretations and emphasises the importance of uncovering the deeper causes and processes that shape the phenomena we observe. This epistemological position aligned with the research question; the researcher assumes that the extracted data is an embodiment of the objective reality as experienced through various perspectives of the participants and authors.

2.2. Data Collection

2.2.1. Eligibility Criteria

Studies within this review were included if:

1) Participants had to be reported clearly as being from Black ethnic backgrounds. The term Black within this review referred to individuals of Black African and Caribbean descent and origin, as outlined by the Sainsbury Centre for Mental Health (2002).
2) Participants were current or past mental health service users.
3) The studies explored experiences of mental health services.
4) They used qualitative data collection and analysis methods.
5) Reporting of qualitative quotations and findings linked to sample of Black ethnic backgrounds, in studies which also included participants from other ethnic backgrounds. Only the qualitative data where the participant was identified from a Black ethnic background are included in the thematic synthesis.
6) Research conducted in the UK.
7) Written or available in the English language and published in peer-reviewed journals or from grey literature.

Studies were excluded if:

1) Black service users' qualitative data was not identified separately to other ethnic groups.
2) Exploration of solely attitudes towards help-seeking and/or perceptions of mental health disorders and/or access to services.
3) Limited information was provided regarding the qualitative analysis, limiting the possibility of re-analysis in the thematic synthesis (i.e., no reporting of supportive quotations linked to the current reviews participant criteria).
4) Book chapters or books; or case studies that did not report or evaluate service user experiences of services.

2.2.2. Search Terms and Search Strategy

The search terms were identified from conducting a preliminary scoping search and identifying commonly used terminology and language used in the research area. Search terms were linked to four key concept clusters, centred on Black ethnicity, mental health, service users, and experiences. The search terms were combined in the search for example (Black* OR Black British) AND (Mental health* adj4 (service* or setting* or context*)) AND (Service user* or Patient*) AND (Experience* OR Perspective*). See Table 2 for the full search strategy.

Table 1

Summary of Search Terms.

Cluster 1: Black Ethnicity Terms	Cluster 2: Mental Health Services Terms	Cluster 3: Service User Terms	Cluster 4: Experiences Terms
Black* Black British Black Caribbean Black African Afr* Afro Caribbean BME BAME Black and Minority Ethnic Ethnic* Race Minority Marginali* People of colo* POC	Mental health* adj4 (service* or setting* or context*) Psychiatr* adj4 (service* or setting* or context*) Psycholog* adj4 (service* or setting* or context*)	Service user* Patient* Expert* EbE* Client* Participant* People Individual* Psychiatric patient* Psychiatric client*	Experience* Perspective* View* Perception* Attitude*

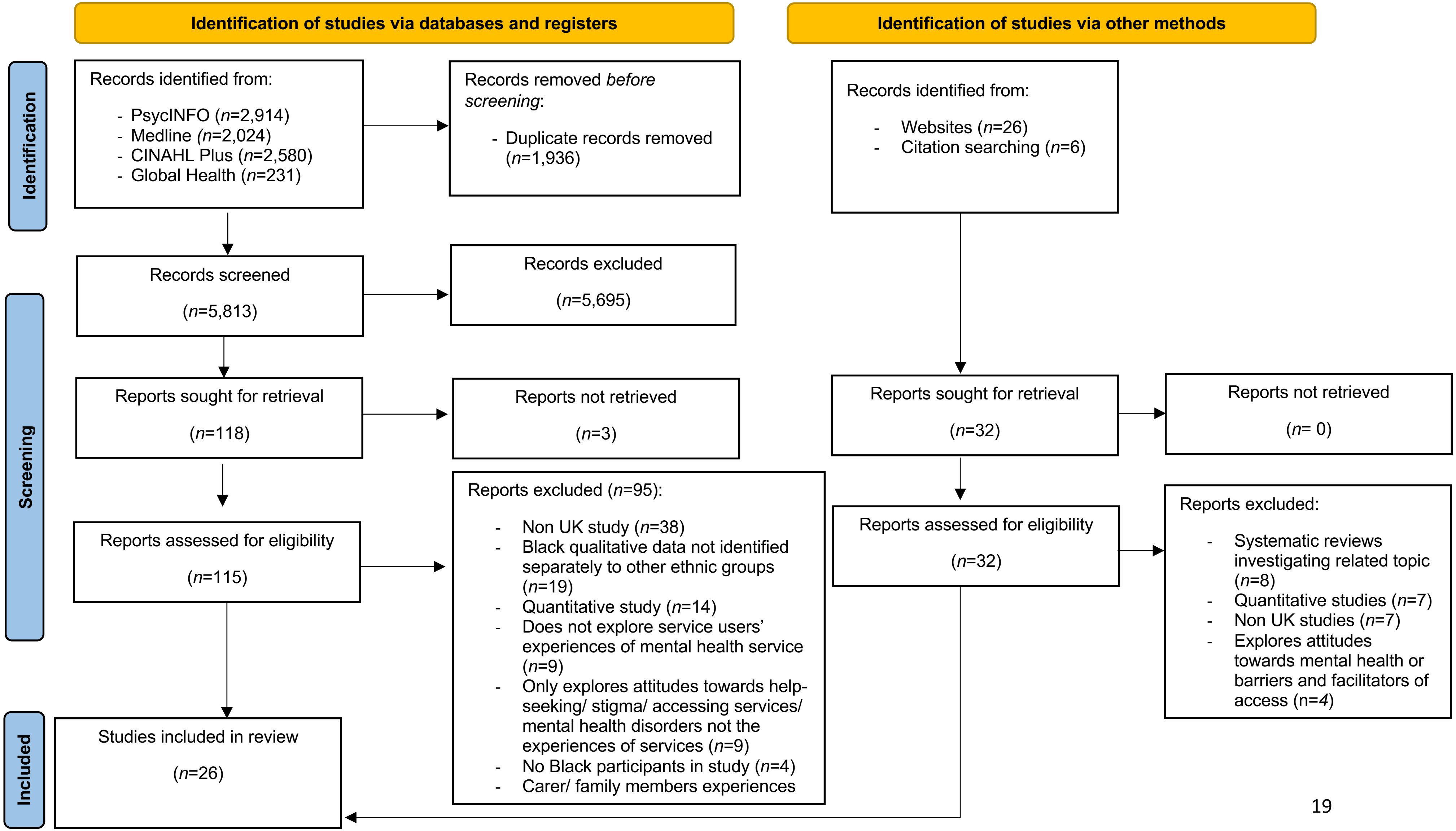
Relevant studies were identified by conducting systematic searches on PsycINFO, Medline, CINAHL Plus, and Global Health. These data bases were selected to obtain a comprehensive understanding of mental health, psychology, and psychiatry research. Grey literature searches were also carried out on these search platforms by checking the box to include grey literature in the search and via Google scholar. The searches were completed on 9th February 2023 and were set to search from the start of the database history. References lists of ascertained studies were also searched for applicable studies, and the included studies of a relevant systematic review were searched (Devonport et al., 2023).

The PRISMA guidelines for reporting systematic reviews were utilised to identify relevant papers from the initial database search (Moher et al., 2009; Page et al., 2021). Firstly, all studies identified via the database platforms were exported to Endnote reference management software. Duplicates were removed, and the remaining studies were screened against the eligibility criteria based on title and abstract. For the remaining studies, full texts were retrieved and read in full to assess if they met the systematic review's eligibility criteria.

One hundred and fifteen full texts from the database searches and an additional six full texts from relevant citation list searches were assessed for eligibility. Ninety-five studies were excluded, as they did not meet inclusion criteria. A total of 25 studies met criteria for inclusion in this review. See Figure 1 for the PRISMA flowchart of the identification of studies and the main reasons for study exclusions.

Figure 1

PRISMA Flow Diagram Showing Study Selection Process.



2.3. Data Extraction

Key characteristics of included studies were extracted: study aims; total sample and ethnicity; Black participant demographic information; how ethnicity was coded in studies; participant diagnoses; the mental health setting; and the data collection and analysis methods (see Table 1). This allowed for an overview of the literature and facilitated the initial evaluation of the range of studies included. The data was extracted and inputted into a Microsoft Excel spread sheet.

Variation has been reported in the literature about what is considered as 'data' in qualitative syntheses (Noyes et al., 2018). In relation to the current systematic review, '*data*' was regarded as any text in the results or findings sections, including quotations and in tables. In instances that included experiences that were not relevant for the current review, for example reported mental health professionals or carers views, only the data applicable to the review question was extracted. This data was then imported and analysed using NVivo (QSR International Pty Ltd, 2020).

2.4. Analysis

2.4.1. Quality Assessment

The methodological quality of studies was assessed using the Critical Appraisal Skills Programme ([CASP]; 2018). See Appendix 1. This appraisal tool is commonly used in qualitative evidence synthesis for health and social care research (Dalton et al., 2017; Long et al., 2020). It consists of 10 items related to research aims, methodology, design, recruitment strategy, ethical considerations, data analysis and interpretation of results.

To rate the quality of each study, an overall score out of 10 was provided. Each question was marked out of one. If a question had a possible response of "yes", it was scored as 1, "can't tell" was scored a 0.5 indicating that not enough information was provided. Questions that had answers of "no" were scored as 0. Studies rated above 8 were categorised as being of high methodological quality and studies scoring between 4.5 and 7.5 were identified as moderate. The author conducted the CASP assessment for all included studies, and a random sample of 25% (*n*=6) of the studies were independently evaluated by another researcher. Initially, inter-rater reliability agreement was 100%.

2.4.2. Thematic Synthesis Methodology

Thematic synthesis is a qualitative research method used to identify, analyse, and integrate patterns or themes across a range of literature (Thomas & Harden, 2008). Thematic synthesis methodology was employed using the three-stage process outlined by Thomas and Harden (2008). In the first stage (1) line by line coding was carried out by systematically coding the data that met inclusion criteria in the studies. This process was conducted by reading and coding each line or excerpt of text and assigning descriptive codes to them which captured key concepts, ideas or meanings identified from the data. In the second stage (2) the researcher identified similarities and patterns across the coded data and grouped codes that had similar content or meaning into descriptive themes. In the final stage (3) the researcher moved beyond the descriptive level and aimed to generate higher-order analytical themes. These analytical themes represented an interpretation of the data and provided a more conceptual understanding of the data. This process resulted in a theme structure of 14 descriptive themes and four overarching analytical themes.

3. Results

3.1. Study Summary

Key study characteristics were extracted and are presented in Table 1 below. All studies were conducted in the UK and were published between 1999 and 2022. Of the 607 total individuals who had contact with mental health services across all studies, 49% (*n*=298) were identified as Black. One study did not differentiate sample demographic information based on whether participants were service users or providers and therefore the sample size was not included in this figure (Mclean et al., 2003). The current review focused only Black participants with sample sizes ranging from two to 35 participants. The sample was primarily composed of African-Caribbean participants, followed by Black African and then Black British individuals. The most commonly reported diagnosis within the sample was Schizophrenia or a psychosis related diagnosis. Gender was reported for 77% (n= 222) of the sample. Of these, 55% were male (*n*=122) and 45% were female (*n*=100). All studies employed a qualitative methodology, utilising focus groups or semi-structured individual interviews.

Although specific study aims varied, generally studies aimed to explore service users' experiences of mental health services and mental health treatment, with some studies aiming to explore participants' experiences of help-seeking, barriers to accessing services and differences in perceptions of mental illness amongst ethnic groups. There were some studies that aimed to explore participants' experiences of specific service contexts including inpatient settings (Gilburt et al., 2008; Secker & Harding, 2002a), early intervention psychosis services (Islam et al., 2015; Lawrence et al., 2021a; Singh et al., 2013), assertive outreach (Priebe et al., 2005), and an ethnic specific service (Secker & Harding, 2002b).

Table 2

Summary of Studies Included in Thematic Synthesis.

Study	Main Aim	Total Sample	Black Participant Service User Sample	Ethnicity Coding Method	Diagnoses	Mental Health Setting	Data Collection and Analysis Method
Bowl (2007)	To gain further insight into the processes shaping black service users' engagement with services	*n*= 39; African Caribbean (*n*=13) and South Asian (*n*=26)	*n*=13: African Caribbean; 9 men and 4 women aged 21 to 60 plus years.	Not specified	Schizophrenia and two had bipolar disorder. 11 described inpatient experiences, six referred to compulsorily detainment, one was subject to a compulsory order	Clinical and community	Focus groups and individual interviews Thematic analysis
Chakraborty et al. (2009)	To compare Black Caribbean and White British peoples' experiences of perceived unfair treatment and perceived causes of this	*n*= 20; White British (*n*=10) and African Caribbean (*n*=10)	*n*=10: African Caribbean; 5 male and 5 female aged 27 to 59 years	Self-described	Psychotic illness; Schizophrenia (*n*=7), Delusional disorder (*n*=1), Manic psychosis (*n*=1), and Depressive psychosis(*n*=1)	Clinical	Open ended ethnographic interviews Text unit analysis
Cinnirella & Loewenthal (1999)	To map some of the key group differences in beliefs about mental illness among the groups studied	*n*= 52; White Christian, Pakistani Muslim, Indian Hindu, Orthodox Jewish and Afro-Caribbean Christian	*n*= 7: Black, African & Afro-Caribbean Christian, all female	Not specified		Community	Semi structured interviews Thematic analysis
Gilburt et al. (2008)	To explore the experiences of admission to acute psychiatric hospital from the	*n*= 19 service users: White British (*n*=13), White European (*n*=1), Black British (*n*=3) and Asian	Black British (*n*=3)	Not specified	Not stated, but had a previous psychiatric hospital admission(s)	Community	Focus groups and interviews

	perspective of services users	British (*n*=2).					Inductive thematic analysis
Islam et al. (2015)	To understand challenges facing mental health service provision in relation to cultural appropriateness, accessibility, and acceptability by BME groups and develop ways forward in providing cross-cultural mental health care to reduce ethnic disparities in care and outcome	Early Intervention (EI) service users (*n*=22), carers (*n*=11), community and voluntary sector organizations (*n*=6), service commissioners *(n*=10), professionals (*n*=9), and spiritual care representatives (*n*=8). Service users: Asian/Asian Pakistani (*n*=9), Asian/Asian British Bengali (*n*=1), Black/Black-British African (*n*=3), Black/Black-British-Caribbean (*n*=8)	*n*=11: Black/Black British-African (*n*=3), Black/Black British-Caribbean (*n*=8*) *includes 3 mixed White and Black Caribbean)	Self-described	Not stated but includes current or past EIS service users	Clinical	Focus groups Thematic analysis
Hui et al. (2021)	To investigate sources of institutional injustice and their effects on marginalised people with experience of mental health problems.	*n*=77	*n*=10: Black British (*n*=3), Black African/Caribbean (*n*=3), White & Black African/ Caribbean (*n*=4)	Self-described	Black participants diagnose not stated separately to other BAME ethnicities	Clinical and community	Semi-structured interviews Inductive analysis
Johnson & Weich (2010)	To obtain narratives from young men of both white and black ethnicity about their early experiences of seeking help for serious mental health problems in primary care	*n*= 7: African–Caribbean (*n*=4) and White European (*n*=3). The average ages were 23 and 27, respectively.	African–Caribbean (*n*=4), all males, average age 23	Self-described using 2001 census	Noted stated but under the EIS team's caseload	Clinical	Semi structured interview Grounded theory
Keating & Robertson (2004)	To explore the content and consequences of fear; identify service and community impediments	Service users, families and carers, and MH professionals	*n*=29: African Caribbean (*n*=18) and African (*n*=11); 19 males and 10 females; average age	Self-described	Not stated	Clinical	Focus groups Thematic analysis

	to change and recommend solutions		was 35 years (range=20– 60 years).				
Lawrence et al. (2021a) *	To investigate the long-term experience of living with psychosis and navigating mental health services within the Black Caribbean and White British people with psychosis	Black Caribbean (*n*=17), White British (*n*=15) and non-British White (*n*=3)	Black Caribbean (*n*=17), male (*n*=6) and female (*n*=11), age groups: 21-30 years (*n*=10), 31-40 years (*n*=6), 41-50 years(*n*=1)	Not specified	Schizophrenia (*n*=10), Mania (*n*=4), Depression (*n*=3)	Clinical	Individual interviews Thematic narrative analysis
Lawrence et al., (2021b) *	To explore the journey through mental health services from the perspective of individuals from the black Caribbean and majority white British population to help understand variation in the use of mental health services	Black Caribbean (*n*=17), White British (*n*=15) and non-British White (*n*=3)	Black Caribbean (*n*=17), male (*n*=6) and female (*n*=11), age groups: 21-30 years (*n*=10), 31-40 years (*n*=6), 41-50 years(*n*=1)	Not specified	Schizophrenia (*n*=10), Mania (*n*=4), Depression (*n*=3)	Clinical	Individual interviews Thematic narrative analysis
De Maynard (2007)	To investigate the process of "visibly-black-men-becoming-ill"	African-Caribbean descent (*n*=8), Mauritian descent (*n*=1), and West African descent (*n*=2). Age range 18 to 45, all males	African-Caribbean origin (*n*=8); one was from Barbados, two were from Jamaica, two were mixed West Indian heritage, and two were British born of West Indian heritage. Narratives were also obtained from a patient of Mauritian decent and two of African descent. Age range 18 to 45, all males	Not specified	Severe mental illness diagnosis usually schizophrenia made by Consultant Psychiatrist using sing International Classification of Diseases (ICD- 10) criteria. Detained under the Mental Health Act of 1983	Clinical	Interviews Thematic analysis
Mclean et al. 2003)	To elicit African-Caribbean perspectives on	30 individuals from, or working with, the African-Caribbean community in the	Did not differentiate sample demographics based on whether they	Not specified	Not stated	Clinical and community	Focus groups

	mental health treatment and promotion	town including members of voluntary groups, service providers and lay African-Caribbean community members	were service users or providers				Grid coding method
Memon et al. (2016)	To determine perceived barriers to accessing mental health services among people from these backgrounds to inform the development of effective and culturally acceptable services to improve equity in healthcare	*n*=26: Asian/Asian British (*n*=4), Black/Black British (*n*=6) and mixed (*n*=3) communities; 13 participants did not respond to the question on ethnicity.	Black/Black British (*n*=6)	Self-described	Not stated	Community	Focus groups Thematic analysis
Pilav et al. (2022)	To explore minority ethnic women's experiences of access to and engagement with perinatal mental health care.	18 women; Black or Black British (*n*=8), Asian or Asian British (*n*=4), Arab (n=2) and Mixed Other or White Other (*n*=4)	Black or Black British women (*n*=8)	Self-described	Diagnosed with perinatal mental health difficulties by a specialist perinatal mental health service; Primary diagnoses:Bipolar Affective Disorder, anxiety, Trauma-Related Diagnoses and Emotionally Unstable Personality Disorder), Depression, and Psychotic Disorders	Community	Semi-structured interviews Thematic analysis
Priebe et al. (2005)	To explore the views of disengagement and engagement held by patients of assertive outreach teams.	*n*=40: African–Caribbean (*n*=18), White UK (*n*=16), African (*n*=4) and Other (*n*=3)	*n*= 22: African–Caribbean (*n*=18) (7 first generation and 11 second-generation) and African (*n*=4)	Not specified	A diagnosis of psychosis according to ICD–10	Clinical	Interviews Thematic analysis and grounded theory components

Rabiee & Smith (2013)	To examine the views and experiences of using and providing mental health services from the perspectives of black African and black African Caribbean mental health service users, their carers, voluntary services and a range of statutory mental health professionals and commissioners	*n*=97; 15 voluntary organizations, 25 service users, 24 carers, 16 statutory health professionals, 2 commissioners and 15 key members of the statutory service providers.	African and African Caribbean service users (*n*= 25), female (*n*=14) and male (*n*=11); 12 African (Congo & Somalia) and 13 African Caribbean	Not stated	None were suffering from an acute mental health problem at the time of the study	Community	Focus groups for the service user group. Krueger's framework and Rabiee's guidelines (Krueger & Casey, 2000; Rabiee, 2004)
Schofield et al. (2019)	To determine how Black African and Caribbean service users perceive and explain these apparent differences	35 participants from the Black African and Black Caribbean	Black African and Black Caribbean (*n*=35); Mixed Black African/Caribbean (*n*=14), Black African (*n*= 9), Black Caribbean (*n*=12). Male (*n*=24 and female (*n*=11)	Self-described	Current or past diagnosis of psychotic illness.	Community	Four focus groups Thematic analysis
Secker & Harding (2002a) *	To explore the inpatient experiences of a sample of African and African Caribbean people	*n*=26; African Caribbean heritage (*n*=18) and African heritage (*n*=6)	*n*=26; African Caribbean heritage (*n*=18) and African heritage (*n*=6); two-thirds were aged between 25 and 44, with two in the younger age group (18–24) and six in the older age groups (45–64). Male (*n*=16) & female (*n*=10)	Patient records	The majority (*n*=16) had a diagnosis of schizophrenia.	Clinical	Semi-structured interviews Content analysis
Secker & Harding (2002b) *	To explore a sample of resource centre clients' perceptions of the service provided by obtaining grounded examples of what exactly it was that made a positive or	*n*=26; African Caribbean heritage (*n*=18) and African heritage (*n*=6)	*n*=26; data available for 24/26 participants; African Caribbean heritage (*n*=18) and African heritage (*n*=6); two-thirds were aged between 25 and 44, with two in the younger age	Patient records	The majority (*n*=16) had a diagnosis of schizophrenia.	Clinical	Semi-structured interviews Content analysis

	negative difference to them		group (18–24) and six in the older age groups (45–64). Male (*n*=16) & female (*n*=10)				
Singh et al. (2013)	To determine the appropriateness, accessibility, and acceptability of generic early intervention services for different ethnic groups and establish the care needs and preferences of service users and other stakeholders	EI service users (*n*=22), carers (*n*=11), community and voluntary sector organisation representatives (*n*=6), commissioners (*n*=10), professionals (*n*=9) and spiritual care representatives (*n*=8) Service users: 9 Asian/ Asian British-Pakistani, 5 Black/Black British – Caribbean, 3 mixed White and Black Caribbean, 3 Black/ Black British–African,1 Other,1 Asian/Asian British – Bangladeshi	*n*= 22; early intervention Black service users (n = 11), 5 black/black British – Caribbean, 3 mixed white and black Caribbean, 3 black/black British – African	Self-described	Diagnosis of psychosis, all participants under an EI service	Clinical (for service user focus groups)	Focus groups Thematic analysis
Sisley et al. (2011)	To explore African Caribbean women's conceptualisations and experiences of distress and help-seeking	African Caribbean women (*n*=7); age-range:30's-50's	African Caribbean women (*n*=7); age-range:30's-50's	Self-described	Not stated, all women reported experiencing emotional distress at the time of workshop attendance	Community	Semi-structured interviews IPA (Interpretative Phenomenological Analysis)
Sweeney et al. (2015)	To explore the role of fear in adult mental health service users' lives and describes its implications for mental health services	*n*=32: White British, Irish or Other (*n*=24) Asian/Asian British or Chinese (*n*=2), Black/ Black British (*n*=2), and mixed heritage (*n*=4)	Black/Black British (*n*=2)	Not specified	Not stated	Community Mental Health Service	Focus groups Thematic analysis
Tuffour et al. (2019)	To explore Black African service users' experiences	12 Black African service users (three males and nine	12 Black African service users (three males and	Not specified	Schizophrenia (*n*=7), Paranoid	Community Mental	Semi-structured interviews

	of recovery from mental illness and to understand how they conceptualise recovery.	females). Age range= 23 years to 57 years	nine females). Age range= 23 years to 57 years		Schizophrenia (*n*= 4), Organic delusional (schizophrenia-like) disorder, *n*=1)	Health Service (*n*=8), Clinical (inpatient) (*n*=4)	IPA
Wagstaff et al. (2018)	To explore experiences of mental health services for Black men with a diagnosis of schizophrenia and have a history of ‘disengagement’ from mental health services	7 Black Males, age range= 31 to 64 years	7 Black Males, age range= 31 to 64 years	Self-described	Schizophrenia (*n*=7)	Clinical	Semi-structured interviews IPA
Warfa et al. (2006)	To explore the experiences of African-Caribbean, Black African and White British men who report a dual diagnosis and are in contact with health and social care services in east London	*n*=9: two African-Caribbean men, four Black Africans and three White British men. Aged 18 to 35 years	*n*=6 (two African-Caribbean men, four black Africans including Black Caribbean (*n*=2), Somali (*n*=2), Ethiopian(*n*=1), Ghanian and Scottish (*n*=1)	Self-described	Self-reported. Schizophrenia (*n*=2), Psychosis (*n*=1), PTSD (*n*=1), Psychosis/ PTSD(*n*=1), Psychological problems (*n*=1)	Voluntary and statutory	Semi-structured interviews Content analysis using the Framework Method
Weich et al. (2012)	To explore service users’ and carers’ accounts of recent episodes of severe mental illness and of the care received in a multi-cultural inner city.	*n*=40: South Asian (*n*=16), Black (*n*=8), White (*n*=16)	*n*=8 (4 males and 4 females). Black British (*n*=3), Black-Caribbean (*n*=3), Mixed (*n*=1), Black African (*n*=1). Age range= <25- 45 years or more	Self-described using the 2001 Census categories	All have a psychosis diagnosis; non-affective (*n*=6) and other (*n*=2). Sectioned under MHA (*n*=5), informal admission (*n*=3)	Clinical	In-depth interviews Thematic analysis providing an analytic interpretation

Note. *Same sample used in these studies

3.2. Quality Assessment

The CASP checklist was used to rate each of the included studies (CASP, 2018). The scoring of this tool consisted of rating studies between 0 (being the lowest methodological quality) and 10 (being the highest methodological quality). The methodological quality in the current systematic review ranged between 7.5 to ten. Twenty-five out of the 26 studies were classified as high quality (scores between 8 and10), with only one study from the review scoring a 7.5 (Mclean et al., 2003) indicating medium methodological quality.

All the included research clearly reported their study aims and findings, employed an appropriate qualitative methodological design, collected data appropriately, contributed valuable findings to the research field, and identified clinical implications and directions for future research. The most common area that was not described in studies was whether the relationship between the researcher and participants was considered despite the given importance on the impact authors bias could have on research. Some studies also failed to report if ethical considerations or if ethical approval was sought.

Table 3

Summary of CASP Ratings of Included Studies.

CASP items	Bowl (2007)	Chakraborty et al., (2009)	Cinnirella et al ., (1999)	Gilburt et al., (2008)	Hui et al., (2021)	Islam et al., (2015)	Johnson et al. 2010	Keating et al., (2004)	Lawrence tt al., (2020)	Lawrence et al., (2021)	De Maynard (2007)	Menon et al., (2016)	McLean et al., (2003)	Pilav et al., (2022)	Priebe et al., (2005)	Schofield et al., (2018)	a Secker et al., (2002)	b Secker et al., (2002)	Singh et al., (2013)	Sisley et al., (2011)	Sweeney et al., 2015)	Tuffour et al., (2019)	Wagstaff et al., (2018)	Warfa et al., (2006)	Weich et al., (2012)	Rabiee et al., (2013)
1. Statement of the aims	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Appropriateness of qualitative method	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Appropriateness of design	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4. Appropriateness of recruitment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5. Appropriateness of data collected	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6. Researcher & participants relationship consideration	⋆	⋆	✓	✓	✗	✗	✗	✗	✓	✓	⋆	✓	✗	✓	✗	✓	✗	✗	✗	✓	✗	✓	✓	✗	✗	✓
7. Consideration of ethical issues	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	⋆	✓	⋆	⋆	✓	✓	✓	✓	✓	✓	✓	✓
8. Rigour of data analysis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	⋆	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
9. Clear statement of findings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
10. Value of research	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Total score	9.5	9.5	9	10	9	9	9	9	10	10	9.5	10	7.5	10	8.5	10	8.5	8	9	10	9	10	10	9	9	10
Classification category	H	H	H	H	H	H	H	H	H	H	H	H	M	H	H	H	H	H	H	H	H	H	H	H	H	H

Note: Studies were classified as high quality (total score 8 and above), medium quality (total score between 5 and 7) and low quality (below 5).

Key: H = High; M = Medium; ✓ = 1; ⋆ = 0.5; ✗ = 0.

3.3. Thematic Synthesis Findings

A thematic synthesis (Thomas & Harden, 2008) was used to provide insights into Black service users' experiences of mental health services in the UK. Four overarching analytical themes were revealed; '*racial bias and discrimination in mental health services', 'power, control and fear', 'building positive relationships and experiences', and 'cultural responsivity and competence"*. These comprised of 14 descriptive themes. An overview of the analytical themes is presented in Table 4 below, and the full theme structure is presented in Figures 2 to 5 below.

Table 4
Overview of Analytical Themes from the Synthesis.

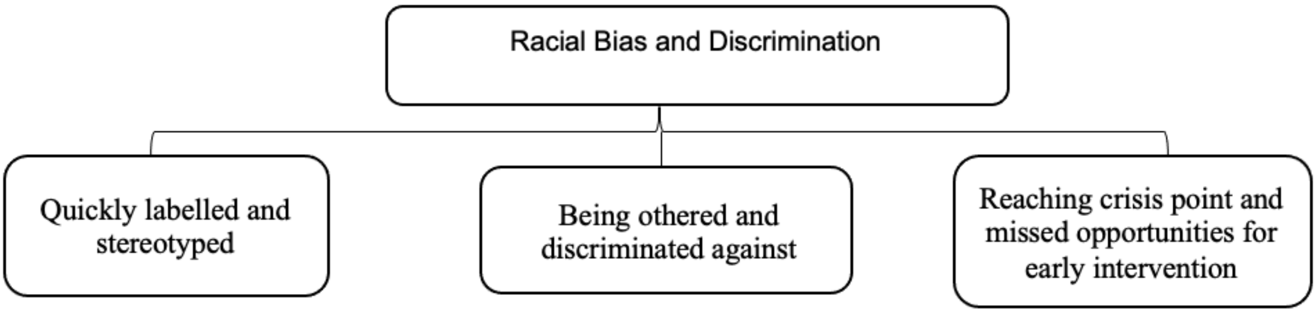
Theme	Analytical Theme	Descriptive Themes
1	**Racial Bias and Discrimination in Mental Health Services**	Quickly Labelled and Stereotyped Being Othered and Discriminated Against Reaching Crisis Point, and Missed Opportunities for Early Intervention
2	**Power, Control, and Fear**	Feeling Powerless and Controlled Dehumanised Fear and Mistrust Lack of Information Sharing Stuck in the System
3	**Building Positive Relationships and Experiences**	An Individual Beyond a Diagnosis: Feeling Seen, Heard and Understood A Formal Friend: Dropping Boundaries A Place of Safety and Respite
4	**Cultural Responsivity and Competence**	Pathologising Expression and Missing the Systemic Cultural Awareness and Competence Importance of a Diverse Workforce and Representation

Analytical Theme 1: Racial Bias and Discrimination in Mental Health Services

The first analytical theme depicted three descriptive themes which included, experiences of stereotyping, discrimination, and missed opportunities for early intervention. This theme shed light on the pervasive nature of racial stereotyping and discrimination that Black individuals regularly encounter. The structure of this analytical theme is presented in Figure 2. Illustrative quotations for these descriptive themes have been depicted in Table 5.

Figure 2

Analytical Theme 1.



3.4.1. Quickly Labelled and Stereotyped

Participants frequently described their experience that “people from the Black community are quickly diagnosed as being psychotic” (Schofield et al., 2019). This perception of “*immediately being labelled*” with terms such as “’*mad*”, “*aggressive*” and “*dangerous*” was evident amongst the data. Additionally, service users made reference to internalising the stereotypes they were labelled with, “*if you’re told enough times, you believe it*” (Lawrence et al., 2021b). Despite services being quick to ‘label’ individuals with racial stereotypes and diagnoses, participants described a lack of support from and access to services and they reported that services were more likely to quickly enforce restrictive practices such as medication “*they were all just take, take, take*” (Lawrence et al., 2021a) or being “*sectioned*” under the Mental Health Act (Chakraborty et al., 2009). This was linked to service users feeling that professionals wanted to “*suppress black people*” (Secker &

Harding, 2002a) and that they immediately felt unheard and misunderstood based on these racial stereotypes and interactions.

Participants emphasised that racial stereotypes had far-reaching effects beyond their interactions with NHS services. They noted that these stereotypes influenced not only their access to and encounters within the NHS but also shaped their experiences within other systems. Preconceived labels assigned to them before any contact with mental health services significantly influenced their journey into the mental health system. For instance, it was shared that police involvement prior to hospital admissions exacerbated racial bias. Notably one participant discussed police coming to his family numerous times when he was admitted to hospital, and how this brought feelings of "*shame*" linked to his perception that neighbours made assumptions that he was involved in "*criminal activities*" because of his race (De Maynard, 2007).

3.4.2. Being Othered and Discriminated Against

Participants shared that racial stereotypes resulted in them being discriminated against, and they distinctly highlighted that the treatment they received was different to their White counterparts. Some individuals spoke to the interplay of intersectionality and how aspects of identity privileged some individuals or oppressed others, "*if I was white and middle class … they wouldn't have done that to me*" (Secker & Harding, 2002a). Service users described experiencing microaggressions, such as being greeted differently or being ignored by receptionists and indicated that this was due to their race. Additionally, they described explicit forms of racism and discrimination. For example, many participants reported that they only had access to medication as a treatment option and they spoke to psychological therapy being inaccessible and "*refused*" when requested. Prominently, some participants expressed feeling that professionals held the belief that Black people could not be supported with talking therapies, "*they don't believe—they really don't believe that black people can be treated, that black people can be given therapy, that you can talk to black* *people*” (Mclean et al., 2003). Many spoke to professionals not understanding or supporting participants with the underlying difficulties they faced and instead were “*forced*” to take medication based on racial prejudices, and that they were given “*heavy injections, very high doses of medication*” (Schofield et al., 2019). It was noted that the individual scenarios of being othered, discriminated against, and subjected to oppressive treatment were repetitive experiences that they had encountered with different systems throughout their lives. Some participants described that the mental health system was re-enacting the controlling and coercive treatment they had encountered in other institutions, such as school exclusion and contact with the criminal justice system.

3.4.3. Reaching Crisis Point and Missed Opportunities for Early Intervention

Some participants commented that from their experiences they accessed mental health services when they reached crisis point (e.g., after taking an overdose), and it was only then that they were admitted to hospital and “taken seriously” (Sisley et al., 2011). Participants described that professionals missed opportunities for earlier intervention due to them expecting them to exhibit racially stereotypical “aggressive” behaviour and “that’s when the five police cars come around”. Individuals described that when they were in a “docile” state or when they “looked tidy” they did not access services or were turned away.

Experiences of being dismissed were pertinent in the interactions that were described with General Practitioners (GPs). They shared that GPs were slow to recognise earlier indicators of requiring support which negatively impacted their journey into the mental health system. Additionally, many participants indicated that psychological therapy was not offered or refused to participants when they required it, missing opportunities for early intervention and support, “*who in this room has been offered, you know, talking therapy when they needed it at the beginning?”* (Schofield et al., 2019).

Table 5

Illustrative Quotes for the Three Descriptive Themes Under Analytical Theme 1.

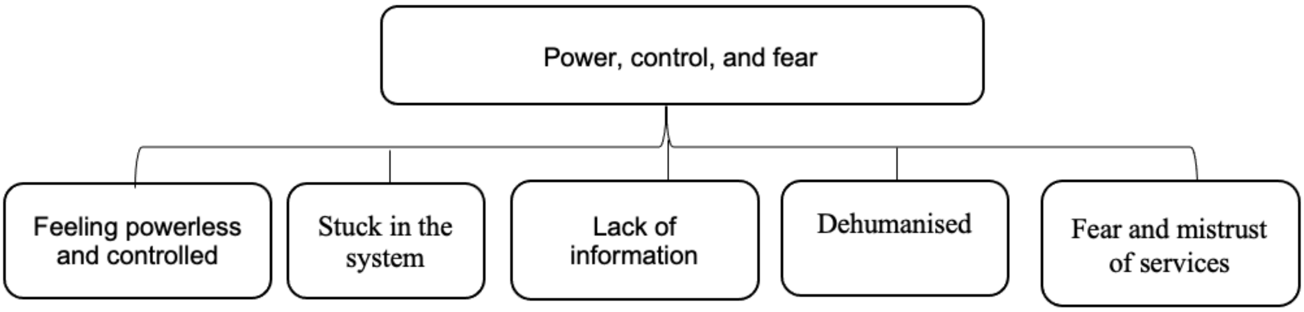
Descriptive Theme	**Illustrative Quote**
Quickly Labelled and Stereotyped	“What they see in me is like ‘oh he’s mad’, they’re not listening to what I was actually saying, so they’re not even understanding” (Hui et al., 2021) “‘I was immediately labelled, I didn’t feel as though they took their time out to address any of my problems, they were all just take, take, take” (Lawrence et al., 2021a) “I’ve never, in 15 years, I never put my hand on anybody, patient or nurse. Yet they perceive me as being aggressive so I can’t work that quite out. I think it, it’s just to do with black people, you know. It’s like, they don’t, they don’t really . . . They don’t understand, or like, and do want to suppress black people. That’s my experience. It’s very racist…” (Secker & Harding, 2002a) “…the next minute there’s three of them grabbing me, [they] took me to the room and gave me an injection… So I was obviously some danger to them…judging me by my skin-colour. I think it must definitely come into it. Cos on TV it’s always “black mad-man” or “black madwoman” kills passer-by… I think they’ve got this basic form that they judge people by and it’s not right” (Chakraborty et al., 2009)
Being Othered and Discriminated Against	“...I think at the time it was appalling what happened to me. If I was white and middle class or something you wouldn’t, they wouldn’t have done that to me” (Secker & Harding, 2002a) “if that had been me, they would have given me medication and pinned me down” (Sweeney et al., 2015) “I asked to see a psychologist and they point blank refused to let me see a psychologist at any time at all...I thought if I could get to talk to somebody instead of having all this injection and medication that used to make me feel terrible and really paranoid and horrible and terrible feeling, uh . . . and they refused to let me, they said they can’t do that” (Secker & Harding, 2002a)
Reaching crisis point for support: Missed opportunities for early intervention	“It wasn’t until I ended up in hospital…that it was…taken seriously” (Sisley et al., 2011) “Certain people seem to think that as a Black person to be considered to need the services of the mental health services, you have got to look a particular way, act a particular way. They turn you away at one stage because you don’t fit that bracket. Dr ## says, `Oh. He looked tidy” (Schofield et al., 2019) “Who in this room has been offered, you know, talking therapy when they needed it at the beginning?”(Schofield et al., 2019)

Analytical Theme 2: Power, Control, and Fear

The second analytical theme encompassed five descriptive themes pertaining to participants experiences of feeling disempowered, feeling stuck in the system, fear and mistrust of the system, and the lack of information sharing resulting into exclusion from one's own care. The structure of this theme is illustrated in Figure 3. Quotes to illustrate the five descriptive themes are depicted in Table 6.

Figure 3

Analytical Theme 2.



Feeling Powerless and Controlled

Feelings of being controlled and experiencing powerlessness within the mental health system were prevalent amongst participants. They commented on having a lack of agency in determining their own wellbeing, the power lying within the psychiatric system, being powerless in an environment where professionals held the cards and feeling a lack of care from professionals towards service users. It appeared that this sense of powerlessness was heightened in the inpatient context. there was a feeling of shock and realisation of being 'sectioned' and that being in hospital felt like a lack of control to participants.

> *…by the time I got into hospital I was so scared of what was actually going on, it hit me then: "Oh no, I've been sectioned (legally detained in hospital), I'm in the mental hospital…somebody else is yet again in control of my life." It was like my whole life the control was in other people's hands all the time* (Chakraborty et al., 2009).

There was a general perception that professionals held the power and participants accepted diagnoses and guidance based on professionals' expertise which further contributed to feelings of powerlessness. Psychiatrists were viewed as holding a significant amount of power within the system. Therefore, some participants felt that they could not speak to other professionals' inpatient settings "*because everyone complies with the regime of the consultant psychiatrist*" (Secker & Harding, 2002a). A "*compliant*" relationship was described as one where they "*carry on with them rather than listen to them*" (Wagstaff et al., 2018). This was linked to participants feeling they had no choice and accepted treatment decisions without agreeing with them due to them being "*the experts*" (Bowl, 2007).

Feelings of powerlessness were frequently centred around medication linked to the lack of agency and choice participants had in their medication treatment and management. Medication experiences were associated with a lack of autonomy, feeling unheard, feeling threatened that they would go back to hospital if they refused to take it, a sense of powerlessness and imprisonment, and a lack of control, "*but I want to know why they keep giving me injections from in the jail. ... Now I am a free man they are still treating me like a prisoner*" (Wagstaff et al., 2018). Additionally, many participants stated when given medication healthcare professionals failed to provide explanations about the purpose and side effects of the medication, and instead were just expected to take it. This further contributed to feelings of powerlessness. Moreover, some participants spoke about how the medication's side effects further disempowered them due to the sedative impact of the medication. This was linked to feeling physically disconnected from their bodies which impacted their ability to advocate for themselves and the treatment they received.

> *I used to communicate to them to say that I wouldn't like that, in other words, 'Don't give it me'. But they insist ...I just seemed to drift away and just slumber* (Wagstaff et al., 2018).

Stuck in the System

Participants described the mental health system symbolising a "*revolving door*" and that once they were in it, they were stuck in the system "*for life*" (Schofield et al., 2019). Some individuals mentioned that treatment was not recovery-focused and felt that they were broken or worsened by the system. A lack of person-centred care and rehabilitative activities contributed to this sense of feeling stuck in the system. Recommendations were made addressing breaking this cycle of being stuck in the system, including offering "coping services" to service users which was described as a service that prevented hospital admissions. Specifically, participants spoke to self-care, relaxation techniques, healthy diet, exercise, having someone to talk to, family involvement, community, and spiritual support as being helpful to manage their difficulties. Additionally, ongoing support for "survivors" post-discharge was requested. Participants described inpatient admissions and the physical process of anti-psychotic injections to be a traumatic and painful experience. Notably one described the injections as a "*racist motive*" and was a reminder of regular experiences of racism and suffering they had encountered (Secker & Harding, 2002a). There was no space to think or talk about these traumatic experiences, which further exacerbated service user's feelings of being stuck in the system's cycle.

Lack of Information

A prominent theme that emerged from the data was the lack of information that was shared with service users, which was heightened in inpatient settings. Service users expressed that mental health professionals failed to give "*good, clear and precise information*" to them about their difficulties (Secker & Harding, 2002a). This contributed to them not understanding their difficulties, and negatively impacted their relationship with staff and their recovery.

> *If you don't know what is going on then you can't solve the problem, and if part of the problem is within you, how can you do that if you don't know what the hell is going on* (Secker & Harding, 2002a).

Many highlighted that staff failed to provide explanations about the purpose of medications, "*I didn't know what I was taking"* (Lawrence et al., 2021a)*,* or to give adequate information about the medication and its side effects, Additionally, there was a lack of communication regarding hospital admissions. For example, participants stated that the reason for their admission was not explained, they were provided with misinformation about the expected duration of their admission, they were excluded from meetings about their care, and they expressed that they were not made aware that voluntary hospital admissions were an option. Instead, participants described a cycle of being sectioned under the Mental Health Act with police involvement, which they deemed "*unnecessary and punitive*" (Lawrence et al., 2021a) . This general lack of transparency and communication from the mental health system contributed to participants feelings of powerlessness and lack of control over their lives, as they did not feel involved in their treatment or able to influence decisions about their care.

Dehumanised

Participants expressed they felt they were treated without respect and with a lack of humanity. They described already feeling disempowered prior to their contact with mental health services, and that services further perpetuated this narrative of dehumanising and disempowering service users, "*you come to services dis-empowered already, they strip you of your dignity … you become the dregs of society …"* (Keating & Robertson, 2004). This lack of humanity was frequently linked to inpatient experiences, where participants felt they did not have a voice, they were labelled as "*mad*" and "*sick*", and their contributions were viewed as "*worthless*". Individuals shared that the coercive and traumatic environment they encountered in inpatient settings, for example the frequent experiences of being "*restrained*" "*forced"* and "*dragged*" and a lack of dignity during medication administration further added to the dehumanisation. *"Sticking the needle and dropping my trousers and looking at my arsehole and all that"* (Wagstaff et al., 2018).

Fear and Mistrust of Services

Service users described a profound mistrust and fear of the system, "*I don't know how to say it in many words, but I fear … I fear the mental health system*" (Keating & Robertson, 2004). For many, lack of information sharing, and negative past experiences resulted in feelings of powerlessness and a lack of control, which subsequently contributed to their mistrust of the system. In accounts, it was evident that this intense fear was magnified in inpatient settings. Strikingly, one participant experienced such intense trepidation towards the mental health system that they associated it with a fear of death, "*I remember when I first went into hospital…I feared that I was going to die*" (Keating & Robertson, 2004). Some service users spoke to high staff turnover or a lack of continuity of care with staff in mental health services. They described how this led to repeatedly discussing the difficult life events they had experienced with new staff members, thus hindering the formation of trusting relationships, and negatively impacting engagement and treatment. This sense of not feeling able to rely on staff due to this lack of continuity of care further contributed to their fear of the system.

Table 6

Illustrative Quotes tor the Five Descriptive Themes Under Analytical Theme 2.

Descriptive Theme	Illustrative Quote
Feeling Powerless and Controlled	“To be in such an environment where people don’t care, and they hold all the cards, and you have absolutely no rights and you have, you know, there’s no respect, I mean it was…a nightmare” (Lawrence et al., 2021a) “… especially when you’re the only one that has to have the outcome of it if you take a pill or something…If I’m in a situation you know I read up on medication on the internet before I even let it pass my lips or whatever, but… they don’t want that… and I’ve known that from, that’s been my experience from day one you know” (Lawrence et al., 2021a) “I’ve been taking my medication just for the fact that I don’t want to go back to hospital ....but, if I had a choice of taking the depot or not taking it, I wouldn’t take it” (Priebe et al., 2005)
Stuck in the System	“… a lot of black people get into the mental health system. I think it’s like a revolving door. Revolving door, yeah. You see it’s a vicious circle. Once you’re in that system it’s as if you’re going to be in it for life” (Schofield et al., 2019) “He has seen me go through worse then what I was before going through the system. The system never helped me, he has seen me actual go worse, you know, since coming here” (De Maynard, 2007)
Dehumanised	“When you’re in hospital and you got no-one to talk for you…they just crap all over you. Just walk all over, like, take no notice of what you say, you know, you’re mad. That’s all there is to it. You’re sick. and what you say is not worth nothing”(Secker & Harding, 2002b) “I know it sounds a bit, uh, it sounds a bit kind of not right but I think it was that racist motive that they wanted to make people suffer, some of the nurses. and they used to come along and drag you from the dinner table, about six of them, just pick you up and drag you . . . hands and everything, you know, your hands and arms would be all over in the air, and they’d be dragging you down the corridor and then take you into a room and hold you down and inject you. This was the kind of experience I was experiencing – continuously” (Secker & Harding, 2002a)
Lack of Information	“I didn’t know what I was taking, they didn’t explain to me what was wrong with me, then they had meetings, but they didn’t have meetings with me involved in there, so I didn’t really understand why I was there” (Lawrence et al., 2021a) “I definitely didn’t have the rapport [with staff] I would’ve liked. I’m sure I would’ve got better a lot sooner…all I needed was information… good, clear and precise information about my own circumstances and my own health and my own condition, and it, it took me a couple of years to get that information”(Secker & Harding, 2002a)

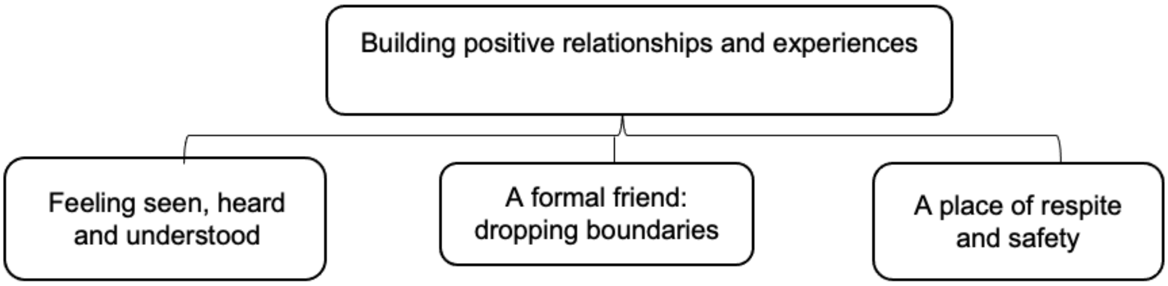
	“they could have explained to me exactly what were the problems that they found, um, the symptoms that I was having. And, and . . . but they sectioned me and injected me and shipped me off to a closed ward unit” (Secker & Harding, 2002a)
Fear and Mistrust	"I remember when I first went into hospital, I had a very bad panic attack … I couldn’t breathe, you know, and that went on for days … I was just so scared …” (Keating & Robertson, 2004) “from then I couldn’t talk to anyone, I didn’t feel I could trust anyone there, to be treated like that I just lost so much trust” (Lawrence et al., 2021a)

Analytical Theme 3: Building Positive Relationships and Experiences

The third analytical theme encapsulates factors that contributed to positive relationships formed between professionals and service users. The structure of this theme is presented in Figure 3, and illustrative quotations for these descriptive themes have been depicted in Table 7.

Figure 4.

Analytical theme 3.



Feeling Seen, Heard and Understood

Participants expressed the importance of being recognised as an individual beyond a diagnosis, with feeling “*heard and understood*” as being core elements for building positive relationships with mental health professionals. These interactions encompassed instances when professionals normalised their feelings, provided “clear” and “concise” descriptions about diagnoses and treatments, and instilled service users with a sense of hope about their recovery by stating that they would "*get better*" (Weich et al., 2012) and that they would be supported by the service. Additionally, providing participants with options and choice in treatment decisions further contributed to positive interactions with services. For example, having a choice in appointment locations i.e. at home or in clinic and the frequency of appointments allowed individuals to feel understood (Singh et al., 2013) .

Some participants who attended the African Caribbean resource, an ethnic specific service, discussed the importance of having professionals from this service with them to advocate from them in their interactions with other statutory services. Participant shared that they felt heard by the staff member who advocated for them, particularly when talking to other professionals who held positions of power (e.g., doctors and nurses in inpatient settings). Furthermore, participants shared that when professionals gave them practical support this played a significant role in building relationships. For example, support with letters, housing, finances, and employment made them feel seen as humans. Participants shared that when their whole context was taken into account, they felt like their whole lives and all their difficulties were considered.

> *With the African Caribbean Mental Health Service, they seem to, to look at the whole person and their background and the family as well. … which means that all of your concerns are addressed* (Secker & Harding, 2002b).

It is important to note that a large number of participants who spoke to these positive experiences were discussing their interactions with African Caribbean, ethnic specific, services. These positive experiences discussed often related to the value of an ethnic specific service. Yet, such positive experiences were not shared when considering other statutory mental health services. Participants felt valued in ethnic specific services, like they "belonged and felt understood", that their wider contexts were being considered, and that they were seen as an individual. They also conveyed that staff in this centre had shown kindness by providing them with food, practical support, and a relaxed environment, which contributed to the formation of positive relationships, a welcoming environment, and a sense of humanity between them. Additionally, participants made recommendations for ways to improve their experiences with mental health services. This included creating systemic change by involving service users' voices in all stages of planning and implementation of services. They also identified other ways to improve their experiences, including having more time and support from professionals, community support and involvement (e.g., home visits), and family involvement in their care.

A Formal Friend: Dropping Boundaries

Participants emphasised the importance of having opportunities to connect with others and building trust with staff working at the African Caribbean mental health resource centre. These included professionals dropping their boundaries and giving them some insight into their own lives and experiences, and having a "*warm, caring, and loving*" approach (Secker & Harding, 2002b). This appeared to reduce the power imbalance and brought humanity to the relationship. This played a significant role in establishing confidence in their working relationships with staff and trust in their interactions.

> *When they speak to you about your condition, they speak openly about themselves as well. Because it seemed to me that all the nurses or whatever at [the local hospital] knew everything about you, but you didn't know anything about them. Whereas it's very different with the African Caribbean mental health resource centre. Um, they allow you to get to know them on a very personal basis. On a one-to-one basis as well. So, you can form relationships which will form confidences as well* (Secker & Harding, 2002b).

Additionally, professionals balancing the ability to be both friendly and professional in this context further contributed to them building a unique and trusting relationship with service users, "*she is more formal but my friend*" (Secker & Harding, 2002b). Participants stated this contrasted with their experiences of other services where health care staff had extensive information about them, but that they had no information about the professionals.

This led to feeling as though there was no link to humanity between staff and themselves, making it more difficult to form trusting relationships.

A Place of Respite and Safety

While many service users described inpatient services as traumatic and consisted of racial discrimination, some participants expressed that it was a place of respite and safety away from social and personal stressors such as having "*limited access to illegal drugs*" (Warfa et al., 2006). One participant expressed an internal conflict of inpatient services providing a sense of safety, yet it being an "awful place".

> *I don't think I did anything but lie there let my mind wander, eat, lie there, eat, but then as I got through that, it was horrible…because I'd got through that just needing to feel safe kind of period, and then I suddenly remembered what an awful place it was* (Lawrence et al., 2021a).

Service users that attended the African Caribbean resource centre, similarly, described the service as providing a sense of safety and a relaxed environment where "*there's no pressure on you to behave, or be a certain way*" (Secker & Harding, 2002b). They additionally highlighted that it was an environment where they experienced respite from the racism that they witnessed and experienced in hospitals (Secker & Harding, 2002b). Illustrative quotes for each of the descriptive themes have been collated in Table 7 below.

Table 7

Illustrative Quotes for the three Descriptive Themes Under Analytical Theme 3.

Descriptive Theme	Illustrative Quote
Feeling Seen, Heard and Understood	"He was very kind of understanding and he just listened to what I had to say. And I think at one point he explained what was actually happening to me. And er… what the treatment was and let me know that I would get better and that they could help" (Weich et al., 2012) "But with the African Caribbean Mental Health Service, they seem to, to look at the whole person and their background and the family as well.

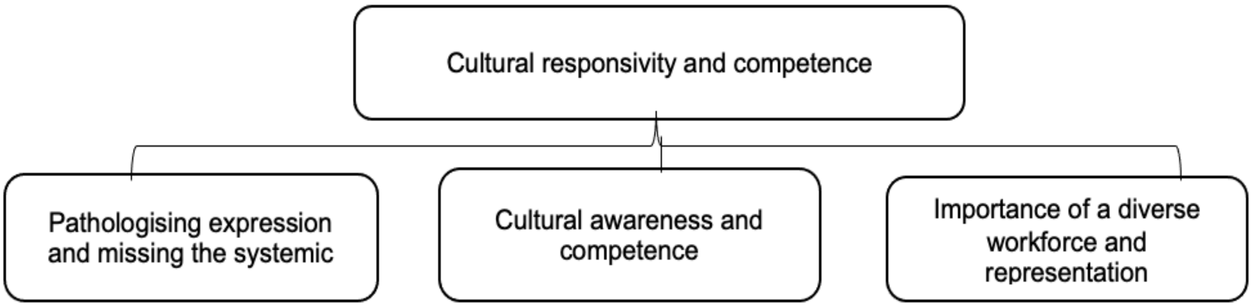
	and … which means that all of your concerns are addressed. Your anxieties about work, your anxieties about medication, the anxieties about how well you're moving through the system. The anxieties about home, ah, all of those things are addressed for you and with you. and they can help you budget, for instance, your monies, your financial monies, … these are areas that, um, in the hospital that you just couldn't get any help at all with" (Secker & Harding, 2002b)
A Formal Friend: Dropping Boundaries	"I built up a trust with [my outreach worker]. Because I find it hard to just trust anybody … I've told [her] everything and it's like, certain people I can't do that with, you know … But I think maybe because [my outreach worker] is a worker here as well, as well as like a friend, it's like different you know. She is more formal but my friend" (Secker & Harding, 2002b) "Well … when they come to see me they come to see me. See how I am. Not like my CPN [community psychiatric nurse] or social worker who comes for a job" (Secker & Harding, 2002b)
A Place of Respite and Safety	"It is a place where you can go. Where you need to go and you go there" (Secker & Harding, 2002a) "Coming here we're not going to get racism, because everybody is black and everybody is like trying to get on in this society, you know. and I think they should have more places like this, in all different areas, because there is some black people that don't know … that are not so lucky. Because in hospitals, if you go to a lot of hospitals, mental, you see a lot of black people that are not treated properly and things like that and it's good to have this service" (Secker & Harding, 2002b)

Analytical Theme 4: Cultural Responsivity and Competence

The fourth analytical theme covered three descriptive themes, describing participants views on the importance of a diverse workforce, cultural competence in mental health services, and the need for services to take social and systemic issues into account. This has been illustrated in Figure 4 below, and illustrative quotations for these descriptive themes have been represented in Table 8.

Figure 4

Analytical Theme 4.



Pathologising Expression and Missing the Systemic

Participants shared that mental health professionals often misinterpreted and pathologised cultural expressions within Black communities. For example, their experience of having visions was associated with, "*so you're seeing things then*" (Schofield et al., 2019). Additionally, it was highlighted that this pathologisation resulted in the misdiagnosis of mental health conditions such as psychosis. It was expressed that professionals associated hearing voices with psychosis instead of Post-Traumatic Stress Disorder (PTSD) into account, due to racial biases clinicians held.

> *What they see in me is like 'oh he's mad', they're not listening to what I was actually saying, so they're not even understanding—they didn't even see the post-traumatic so what they was seeing was psychosis, because I can hear voices* (Hui et al., 2021).

There were also several accounts that described pathologisation of responses to contexts and understandable reactions to stressors, such as harmful interpersonal difficulties, medical conditions, and difficult social circumstances, which were interpreted as a mental illness. Notably, one participant recounted a punitive hospital admission with police involvement, following an understandable response of them shouting at a parent who had physically abused them (Lawrence et al., 2021a). Furthermore, participants expressed that the social and systemic factors that impacted their emotional wellbeing were often ignored, and they were unsupported with them. These factors included social disadvantage, lack of employment, housing difficulties, financial issues, lack of childcare, and social isolation which impact individuals' mental wellbeing and recovery. An account by one participant discussed how migration to the UK leads to social isolation due to a lack of social and family connections, "*the mental health service does not always understand. That we are really, really isolated*" (Memon et al., 2016). The importance of addressing these social factors was highlighted as being instrumental in supporting recovery, otherwise they remain in a "*vicious circle*".

The above data indicated that participants did not feel heard, professionals did not give space to formulating wider systemic contexts and lacked taking cultural considerations into account. Instead professionals often made quick assumptions of participants. When cultural expressions or reactions to stressors were not understood by mental health professionals, they were misinterpreted as symptoms of a mental disorder. For instance, manifestations of distress or spiritual experiences that were culturally normative within Black communities were often misdiagnosed or viewed as a severe mental illness, mostly commonly psychosis.

Cultural Awareness and Competence

Participants spoke to their experiences of professionals lacking cultural awareness and being culturally insensitive which resulted in their misdiagnosis. They discussed that their culture, spirituality, and religion was not considered and that they were pathologised, misunderstood and not believed for having experiences which were considered culturally typical and acceptable within their communities. For example having "visions" or dealing with "*magic or things like voodoo*" (Gilburt et al., 2008). Some studies clearly emphasised psychiatry as a discipline that 'lacked cultural competence' and they described experiences with psychiatrists where individual's beliefs and cultural constructs of mental health were not considered. Participants associated psychiatry with being very "*narrow*" and "*sterile*" and that psychiatrists failed to learn about the individual and important aspects of their lives which contributed to understanding themselves and their difficulties.

Service users emphasised the significance of cultural awareness and understanding, and expressed they developed more trusting and meaningful relationships with staff who exhibited these attributes, "*the ones that do have it are the ones that I do trust, that I do work with*" (Warfa et al., 2006). Some studies highlighted the importance of institutional inclusion, for example the inclusion of foods from participants cultural backgrounds in inpatient settings was described, and this was highly valued by participants. Additionally, professionals having knowledge and an understanding of participants wider contexts, such as their culture and spirituality was significant. Moreover, supporting service users to explore their identities gave them a sense of "*freedom*" which helped them discuss their emotions and difficulties. For service users and mental health professionals that had different ethnic backgrounds, sharing information about each other's cultural backgrounds appeared significant and was viewed as an important way of connecting, "*I would have liked people [health providers] to know about my culture and I know about their culture*" (Warfa et al., 2006).

Importance of a Diverse Workforce and Representation

The importance of staff representation and the lack of ethnic diversity within the workforce was highlighted across the data. Participants commented on feeling more understood and engaging better with BME professionals, specifically noting that Black staff had "a certain energy and understanding" (Bowl, 2007), and they were "able to understand my lived experience" (Pilav et al., 2022). In the accounts, this represented someone who participants could identify with physically, and someone who could relate to their difficulties, emotions, culture, and experiences. One participant explained that speaking Patois occasionally with a professional and the positive impact this had on them, as it left them feeling a sense of connection and shared understanding. Many studies referenced that the physical presence of Black staff and professionals from other ethnic minorities had a profound impact on enhancing participants sense of self-worth and confidence, pertaining to reduced stigma related to mental health in their communities.

Additionally, participants described their experience of witnessing other racial groups having more support or less coercive interventions imposed on them when the psychiatrist was from the same ethnic background as them, "*but black people, you know, it's either hospital or prison*" (Rabiee & Smith, 2013). There were some studies that spoke specifically to the lack of representation of Black staff in psychological therapy which left participants feeling like that their experiences were not understood or that they were unable to discuss their "*deep seated*" difficulties (e.g., experiences of racism), due to finding professionals from other ethnicities to be unrelatable. This was deemed as a barrier for support as service users did not feel they could discuss their difficulties or express themselves fully. Furthermore, participants expressed that being unable to relate to staff culturally, ethnically or explaining "the black experience" to professionals impeded their experiences of effective therapy and left them feeling unable discuss important aspects of their identity. Participants also spoke to an under-representation of Black doctors within the psychiatric system whom they perceived to be more understanding to their perspective and difficulties.

> *Bring in the Africans. I'm serious, I think it would be very, very different, because unless they're completely taken in by this whole system business… but they'd just have a completely different way of hearing you when you were saying things* (Lawrence et al., 2021a).

Although the positive influence of a diverse ethnic and cultural background among mental health professionals was highlighted in the data, few studies emphasised that there are "*good and bad staff*", and this was not related to their ethnic background but rather to their individual qualities. These participants valued key qualities in professionals, including respect, empathy, understanding, reliability, trustworthiness, and competence.

Table 8

Illustrative Quotes for the Three Descriptive Themes Under Analytical Theme 4.

Descriptive Theme	Illustrative Quote
Pathologising Expression and Missing the Systemic	“A lot of us have been misdiagnosed because somebody thinks that if you’re somebody from the Caribbean and you happen to mention something like, you had a vision: So you’re seeing things then” (Schofield et al., 2019) “We express ourselves a bit different, you know, because we’re not white and we talk differently, so we might express ourselves differently and they feel that we are paranoid schizophrenia” (Mclean et al., 2003) “If the fact that outside stressful, extreme outside stressful situations and medical illness happen to me and that makes me have, you know, react then yes fine then, I have a mental illness, if that’s what the definition is” (Lawrence et al., 2021a) “Mental illness is a social problem, I don’t think it’s necessarily an individual problem, it’s a social problem. I mean there’s lots of things that can make people go off their head; if they haven’t got proper accommodation, if their house is leaking or if their partner’s gone off or if there’s a bereavement or divorce; all those issues can make people just flip, you know what I mean?” (Rabiee & Smith, 2013) “People recover in the Caribbean and Africa and they recover in Asia, whereas over here we’re just in a vicious circle of poverty where you’re just going round and round and round” (Schofield et al., 2019)
Lacking in Cultural Awareness and Competence	“They’re culturally insensitive, they are not aware of Caribbean African culture (..) we are very spiritual people who believe that people have visions, yeah, and believe that people have enlightenment or whatever you want to term it. And so it’s acceptable in our community” (Schofield et al., 2019) "It was like a misunderstanding, they didn't want to believe that the unknown, the unknown, meaning someone who like deals with like magic or things like voodoo, that's what sort of like brought this all about" (Gilburt et al., 2008) “My critique of psychiatry is like I said to you before if you don’t believe in the spirit world then you, or even accept that it exists even if you don’t believe in it, then you’ll have a hard time coping with psychiatry especially in a multi-cultural way. …, it’s very sterile, a lot of it is very sterile and it is very clinical, and it’s a narrow perspective of life.”(Lawrence et al., 2021a)
Importance of a Diverse Workforce and Representation	“For me, a plus was that most of the people that I came in contact with were Black, or some ethnic background, and to me that’s quite important because they would be able to understand my lived experience”(Pilav et al., 2022) “It’s only natural because birds of the same feather. . . I think you feel more confident that you’re trying to relate the problem to

	someone culturally and emotionally...” (Cinnirella & Loewenthal, 1999) “Talking on a one-to-one with people as a Black person I find it very difficult because I can’t really, they can’t relate to some of the things that are going on in my head, and I can see that they can’t and that frustrates me. If I was sitting and talking to a Black person every now and then I’d break into a little piece of patois and I know she can understand me. . . but there wasn’t anybody I felt I could identify with or who could identify with my particular problems. . . there were the things on the periphery like the lads {her two sons}. . . and my mortgage and stuff like that, yeah, they could deal with stuff like that, but the deep-seated things you’re not able to talk to them about it because you know they won’t understand, so it would help if more Black people were within the mental health system” (Cinnirella & Loewenthal, 1999)

4. Discussion

This review aimed to synthesise existing research regarding Black British, Black African, and/or Black Caribbean service users’ experiences of mental health services in the UK. A recent mixed methods study, employing both qualitative and quantitative approaches, investigated determinants of mental health and interventions designed to improve experiences of mental health services among Black populations (Devonport et al., 2023). The current review expands on the existing literature by providing insight into the experiences of Black individuals within mental health services. Twenty-six qualitative studies exploring service users’ experiences of mental health services were identified and the data was analysed using thematic synthesis. The synthesis generated four overarching analytical themes consisting of 14 descriptive themes pertaining to participants experiences. These analytical themes were: (1) *‘racial bias and discrimination in mental health services’*, (2) ‘*power, control, and fear’,* (3) ‘*building positive relationships and experiences’*, and (4) ‘*cultural responsivity and competence’*.

4.1. Main Findings

The findings of this review consistently highlighted the existence of immediate racial stereotypes that contributed to a biased treatment approach towards Black service users, particularly when compared to their White counterparts. This bias was noted to be in both direct and indirect forms of bias, such as microaggressions, differential diagnoses, treatment recommendations, and a lack of choice and transparency related to service users' care. Of the studies that stated participants' diagnoses, a psychosis related diagnosis, specifically Schizophrenia was most prevalent. This is unsurprising given the overrepresentation of psychotic diagnoses among Black individuals (Kirkbride et al., 2017; Zahid et al., 2023). However, the reasons for this overrepresentation are complex (Sharpley et al., 2001), and racial bias and systemic inequality can be part of the picture. Racially biased stereotypes such as 'Big, Black, Bad and Dangerous' impacts how Black people are viewed, particularly men, which has previously been documented to lead to a reduction in empathy and increase the dehumanisation of Black individuals (Walker, 2020). Previous studies demonstrated a clear link with clinicians racial stereotyping and prejudice with adverse impacts on clinical encounters (Adams et al., 2014; Fitzgerald & Hurst, 2017). Such racial stereotypes and experiences of discrimination has not only hindered accurate assessment, treatment, and engagement with mental health services, but also resulted in a lack of trust or engagement with services. This has caused Black service users to access mental health support at a later crisis point. Alike findings in this review, a previous systematic review reported that Black communities accessing services at crisis points increases the likelihood of being detained under the mental health act or accessing services via the criminal justice system (Devonport et al., 2023). Existing research has highlighted how accessing services via these pathways reinforces the stereotype that Black individuals with mental health difficulties are perceived as being more "dangerous", therefore necessitating more extreme interventions (Dyer & Gilbert, 2019; Sewell et al., 2021).

Furthermore, the review highlighted how the mental system 'sadly too often fails Black communities', which was noted to occur from the point of access to services and throughout their journey in the mental health system. The results described various points of missed opportunity for support, such as GPs failing to identify mental health difficulties or make ongoing referrals for specialist mental health support, or less access to psychological treatment for Black service users when they had contact with mental health services, thus impacting access to supportive provision. These findings mirror research which has demonstrated that Black individuals are less prone than other ethnic groups to have their mental health difficulties identified by GPs and are less likely to be referred to specialist mental health services for support (Bhui et al., 2003; Grey et al., 2013; The Centre for Social Justice, 2011; Thomas et al., 1993). Early detection, intervention, and prevention strategies, which are essential for supporting mental health care appeared to be elusive for many Black service users in the current review. This lack of support at earlier stages led to worsening on of their mental health conditions, which resulted in more coercive treatments, therefore maintaining a cycle of service users being stuck in the system. This overall reinforced a cycle of mistrust and fear of the system. This is concordant with previous research reporting high levels of fear and mistrust amongst Black communities, thus impacting their relationship with mental health services (Henderson et al., 2015; Keating et al., 2002), and contributing to them having contact with services when they have reached crisis point. Similarly, existing literature supports a cycle of disempowerment and mistrust with services prompting a lack of acceptance or underutilisation of mental health services by Black service users (Devonport et al., 2023; Wallace et al., 2016).

The synthesis of studies made it evident that restrictive practices were frequently experienced among Black people, resulting in profound feelings of powerlessness, which were particularly heightened in inpatient contexts. These restrictive practices included forced antipsychotic injections, detainment, and sectioning under the Mental Health Act. This is in accordance with previous research that has documented these disparities with Black service users encountering high rates of restrictive practices (Ajnakina et al., 2017; Barnett et al., 2019; Bhui et al., 2018; Das-Munshi et al., 2018).

These coercive and oppressive treatments were described as traumatic and dehumanising, and the mental health system was seen as re-enacting such experiences participants had been subject to in other systems (e.g., in schools or the criminal justice system). Additionally, the experience of a lack of information that was shared with Black service users related to their difficulties, diagnoses, the role of medication, and treatment led to feelings of mistrust, fear of services, feeling stuck and powerless, and being controlled by the system. This lack of information sharing not only hindered their engagement and trust in services, but also reinforced their perception that professionals are the ‘experts’ and that their opinions are not heard or considered further contributing to feelings of powerlessness within the system. This mirrors previous research which shows a lack of involvement in treatment decisions and less person-centred care is prominent in interactions with healthcare professionals and Black service users (Hall et al., 2015).

The ’Breaking the Circles of Fear’ report by the Sainsbury’s Centre for Mental Health discusses the interplay between mental health services and African and Caribbean communities and the factors that contribute to the persistence of mental health racial inequalities (Keating et al., 2002). The findings from this report appears to replicate the findings in the current review and highlights the ongoing relevance of this model in understanding Black communities’ experiences and considerations for how services can improve provisions. These recommendations include building partnerships with community based organisations, service user involvement for developing responsive services, delivering early intervention, ensuring mental health services are accessible and integrated in Black communities and creating 'gateway agencies' to establish connections with statutory services and advocate for Black service users (Keating et al., 2002).

In addition, the current review highlighted other aspects that were important to participants but lacked in services, including not being involved or considered in their care and a lack of cultural competence in their experiences with services. This led to further feelings of powerlessness, fear, misunderstanding and a lack of trust with the mental health system. Participants described instances where their cultural, spiritual, and religious beliefs were often disregarded, and this left them feeling pathologised, misunderstood, and discriminated against. Additionally, Black service users expressed that professionals associated hearing voices with psychotic diagnoses and highlighted that they did not take trauma into account. Previous research has identified trauma as a significant risk factor for psychosis and underscored the significance of trauma-informed care (Wood et al., 2023). However, Early Intervention in Psychosis (EIP) services underutilise trauma-informed care guidelines, assessments, and treatment (Wood et al., 2023). Trauma-informed approaches involves the exploration of distressing voices and beliefs, emphasising the significance of personal and social meaning-making of these experiences and their connections to life stories (Rosen et al., 2017). Similarly to this review, previous studies have associated lower cultural competence with experiences of discrimination, cultural insensitivity, racial bias, poorer clinician-patient rapport, and worse quality of care for minority patients (Betancourt & Green, 2010; Cuevas et al., 2017; Penner et al., 2013).

There was also a resounding request to address systemic and social factors that interplay with mental health experiences. Participants highly valued practical support, such as assistance with housing, employment, or finances, which was associated with a more holistic and effective approach to mental health care. They highlighted the need for mental health services to recognise and engage with the broader societal and structural contexts which significantly impact participants wellbeing, therefore seeing an individual within their context, ‘beyond a sole mental health diagnosis’. This is consistent with previous literature highlighting African and Caribbean ethnic groups experience unfavourable outcomes across key social and health determinants (Mantovani et al., 2017) and social determinants can also be risk factors for mental health (Allen et al., 2014). The findings in the current synthesis underscore the significance of services offering a holistic approach that considers broader social and systemic factors.

Moreover, the review also highlighted critical factors for positive interactions with services, which contributed to Black service users 'feeling seen, heard, and understood.' Participants discussed several attributes that professionals exhibited, such as displaying genuine care, warmth, friendliness, and practicing active listening. These qualities provided a sense of being heard and understood by professionals and significantly impacted their overall engagement and experiences with mental health services. Factors viewed as enhancing their care included increased professional support and time, community engagement, and greater family involvement. Moreover, professionals fostering a friendly yet professional rapport by sharing personal information reduced power imbalances and humanised the interactions. Importantly, these positive experiences were predominantly expressed by participants attending an African-Caribbean resource centre, an ethnic-specific service. This service consistently demonstrated the aforementioned attributes that made participants feel seen and understood, and it provided more positive experiences compared to other statutory services. Furthermore, professionals from this context advocated for service users in other settings, such as inpatient facilities, where power imbalances between service users and professionals were commonly recognised (Cusack et al., 2018). Additionally, staff representation and ethnic diversity played a significant role in shaping positive experiences within the data. Participants felt a stronger connection and engagement with mental health professionals from Black and other ethnic minority backgrounds. Black staff, in particular, were noted for their unique ability to relate to participants' cultural and emotional experiences, fostering a sense of connection and understanding. Additionally, the physical presence of Black staff positively influenced participants' self-esteem and confidence, reducing the mental health stigma within their communities. This preference for healthcare professionals of the same ethnicity aligns with recurrent findings in the literature (e.g. Zestcott et al., 2016). Although, cultural matching can be problematic, for example in relation to confidentiality (Bignall et al., 2019), some studies have proposed that ethnic matching or consideration based on clients’ requests can enhance the duration of treatment engagement and improve outcomes among ethnic minorities (Aggarwal et al., 2016; Ali et al., 2017; Memon et al., 2016).

These findings suggest that ethnic specific services potentially foster trust and meaningful relationships, mitigate power imbalances, and offer more positive experiences for

Black service users. They underscore the importance of providing culturally competent and holistic approaches, which contrast with experiences of traditional statutory services. In line with the recommendations outlined in the 'Breaking the Circles of Fear' report, these findings carry significant implications for service provision (Keating et al., 2002). These include promoting co-production and fostering partnerships with Black community organisations, diversifying the workforce to enhance cultural representation, improving mental health professionals' cultural competence, and ensuring the availability of advocacy for service users (Keating, 2002). Cultural competence has been described as "the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)" (Campinha-Bacote, 2002, p. 181) and requires professionals to view it as an ongoing process rather than an achieved state. Previous research has linked enhancing cultural competence in healthcare professionals to a reduction in racial disparities and experiences of discrimination, and to more equitable and person-centered care (Betancourt et al., 2003; Brach & Fraserirector, 2000; Eken et al., 2021; Holden et al., 2014).

Furthermore, it is important to consider temporal dimensions when exploring the experiences of Black individuals with mental health services in the UK. The current review observed shifts in terminology over time, reflecting evolving societal awareness. Notably, the term 'microaggressions' emerged in a recent study conducted by Pilav et al. (2022), suggesting an increased recognition of subtle forms of discrimination. Moreover, recent movements, such as Black Lives Matter and cultural changes for example changes in attitudes towards mental health and societal recognition of the role of culture in mental health care (Mantovani et al., 2017), may influence how Black communities experience mental health services. Nevertheless, the present review underscored that, irrespective of temporal variations and the introduction of NHS initiatives targeting racial inequalities, Black individuals consistently reported similar experiences in their encounters with mental health services, regardless of when the research was conducted.

4.2. Future Research and Clinical Implications

Key areas for future development were highlighted in the current review. Black service users in the current review consistently detailed encounters with racial prejudice, discrimination, and a lack of cultural responsiveness within mental health services. It is imperative to conduct and evaluate trainings aimed at addressing racial inequalities to assess their efficacy in impacting the attitudes and clinical decision-making of mental health professionals, as well as their influence on the experiences of Black service users with mental health services. Moreover, the ethnic specific African-Caribbean resource centre was highly valued by participants as indicated in the findings of the current review (Secker & Harding, 2002b). Future research could further explore the value of ethnic specific services and consider how factors identified as contributing to the positive experiences in these settings could generalise to other services, particularly inpatient contexts where stark accounts of racism and discrimination were described.

Research indicates that to enhance mental health service experiences, it is essential to undergo a systemic transformation that incorporates service users' perspectives throughout service planning and implementation (Devonport et al., 2023). The qualitative data gathered in the current review plays a crucial role in reshaping and improving these services. GPs were identified as not recognising early indications of mental health symptoms or dismissing Black individuals' difficulties. Given the importance of primary care in the identification and management of mental health difficulties and how previous research has found GPs less likely refer Black individuals for specialist mental health support, this is suggested an essential setting for training on cultural competence and anti-racism intervention training. This holds true for mental health services as well, as the findings revealed a deficiency in the support provided to Black service users, with services failing to integrate essential elements such as community support, spirituality, cultural sensitivity, a holistic approach that recognises individuals beyond their diagnosis, addresses social and systemic factors and uses trauma-informed care approaches. The preference for healthcare professionals of the same ethnicity, emphasised in the current review, highlights the importance of diversity among mental health professionals. It is important to recognise confidentiality challenges in smaller communities and advocate for a system that allows individuals the choice of cultural or ethnic matching. Furthermore, ensuring adequate resource allocation and the availability of trained staff from diverse ethnic backgrounds in mental health services is essential. In addition, the review underscores the positive impact of culturally sensitive care on the experiences of Black individuals in mental health services. This warrants training implementations across mental health services to enhance clinicians' awareness, understanding, and responsiveness to diverse cultural backgrounds. The findings stress the crucial role of culturally sensitive care in improving engagement, breaking the cycle of mistrust, potentially leading to earlier service utilisation and less severe presentations at crisis point. Furthermore, the findings highlight the importance service user involvement and co-producing training and initiatives focused on anti-racism, cultural competence, and self-reflection about clinical practice. This could significantly enhance the mental health experiences and outcomes of Black service users.

4.4. Strengths and Limitations of the Current Review

This review is considered to have several strengths. A replicable and comprehensive search strategy was carried out using the Cochrane Guidelines (Higgins & Green, 2011) and the PRISMA statement (Page et al., 2021). Furthermore, an extensive evaluation of research rigor was implemented, and strict eligibility criteria were applied to minimise potential biases due to weak methodologies. Additionally, it is the first thematic synthesis of the author’s knowledge that explores Black people’s experiences of mental health services in the UK.

Nonetheless, limitations of this review should be noted. Firstly, 19 studies did not meet eligibility criteria and were excluded from the review, due to Black participant data not being clearly identifiable. Ethnicity was not reported separately to those from other ethnic minorities. Therefore, the voices and experiences of participants who identified as Black in those studies were not captured in the current review, potentially missing crucial information. Therefore, it is imperative for future research to define ethnicity to allow for further data to be included in future research related to Black service users specifically. Additionally, the current review only represents participants who were current or past mental health service users. Those who disengaged from mental health services did not have the opportunity to participate in these research studies, which could have meant that individuals with severe mental health presentations were not represented in the current review (Devonport et al., 2023) or factors might be missed from a group that received little or no support, limiting the ecological validity of findings. Additionally, the majority of included studies did not provide information about whether the relationship between the researcher and participants were considered. While it was essential to include these studies in the current review to ensure service users' voices and experiences were not missed or excluded, the lack of descriptions regarding this relationship introduces a potential limitation. It may lead to undisclosed author biases, impacting the overall reliability and interpretability of the findings. Furthermore, six of the 26 included studies primarily focused on barriers, challenges, or perceived experiences of injustice within mental health services for Black individuals. While the overall data highlighted frequent negative experiences, it is important to note that positive experiences may not have been fully captured, potentially due to the omission of positive experiences in the interview schedules of these studies.

Additionally, despite endeavours to search grey literature databases and examine citation references from the included studies, it remains possible that applicable studies may not have been identified. Furthermore, this review omitted non-English language publications, which could have resulted in language bias, leading to an underrepresentation and incomplete picture of the experiences of Black service users who do not speak English or where English is not their first language. A final noted limitation was that using 'Black' as a broad term may inadvertently overlook the diverse ethnic, cultural, and national identities within African and Caribbean communities (Aspinall, 2002). Additionally, the experiences of

UK-born Black individuals may significantly differ from those who migrated to the UK, posing a limitation in the reviewed studies. Most studies did not report participants' migration status, making it challenging to distinguish generations. Migration history, language, and cultural norms significantly shape mental health experiences, healthcare access, and exposure to racism. This poses a risk that the research may not fully capture these distinctions.

4.5. Conclusion

This review aimed to systematically explore Black service users’ experiences of mental health services in the UK. The synthesised findings of 26 studies paint a sobering picture of the clients’ views and experiences of persistent racial biases, discriminatory practices, and racism present within mental health services. These issues encompass not only overtly prejudiced attitudes but also ingrained stereotypes and systemic factors that hinder equitable treatment for Black service users. It also highlighted the importance of considering wider social and cultural factors to enhance care, sharing information to improve trust, addressing power and control within the system, and providing trauma-informed and culturally competent approaches. It is imperative that mental health services recognise and address these issues, striving for culturally sensitive care that actively dismantles harmful racial biases and fosters an environment of trust, support, and understanding, allowing service users to feel heard. Culturally responsive approaches that actively empower individuals, respect their agency, and address systemic biases are essential to breaking this cycle of disempowerment, particularly when delivering effective and responsive mental health care for Black individuals.

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Part 2: Empirical Paper

Addressing Inequalities in the Care of Black People with Psychosis: A Quantitative Study Evaluating the Impact of the ‘SEE ME’ Training on Mental Health Professionals

Abstract

Aims*:* Despite compelling evidence documenting racial disparities amongst Black mental health service users there are limited interventions aimed at addressing racial inequalities. The ‘SEE ME’ training was co-produced by Experts by Experience (EBE’s) and mental health professionals and aims to improve the care of Black service users with psychosis in the UK. It involves the viewing of a co-produced film and engaging in reflective tasks. The study aimed to quantitatively evaluate the impact of the ‘SEE ME’ training on mental health professionals working in Early Intervention Psychosis (EIP) services. A further aim of the study was to investigate the possible impact of mental health professional’s ethnicity on the variables of interest.

Method: Seventy mental health professionals working in EIP NHS services across four ethnically diverse boroughs in London participated in the study. Participants completed the Race Implicit Association Test (IAT; Greenwald et al., 1998), the Cultural Competence Assessment Tool (CCAT; Papadopoulos, 2001), the Reflective Functioning Questionnaire - 8 item version (RFQ-8; Fonagy et al., 2016), restrictive practice recommendations using clinical vignettes and commitment to address racial inequalities before and after the training. A measure of social desirability was also completed at baseline (SDRS-5; Hays et al., 1989).

Results: Overall, the ‘SEE ME’ training resulted in significant improvements in cultural awareness and commitment to addressing racial inequalities. The training did not significantly change unconscious racial bias, self-reflection about the role of one’s own ethnicity, feelings of discomfort discussing the inequalities Black people face, mentalising capacity, and the likelihood of recommending restrictive practices.

Conclusions: This is the first study to quantitatively evaluate the impact of mental health professionals attending the ‘SEE ME’ training. The training improved cultural awareness and commitment. Further implementation and evaluation of the training is recommended.

1. Introduction

1.1. Racial Disparities

Health inequalities in the UK among Black and Minority Ethnic (BME) individuals have been reported for decades (Bagley, 1971; Cochrane & Bal, 1989; Kiev, 1965; Van Os et al., 1996). BME communities experience poorer mental health treatment and outcomes compared to their White counterparts, with Black individuals facing the most pronounced adversities (Bhui et al., 2003; Care Quality Commission, 2011; Commander et al., 1997; Kapadia et al., 2022; Keating et al., 2002; Morgan et al., 2005; Nazroo et al., 2020; Raleigh et al., 2007).

BME individuals, particularly those of Black Caribbean, Black African and Black British backgrounds, are more likely to be diagnosed with severe mental illness, encounter elevated rates of police and criminal justice system interactions, increased psychiatric hospital admissions, reduced voluntary in-patient care, and decreased primary care interventions (Ajnakina et al., 2017; Barnett et al., 2019; Bhui et al., 2003; Grey et al., 2013; Halvorsrud et al., 2018; Singh et al., 2007). Black service users are also subjected to higher rates of restrictive practices compared to their White counterparts, including a greater frequency of compulsory detention under the UK Mental Health Act (Barnett et al., 2019; Halvorsrud et al., 2018; Weich et al., 2017), extended periods of compulsory hospitalisations and re-admissions (Ajnakina et al., 2017), and a significantly elevated likelihood of being prescribed antipsychotic injections (Das-Munshi et al., 2018).

Hypothesised factors contributing to the disparities in higher rates of detention and psychosis diagnoses among Black and African Caribbean service users include differences in symptomatology, institutional racism, perceived racism, differences in attitudes toward mental health services, beliefs about mental illness, help-seeking behaviour, and a greater incidence of social determinants and adversity (Bhui et al., 2021; Mann et al., 2014; Morgan et al., 2008, 2014; Zahid et al., 2023). African Caribbean men experiencing their first episode of psychosis (FEP) had detention odds more than 3.5 times higher than their White British counterparts, while Black African patients experienced odds exceeding four times higher (Morgan et al., 2005). In a study examining longitudinal outcomes following contact with mental health services for psychosis, individuals of Black ethnicity had longer inpatient stays, elevated rates of compulsory admissions, and heightened police involvement during or shortly before psychiatric hospital re-admissions when contrasted with individuals of White British ethnicity (Ajnakina et al., 2017).

1.2. Black Service Users’ Experiences of Mental Health Services

Not only do Black service users face discrimination from mental health services, their experiences, and expectations of racist mistreatment within mental health services constitute significant barriers to their timely access to these services, thereby maintaining mental health disparities (Mclean et al., 2003). These individuals reported immediate labelling of racial stereotypes with terms, such as “mad”, “aggressive” and “dangerous (Hui et al., 2021; Lawrence et al., 2021a; Secker & Harding, 2002a), as well as swift diagnoses of psychotic related conditions (Schofield et al., 2019). Research involving Black experts by experience and with caregivers has highlighted a lack of consideration for the specific needs of black individuals within mental health services, contributing to feelings of powerlessness among Black service users (Lawrence et al., 2021a).

Coercive practices associated with involuntary hospital detention are often experienced as traumatising, intensifying existing racial trauma (Hennessy et al., 2023). Additionally, reports of racism have emerged concerning the type of treatment offered to Black service users, including instances where psychological therapy was denied, and instead, they were prescribed antipsychotic medication or subjected to physical restraint for antipsychotic injections (Secker & Harding, 2002a, 2002b). Furthermore, mental health services frequently fail to provide clear explanations of mental health conditions to service users, involve them in care-related discussions (Lawrence et al., 2021a), or offer information about the role of medication and potential side effects (Bowl, 2007; Secker & Harding, 2002a). Black service users have repeatedly expressed a sense of powerlessness, a feeling of not being heard, perceptions of being controlled by mental health services, and fear and mistrust towards services (Chakraborty et al., 2009; Keating & Robertson, 2004; Lawrence et al., 2021a). Furthermore, narratives underscored the insufficient consideration of diverse spiritual and cultural factors related to mental health within these services (Schofield et al., 2019) . Consequently, there have been calls for the development of innovative collaborative models that prioritise holistic and person-centred care (Islam et al., 2015) .

Early Intervention in Psychosis (EIP) Services have been established to improve accessibility and deliver evidence-based care within community settings, with the goal of decreasing the duration of untreated psychosis and ensuring consistent treatment through robust service engagement during the initial stages of psychosis (Islam et al., 2015; Tait et al., 2003). Nevertheless, disparities persist for Black service users within these settings. Given that EIP Services often serve as the first point of contact for individuals facing psychosis, they present a crucial starting point for anti-racism training.

1.3. Contributors to Racial Disparities

1.3.1. Racial Bias

Implicit and explicit biases have been noted as two significant contributors to racial disparities in healthcare access and outcomes (Fincher et al., 2004; Green et al., 2023; Hall et al., 2015; Liu et al., 2022; Maina et al., 2018; Nelson, 2003; Zestcott et al., 2016). Explicit biases are conscious convictions that individuals are aware of and can be readily expressed via self-report (Dovidio et al., 2002; Greenwald & Mahzarin, 1995). However, self-report measures have reduced accuracy in predicting outcomes linked to socially sensitive topics, where individuals may unconsciously or consciously portray themselves more favourably (Greenwald et al., 2009; Holtgraves, 2004; Maina et al., 2018). Therefore, assessment tools that overcome socially desirable responding are needed. Implicit biases are thoughts and feelings that operate unconsciously (Hall et al., 2015), resulting in a negative appraisal of an individual based on characteristics for example race (Fitzgerald & Hurst, 2017). Unlike overt discrimination, implicit bias may subtly influence clinicians' assessments and decision-making, service users' experiences of the healthcare providers and care quality (Sabin et al., 2009). Individuals can explicitly report that they do not have racial preferences while still showing racial preferences on implicit measures (Fazio et al., 1995; Nosek et al., 2007; Röhner & Lai, 2021). This is in line with the aversive racism theory, which suggests that racial prejudice functions implicitly (Hodson et al., 2002). Hence, when evaluating prejudices and stereotypes, it is important to incorporate assessments for both implicit and explicit biases.

1.3.2. Unconscious Racial Bias: Negative Associations

The most widely utilised and validated tool to assess implicit racial bias is the IAT (Greenwald et al., 1998; Hall et al., 2015; Maina et al., 2018). It has higher reliability compared to self-report measures and is less susceptible, though not entirely impervious to intentional faking (Greenwald et al., 2003, 2009; Nosek et al., 2005, 2007). The IAT is a computerized categorization task in which participants sort stimuli (e.g., pictures, names, and words) into opposing categories as quickly and as accurately as possible. A systematic review concluded that there is compelling evidence for a relationship between unconscious racial bias and adverse outcomes in clinical interactions (Fitzgerald & Hurst, 2017) including associations with inferior communication, reduced care quality (Cooper et al., 2012), impacted treatment decision-making (Green et al., 2007), and diminished ratings for patient-centred care among Black patients (Blair et al., 2013). These findings have been replicated among mental health professionals (Katz & Hoyt, 2014). Systematic reviews consistently report a pro-White/ anti-Black bias in a range of settings among White healthcare participants including physicians and medical students (Maina et al., 2018). Findings among Black participants instead suggested a slight pro-Black (Pennington et al., 2023), no racial bias (Sabin et al., 2009; Weinstock, 2012) or a slight pro-White bias (Haider et al., 2014; Pennington et al., 2023). Findings among Asian participants were mixed, with some findings indicating they exhibited no racial bias (Hagiwara et al., 2013, 2016; Penner et al., 2010) and others showed slight to moderate pro-White racial bias levels that are comparable to those of White respondents (Cooper et al., 2012; Haider et al., 2011, 2014; Pennington et al., 2023; Sabin et al., 2009; Weinstock, 2012).

1.3.3. Attitudes and Decision-Making

In Fitzgerald & Hurst (2017) systematic review the authors emphasised the importance of assessing changes in real-world quality of treatment alongside improvement on healthcare providers' unconscious bias to ensure that interventions lead to behavioural changes in mental health professionals that benefit service users. Most studies used clinical vignettes to explore the impact of patient characteristics on clinician's attitudes, diagnoses, and treatment decision making (Green et al., 2007; Haider et al., 2011; Sabin & Greenwald, 2012). Vignettes are fictional stories, they are considered a non-threatening and objective way to reveal explicit attitudes (Barter & Renold, 1999; Lapatin et al., 2012; Schoenberg & Ravdal, 2000). A vignette study used to explore racial bias amongst psychiatrists in the UK, revealed that African-Caribbean vignette protagonists were perceived as potentially more 'violent' than their White counterparts (Lewis et al., 1990). The content of the clinical vignettes was the same, the only variation was the ethnicity of the patients depicted. Vignettes are a viable and suitable methodological approach for research related to investigating mental health disparities and examining professionals' decision-making (Evans et al., 2015; Lapatin et al., 2012). Furthermore, research studies have demonstrated their correlation with real-life behaviour (Kirwan et al., 1983; Langley et al., 1991; Peabody et al., 2000; Shah et al., 2007; Veloski et al., 2005).

1.3.4 Cultural Competence

Cultural competence is considered crucial for providing culturally sensitive care and improving patient experiences and interactions. Campinha-Bacote's model of cultural competence in healthcare delivery serves as a framework for healthcare providers to foster and apply culturally receptive services (Campinha-Bacote, 2002). This model describes cultural competence as “the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)” (Campinha-Bacote, 2002, p. 181) and necessitates professionals to perceive it as an evolving process rather than an achieved state. It has been recognised as a variable associated with reducing racial disparities by decreasing instances of discrimination and inequality in healthcare (Betancourt et al., 2003; Eken et al., 2021).

1.3.5. Perspective Taking

Improving perspective taking abilities has been identified as one of the important factors that contributes to reducing racial prejudice (Berthold et al., 2013; Burgess et al., 2007; Dovidio et al., 2004; Galinsky & Moskowitz, 2000; Johnson et al., 2017; Ricks et al., 2021; Todd et al., 2011, 2012). It involves cognitive and perceptual processes that enables insight into another individual’s psychological experience (Bartle, 2021), and during this process mentalising is employed. Mentalising or reflective functioning is defined as “the capacity to interpret both the self and others in terms of internal mental states such as feelings, wishes, goals, desires, and attitudes” (Fonagy et al., 2016, pg. 1). Interventions focused on perspective-taking in medical and nursing students efficiently reduced racial disparities in pain management recommendations and improved clinical skills, as indicated by higher patient satisfaction ratings (Blatt et al., 2010; Drwecki et al., 2011).

1.4. Anti-Racism Interventions in Healthcare Settings

Whilst there is persistent and compelling evidence documenting disparities in the treatment of Black service users, there has been limited research evaluating targeted interventions aimed at mitigating these inequalities (Hassen et al., 2021). Hassen and colleagues (2021) conducted a scoping review on existing anti-racism interventions carried out in healthcare contexts and proposed a conceptual model with key principles for carrying out anti-racism interventions. This included clearly defining the problem and setting up clear goals and objectives, establishing shared anti-racism terminology, having leadership support and commitment, allocating specialised resources, funding, and engaging the appropriate expertise and support, and evaluating and monitoring the interventions. Furthermore, a multi-level approach that includes organisational and policy level interventions is essential for sustained change with meaningful community and service user collaborations with Black, Indigenous and racialised communities. Additionally, offering continuous and mandatory staff trainings that are designed for specific settings and professional roles at an individual level are important, such as engaging in self-reflection exercises and completing IATs (Hassen et al., 2021). Moreover, the authors argue that without a steadfast commitment to incorporating anti-racism work created by racialised people, healthcare systems will persist in generating and perpetuating harm (Hassen et al., 2021).

Five out of 37 studies included in the aforementioned review explicitly focussed on anti-racism interventions for Black people, and only three of these studies were empirical papers that evaluated anti-racism interventions (Bennett & Keating, 2008; Shultz & Skorcz, 2012; Steed, 2010). Interventions that were evaluated included a 6-hour cultural competence training (Steed, 2010) , a 2.5 day undoing racism workshop that provided sociohistorical context for racism (Shultz & Skorcz, 2012), and a study that reviewed race-related trainings in the UK (Bennett & Keating, 2008). They were carried out on a range of healthcare providers including occupational therapists (Steed, 2010), medical providers, organisational leaders, teachers, social workers, non-clinical healthcare professionals (Shultz & Skorcz,

2012) and a range of stakeholders including NHS mental health trusts, primary care, and independent sector inpatient mental health services (Bennett & Keating, 2008). Findings varied, with a mixed method design using qualitative and quantitative data suggesting that participants held strong negative attitudes towards African American service users that were not ameliorated after the training (Steed, 2010). A study employing qualitative methods indicated that an intensive anti-racism intervention may impact professionals' beliefs, attitudes, knowledge, workplace environment for diverse communities, and have an organisational influence on how to approach strategies related to addressing racial disparities (Shultz & Skorcz, 2012). However, survey responses in this study were only collected post-training, therefore it was not possible to determine whether changes reported were a result of the workshop or if they were influenced by other factors. Bennett & Keating (2008) concluded that while most mental health services offered staff race equality training, a lack of rigorous evaluations of their effectiveness were evident.

1.4. The 'SEE ME' Training

The 'SEE ME' training was developed to address the challenges outlined in the NHS 'Advancing Mental Health Equalities Strategy' (NHS England, 2020). The framework signifies the most substantial transformation in mental health services over many years highlighting the importance of individualised and trauma-informed care, that is person-centred and holistic, with an emphasis on reducing health disparities and the importance of co-production. It was part of a wider service development initiative by the North-East London NHS Foundation Trust (NELFT) to tackle racial inequalities within Early Intervention in Psychosis (EIP) services across four London boroughs. Therefore, EIP leadership agreed it to be a mandatory training for staff. The decision to produce this training was guided by recommendations from the NELFT Black and Ethnic Minority Experts by Experience (EbE) group to address racial and ethnic disparities and enhance the care that is provided to Black communities. The recommendations included: co-production with service users, community psychology approaches, ongoing feedback and dissemination and improvements in cultural humility, specifically related to spirituality. The ‘SEE ME’ training was co-produced with EbEs (Black service users with psychosis) and with mental health professionals and consisted of a film, followed by reflective tasks (1hr 30 minutes in total). The workshop was designed to be delivered to mental health clinical staff with a range of professional backgrounds, i.e.: nurses, clinical psychologists, psychiatrists, occupational therapists, and social workers.

The 'SEE ME' training was individually delivered to each of the four EIP teams, each serving diverse populations in separate London boroughs. An additional training date was offered for professionals who had been unable to attend their own team training day. The ‘SEE ME’ workshop was facilitated by Clinical Psychologists (working in NEFLT EIP and supervising DClinPsy theses evaluating SEE ME training) and Trainee Clinical Psychologists (on placement in NELFT or conducting their DClinPsy theses linked to SEE ME but not involved in its evaluation). The facilitators were mindful of offering a safe, non-judgmental, and containing space for participants to discuss difficult issues. Additionally, it was important to recognise that the mental health professionals were from a range of ethnicities and that the personal stories that were shared in the training may have resonated and had an impact on them. Participant staff may also have been unaware of the notion that the service is considered a contributor to racism therefore throughout the training, and after the completion of outcome measure, it was emphasised that the research team were available to provide support or sign-posted if required.

The 20-minute film featured four EbE’s from Black African and Caribbean ethnicities (two male, two female) who shared their stories in video testimonials to highlight the dangers of a single story (see appendix A for the ‘SEE ME’ film link). “*The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story”* (Ngozi Adichie, 2009). The writer also states that “*power is the ability not just to tell the story of another person, but to make it the definitive story of that person*” (Ngozi Adichie, 2009). Furthermore, a narrative framework was used as it has been hypothesised to address simplistic racial stereotypes such as overestimation of dangerousness and criminalisation (Lewis et al., 1990; Ngozi Adichie, 2009) by offering more realistic and richer narratives about Black people (Ngozi Adichie, 2009). In the “SEE ME’ film the EbEs told their stories, they discussed who they were beyond their diagnosis of psychosis, what was important to them (e.g., family, hobbies), what being Black meant to them, their experiences of psychosis, and the treatment they had encountered as Black mental health service users. Following this, a scene depicted EbE individuals and three mental health professionals engaging in a group discussion. During this discussion, they reflected on their experiences with mental health services, discussing both the positive and negative aspects and conveying key messages that mental health services should consider in their interactions with Black service users (for example, communication, providing explanations about diagnoses and medications).

The training proceeded with professionals engaging in three reflective tasks (lasted 65 minutes overall) that were designed to invite reflection and committed action (see appendix B). The initial task invited professionals to write down emotional responses, words or images evoked by the film. They were then invited to individually reflect on key messages from the film that they took away, and how these messages resonated with their personal and professional identities, considering more or less visible aspects of their identities (20 minutes). This was followed by a small group task (2-3 clinicians) whereby they were asked to reflect on prompting questions with a client from a racial background in mind with whom they had encountered difficulties with establishing a relationship. The questions revolved around reflecting on the clients' narratives, mentalising with the client to understand what they might have wished the professional to understand or know about them, identifying any additional information from the client's perspective that could aid in their work, and exploring how insights from the film could enhance this (20 minutes). The final task was a larger group exercise (4-6 professionals) that required the professionals to discuss learning points from the training, specific examples of how they would bring their clients’ rich stories into their everyday work, at an individual and team level, and the first steps they would take forward both individually and as a team, and how they would keep the conversations going at a team level (25 minutes).

The foundations of this training are rooted in the social identity theories of bias and discrimination. These approaches aim to diminish prejudice by tackling the cognitive and emotional mechanisms associated with how individuals perceive and interact with their own social group (Dovidio et al., 2005). Prejudice frequently emerges when individuals categorise themselves as members of an ingroup (mental health professionals) and others as members of an outgroup (Black service users with psychosis) (Tajfel & Turner, 1979). The theory proposes that to mitigate prejudice, interventions should focus on diminishing the prominence of group categories and highlighting shared humanity and commonalities among individuals, thereby diminishing the "us vs. them" mindset (Bigler & Liben, 2006). The 'SEE ME' training employs personal stories highlighting individual differences rather than stereotypes to promote de-categorization.

The training was informed by a systematic review that discussed the implementation of anti-racism interventions in healthcare contexts (Hassen et al., 2021), and by identifying strategies for reducing racial disparities in previous research. The areas of focus in the training included:

1. Participating in self-reflection exercises to facilitate awareness of unconscious racial bias and stereotypes (Sukhera et al., 2020; Zestcott et al., 2016)
2. Perspective-taking to promote understanding and empathy (Bartle, 2021)
3. Enhancing awareness of the social and systemic factors that impact health outcomes (Holm et al., 2017)
4. Establishing clear trajectories and goals (Fraser & Barenboim, 2022; Hassen et al., 2021)

Based on the targets of the training, and the factors previous research has implicated as contributing to racial disparities (see section 1.3.), the current study considered the following outcomes as important to evaluate: unconscious racial bias, cultural competence, mentalisation, clinical decision-making related to coercive practices and commitment to addressing racial inequalities. Additionally, participants' feedback and acceptability of the training was collated and will be reported elsewhere[1].

1.5. Study Aims and Hypotheses

This study aimed to evaluate the immediate impact of the 'SEE ME' training on hypothesised mechanisms of change that may influence the long-term outcomes of the service evaluation (i.e., reduced involuntary admission and increased psychology engagement). Specifically, the study aimed to evaluate the impact of the training on mental health professionals' unconscious bias, cultural competence, mentalising capacity, clinical decision making around restrictive practices and commitment to addressing inequalities for Black service users with psychosis in EIP. Additionally, an exploratory analysis aimed to investigate the possible impact of mental health professionals' ethnicity on the variables of interest.

Aims and hypotheses:

***a)* Main aim**: Evaluating the impact of the SEE ME intervention on a range of implicit and explicit measures. Hypotheses:

Primary outcome: *Unconscious racial bias*

- Hypothesis 1: At baseline mental health professionals will be more likely to associate positive attributes with White and negative attributes with Black people.

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[1] The analysis for this is ongoing and is being conducted at service level to inform future implementation.

- Hypothesis 2: Mental health professionals implicit bias against Black will reduce post-training.

Secondary outcomes:

Cultural competence:

- Hypothesis 3: Cultural competence (awareness, knowledge, sensitivity and practice) will improve post- training.

Mentalising capacity:

- Hypothesis 4: Reflective functioning will improve post training.

Clinical decision making about restrictive practices:

- Hypothesis 5: Pre-training participants will be more likely to recommend restrictive practices when the clinical vignette protagonist with psychosis is Black than when the protagonist is White (Main effect of ethnicity (in between subjects)).
- Hypothesis 6: 'SEE ME' training impact: an interaction is predicted whereby the likelihood of recommending restrictive practices for the Black protagonist vignette will reduce post-training compared to pre-training (and remain the same for White protagonist vignette pre-post training). Therefore, no predicted differences in restrictive practice recommendations are predicted post-training between the White and Black protagonist vignettes.

Commitment to addressing inequalities:

- Hypothesis 7: Commitment to addressing inequalities for Black service users with psychosis in EIP will increase post SEE ME training.

b) Exploratory Evaluation: In addition to the main aim evaluating the overall impact of the SEE ME training, an exploratory analysis using data visualisation will be used to examine if there are pre and post training differences on unconscious bias, cultural competence, reflective ability, clinical decision making and commitment to addressing inequalities associated to the ethnicity of the mental health professionals participating in the study.

2. Method

2.1. Study Design

The study employed a pre-post test experimental design to (a. Main aim) as well as exploratory analysis (b. Exploratory aim), with random assignment to the White or Black protagonist clinical decision-making vignettes. Hypotheses 1 and 5 (a. Main aim) utilised a cross-sectional, between-subjects design solely at baseline.

The independent variables were the timepoints (pre and post the intervention) and the dependant variables were variables of unconscious bias, restrictive practices in clinical decision-making, cultural competence, mentalisation, and commitment to addressing racial inequalities (all treated as continuous). Additionally, cultural competence classifications were treated as categorical data.

2.1.1. Participants

Mental health professionals were recruited across four Early Intervention in Psychosis (EIP) NHS services in London. Inclusion criteria were mental health professionals who were qualified or in training (i.e., nurses, psychologists, psychiatrists, occupational therapists, social workers) working in NELFT EIP either in a paid or honorary capacity. Only participants who were attending the ‘SEE ME’ training day were eligible for the current study. They also had to be aged 18 or over and have sufficient English fluency. Individuals were excluded from the study if they had previously actively involved in the co-production and development of the ‘’SEE ME’ training or if they were professionals who did not work in a clinical role (e.g., administration). The questionnaires underwent a pilot with administrators. Based on the feedback received, it was determined that they were not suitable for completion by non-clinical staff as some of the measures focussed on clinical decision making. Consequently, the decision was made to exclude non-clinical professionals from participating in the current study.

2.1.2 Sample Size and Power Analysis

This study was part of a wider service development project which was carried out in NELFT, which expected 80 mental health professionals working across the services to attend the training. Therefore, the maximum number of potential participants that could have been invited to take part in the study was 80.

Limited research exists using the range of outcomes selected to evaluate racial inequalities trainings, therefore the power calculation focussed on data available for the primary outcome, the race Implicit Association Test (IAT). Power analysis for this study was informed by prior work from Sabin et al., (2008) using a paired samples t-test. In this study the authors used the race IAT to assess implicit racial attitudes and stereotypes in a population of paediatricians and found an effect size of d=0.41 (small). Assuming equal group sizes power calculation was carried out using the “G*Power 3” computer program (Faul et al., 2007), specifying alpha = 5% and desired power = 80%. The required sample size was calculated as 49 (49 participants pre-training, and the same 49 participants post-training), this which was deemed to be within the resources of the study. This sample size would also permit an exploratory analysis of the secondary aim, which examines the impact of participants' ethnicity on outcomes.

IAT pre-post data was available for 66 participants. The achieved power of the current study for the unconscious bias variable was 45.4%.

2.1.3. Ethics

The study was granted ethnical approval by the UCL Research Ethics Committee (Reference: 24629/001) (see Appendix C). Prior to taking part in the research, participants were informed of the rationale for undertaking the research and they were fully informed about the study's procedure. It was emphasised that their participation was voluntary and that they had the right to withdraw from the study at any time without requiring an explanation. They were additionally informed that if they decided not to take part in the current study, this would not prevent them from completing the 'SEE ME' training. Informed consent was obtained from all participants preceding their participation in the research. To ensure confidentiality the researcher emailed participants an anonymised questionnaire link via Qualtrics, this was distributed through a contact list which was external to the survey. A random number was generated for each respondent and pulled into the second survey allowing for the pre-post data to be automatically recorded in pairs.

The researcher was present for the post-training administration of the questionnaires. Due to the sensitive nature of the study participants were offered support after completing the outcome measures. The researchers contact details and signposting for local support services were also provided.

2.2. Procedure

2.2.1 Participant Recruitment

All professionals working in EIP services in NELFT were asked to attend the 'SEE ME' training as part of a wider service development initiative. Approximately one month prior to the planned date for the 'SEE ME' training event, mental health professionals working in EIP NELFT were informed about the study. The study advert (see appendix D) and information sheet (see appendix E) were shared with all team members via internal email. The information sheet detailed exactly what the study involved, what was required of participants, the research team's contact details and signposting contact details for support services. Additionally, the research team attended team meetings to provide mental health professionals with an overview of the research, and to give potential participants the opportunity to ask any questions that may have arisen. They were also invited to contact the researcher via telephone or email if they required any further information or had any questions. Those who expressed interest in the research were given at least 24 hours to consider their participation before the consent form was shared with them.

2.2.2. Overview of Evaluation Procedure

Informed consent was obtained via Qualtrics, see appendix F for the consent form at least 24 hours after participants had received the information sheet. Participants were invited to complete online questionnaires at two time-points, pre and post the ‘SEE ME’ training. The lead researcher (MM) facilitated the administration of the online questionnaires via an anonymised Qualtrics link. One week prior to the training participants were invited to complete pre-assessment measures (30 minutes). Pre-arranged time slots were arranged with the four teams where the lead researcher (MM) for participants to complete questionnaires during these slots if they wished to ensure technical support was available if needed. Those who were unable to attend this timeslot were invited to complete the pre-training questionnaires in their own time prior to the ‘SEE ME’ training day. Following the ‘SEE ME’ training, participants were invited to complete post-training measures and a feedback form using an online Qualtrics link (30 minutes) (see details of the evaluation procedure in Figure 1 below). The data was collected across the five ‘SEE ME’ training events. The lead researcher (MM) attended all the training events to administer online questionnaires and to provide any technical support, however she did not facilitate the trainings to minimise potential bias on participants responses.

Upon completion of the post-training measures participants were offered to be individually entered into a prize draw for £50. Additionally, the four teams were offered £50 each for their team’s participation in the study. This was decided in consultation with EIP mental health professionals when planning the study. Additionally, they were given the opportunity to opt in to providing their contact details to the research team, which was stored securely, for dissemination purposes and to opt in if future studies are carried out. All participants were given a debrief sheet (see appendix G) with sources of support if they felt distressed by the participation. Additionally, they were reminded that they could contact the research team if they required further guidance.

Figure 1

Overview of Evaluation of the 'SEE ME' Training Procedure.

Approx. 1-month prior to SEE ME training	Informed consent (at least 24 hours later)	Pre-training (1 week prior)	'SEE ME' training day	Post- training (same day)
• Information about the study shared with potential participants • Information sheet shared	• Informed consent if willing to take part • Assigned anonymised link via Qualtrics • Random allocation to vignette condition (Black/White ethnicity) assessment task	Pre-training measures (30 min): • Demographics • Clinical decision making (vignette) • Unconscious bias • Mentalisation • Cultural competence • Commitment • Social Desirability	Viewing of film (20 minutes) followed by engaging with three reflective tasks (65 minutes)	Post- training measures (30 min) • Clinical decision making (vignette) • Unconscious bias • Mentalisation • Cultural competence • Commitment • Feedback

2.3. Measures

2.3.1. Demographic Form

Participants demographic characteristics were collected (see appendix H), this included information related to age, gender identity, ethnicity, professional role, and length of time working in mental health services.

2.3.2. Primary Outcome Measure

Unconscious bias: The Implicit Associations Test (IAT; Greenwald et al., 1998) is a well validated computerised categorisation task that was used to measure implicit biases and stereotypes. The Race IAT determines the relative strength of associations by examining the speed with which people sort Black/ White facial images with pleasant/ unpleasant words. The stimuli and images used in the current study were used in a previous study (Nosek et al., 2007). See appendix I for the categories and items used and example pairings used in the Race IAT. Items such as 'joy', 'love', 'laughter' represented good categories and items such as 'terrible', 'agony' and 'failure' represented bad categories. The Race IAT consisted of seven blocks which followed the subsequent sequence: two 20-trial single categorisation practice blocks (e.g. Black versus White; Good versus Bad), 20 trial combined categorisation black (e.g. Black versus White and Good and Bad), 40 trial combined categorisation block, 40-trial single categorisation black and two additional combined categorisation blocks(one consisting of 20 and the other consisting of 40 trials) (Nosek et al., 2005; Xu et al., 2014). The Race IAT was programmed to Qualtrics using a free survey software, iatgen, following the procedure outlined by Carpenter et al., (2019). The IAT D-score was obtained by calculating the difference in average response time on the sorting task, with scores ranging between -2 and +2 (Greenwald et al., 2003). The results were categorised into the following groups: scores ranging from 0 to 0.14 represented the absence of racial bias; scores from 0.15 to 0.34 indicated a slight pro-White bias; scores from 0.35 to 0.64 suggested a moderate pro-White bias, while scores exceeding 0.65 reflected a strong pro-White bias. Conversely, negative scores of the same magnitude corresponded to equivalent categories of pro-Black bias (Greenwald et al., 2003; Maina et al., 2018). The categories slight, moderate and strong correlate with Cohen's *d* small, medium, and large effect sizes (Cohen, 1977; Greenwald et al., 2003).

2.3.3. Secondary Outcome Measures

Cultural competence: The Cultural Competence Assessment Tool (CCATool; Papadopoulos, 2001) was administered to assess cultural competence (see appendix J). It consists of four sections (awareness, knowledge, sensitivity, and competent practice) with 40 statements in total taking approximately 5 minutes to complete. Participants were asked to rate their responses to the statements on a 4-point scale (1=completely disagree, 2=disagree, 4=agree, 5=completely agree). This measure has been validated for use amongst mental health practitioners in the UK (Papadopoulos et al., 2004), with Cronbach's Alpha established reliability coefficients exceeding 0.80. Vasiliou et al., (2013) reported good internal consistency and good test-retest reliability on this measure. Scoring was carried out using the author's scoring instructions that were electronically sent to the researcher by the author. Each section was scored out of 10 (correct statements = 1 and incorrect statements = 0). Additionally, the CCATool was used to categorise participants into levels of competence: 'culturally competent' (score of 10 across all four sections), 'culturally safe' (score of five or more in the cultural awareness section, and the four generic statements across the other sections are correct), 'culturally aware' (score of 5 or more in cultural awareness section, regardless of the four generic statements in the other sections being accurate), and 'culturally incompetent' (score of less than five in the cultural awareness section, regardless of scores across the other sections).

Mentalisation: Reflective Functioning Questionnaire (RFQ; Fonagy et al., 2016) eight item version was used to assess mentalisation (see appendix K). The questionnaire comprises of two subscales the Certainty about Mental States (RFQ_C) which assesses hyper-mentalising and is represented with items such as “I don’t always know why I do what I do” and the Uncertainty about Mental States (RFQ_U) which evaluates hypo-mentalising is captured by items such as “Sometimes I do things without really knowing why”. Participants are asked to rate responses on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). The items were scored following the scoring procedure outlined in the original paper (Fonagy et al., 2016). RFQ_C subscale was rescored as 3,2,1,0,0,0,0 (3=strongly disagree and 0= strongly agree), high scores on this subscale demonstrated hyper-mentalising and low scores indicated genuine mentalising. The RFQ_U subscale was rescored as 0,0,0,0,1,2,3 (0 represents strongly disagree and 3 represents strongly agree) with high scores indicating hypo-mentalising and low scores demonstrating genuine mentalising. The questionnaire has good reliability and validity (Anis et al., 2020; Fonagy et al., 2016).It is considered to be a research tool, therefore currently there is no validated clinical cut off for its subscales. It takes approximately three minutes to complete.

Restrictive practices: Clinical Decision-Making Vignette was used to assess the likelihood of clinicians recommending restrictive practices to service users by eliciting unconscious biases, stereotypes, and decision-making processes from responses to the scenarios (see appendix L). Two versions of the vignettes (one version for pre-training, and another version with the same constructs for post-training) were randomly allocated to participants, manipulating only the race of the vignette protagonist. Participants were asked how much they agreed or disagreed with statements related to implementing restrictive practices on a sliding scale from 0-100. Total scores ranged from 0-700 with higher scores indicating more restrictive practice recommendations and less awareness of the person's feelings.

The vignettes were developed specifically for this study based on existing guidelines in the literature for creating vignettes related to assessing clinicians' decision-making (Evans et al., 2015; Heverly et al., 1984). The following steps were carried out: (1) the constructs of interest were identified by conducting a literature search on existing racial disparities within mental healthcare and based on the authors clinical experience, (2) Components of the vignettes were then developed using the relevant literature, and in consultation with three EbE's and three mental health professionals to ensure the vignettes were realistic, (3) The vignettes were then finalised by two supervisors who have significant experience in the field of psychosis to improve the clarity and validity of the vignettes (Gould, 1996; Lauder, 2002; Veloski et al., 2005), (4) The final vignettes were then piloted by mental health professionals (See section 2.2.3.5. patient and public involvement and piloting for details).

Commitment to Addressing Inequalities Questionnaire was specifically designed for this study to measure commitment, efficacy, awareness, and confidence in addressing inequalities (see appendix M). Participants were asked to rate their responses to statements on a 7-point Likert scale (from 1 = 'strongly disagree' to 7= 'strongly agree'). The statements included (1) I understand the impact of existing inequalities on Black people in EIS; (2) I feel confident talking about the inequalities black people face; (3) I feel discomfort when discussing existing inequalities that black service users face ;(4) I am aware of the impact of my own ethnicity/ identity when working with Black people; (5) I have a rich view of Black service users with psychosis in EIS; (6) I feel confident in how to create a supportive experience for Black people with psychosis; (7) I am committed to addressing inequalities for Black service users in EIS. The questionnaire takes approximately two minutes to complete. EbE's were consulted with for the development of this questionnaire.

2.3.4. Other Measures: Social Desirability

The Five-Item Measure of Socially Desirable Response Set-5 (SDRS-5; Hays, Hayashi, & Stewart, 1989) was used to explore participants tendency to provide socially desirable responses. It is a 5-item instrument and is a shorter version of the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) used in the current study to reduce participant burden. Completion time for this scale is one minute on average. Participants were asked to rate how true or false statements were related to their relationships on a scale from 1 (definitely true) to 5 (definitely false). Items were reverse scored as per the authors instructions; all extreme responses were scored as 1, all other responses were scored as 0. The total scores ranged from 0 to five, and higher scores indicating that participants demonstrated higher socially desirable responding. Hays et al. (1989) revealed the internal consistency reliability ranged from .66 to .68, and 1-month test-retest reliability was 0.75.

2.3.5. Patient and Public Involvement and Piloting Outcome Measures

All the above questionnaires exploring the variables of interest were discussed and agreed upon with three members of the NELFT Staff Addressing Inequalities Steering Group (one Black professional and two White professionals) and three Black experts by experience with psychosis under the care of NELFT EIP. They also co-produced the clinical vignettes. It was important to include mental health professionals from White and Black ethnicities in the consultation phase to consider appropriateness, cultural sensitivity, and potential distress for some participants.

The clinical vignettes were piloted by eight Trainee Clinical Psychologists to evaluate face validity and to examine for floor and ceiling effects. Six of the pilot participants identified as female, and two as male from a range of ethnicities who worked in mental health services from a range of 2-10 years, they all had experience of either working in psychosis or had lived experience of psychosis (e.g., lived experience, as a carer, as a family member). Pilot participants were asked if the vignettes were realistic, easy to understand, their experiences of reading the vignettes and rating the questions related to the vignettes, if there was anything that did not feel right about the vignettes, and if relevant information was included. Overall feedback given from the pilot was that they were clear, realistic, and interesting. Completion time for the vignette was 5 minutes.

Additionally, four Trainee Clinical Psychologists and one Clinical Psychologist piloted the 'SEE ME' training to gather feedback on their experience of completion of the questionnaires before and after the training, and to ensure clarity.

2.4. Planned Data Analysis

All quantitative data analysis were conducted using JASP (Version 0.16).

2.4.1. Main SEE ME Evaluation

Prior to testing the study hypotheses correlations between the study variables were explored at baseline to investigate whether the various factors (unconscious bias, cultural competence, reflective functioning, clinical decision making about restrictive practices and commitment to addressing inequalities) were associated.

Detection of unconscious bias differences at baseline (hypothesis 1): A one-sample t-test was conducted to determine whether IAT D-scores significantly differed from zero pre the "SEE ME" training, this evaluated whether an implicit racial bias was present at baseline.

Impact of the training (hypothesis 2, 3,4 and 7): A paired samples t-test was used to assess whether there was a significant change pre and post the training on the following variables: unconscious bias (primary outcome variable), cultural competence, mentalisation and commitment to addressing inequalities (secondary outcome variables). Additionally, a non-parametric Wilcoxon signed rank test was utilised for variables where the assumptions of normality could not be assumed.

A 2x2 repeated measures mixed ANOVA was used to evaluate whether there was a significant difference on clinicians' decision making related to restrictive practices using clinical vignettes (hypothesis 5 and 6). The dependent variable was the vignette total restrictive practice scores (with lower scores indicating clinicians recommended less restrictive practices and higher scores indicating clinicians recommended more restrictive practices). The timepoints (pre-post) were the within factor and the protagonist's race (white/black) were the between factors. A mixed ANOVA was conducted to assess if the vignette protagonists' race had an impact, if the timepoints had an impact and if there was an interaction between them. Following a significant interaction between the independent variables a simple main effects test was used.

Correlation analysis was used to assess the relationship between social desirability and other constructs.

2.4.2. Exploring the Role of Participants' Ethnicity

An Exploratory Data Analysis (EDA; Tukey, 1977) was employed to investigate the possible impact of participant's ethnicities on the expected improvements from the 'SEE ME' training. This analysis approach explores potential trends emerging from the data, with an emphasis on displaying graphical representations. Its application in clinical psychology research is widely supported (Barker et al., 2016) The distribution and normality of all variables will be investigated using univariate non-graphical exploratory data analysis (EDA), such as exploration of mean, range, and skewness, as well as univariate graphical EDA, including histograms and box and whisker plots. For the purposes of the analysis participants self-identified ethnicity was classified into the following categories: Black, White, and Other.

2.5. Data Screening

2.5.1. Missing Data

Pre-training there was missing data for the SDRS-5 (n=4), the RFQ (n=3), the Commitment to Addressing Inequalities Questionnaire (n=2) and the CCAT (n=1). Post-training there was missing data for the Clinical Decision-Making Vignettes (n=2), Matched data for these measures were therefore omitted from the analysis. Four participants were removed from the IAT analysis due to excessive speed responses (below 300 milliseconds in over 10%of trials), indicating participants were responding to stimuli as fast as possible without attempting to categorise them (Greenwald et al., 2003). Missing data was coded as missing values in JASP and were excluded from any analysis utilising the specific questionnaires.

2.5.2 Normality of Distributions

All data was screened for normality and outliers (see appendix N). The normality of variables was examined by calculating Z-scores for skewness and kurtosis, exploring significance levels on the Shapiro-Wilks test, and inspecting histograms. Skewness and kurtosis values outside of the +1.96 and –1.96 range indicated a deviation from normality (Field, 2009). Non-parametric tests were used for data that violated normality.

3. Results

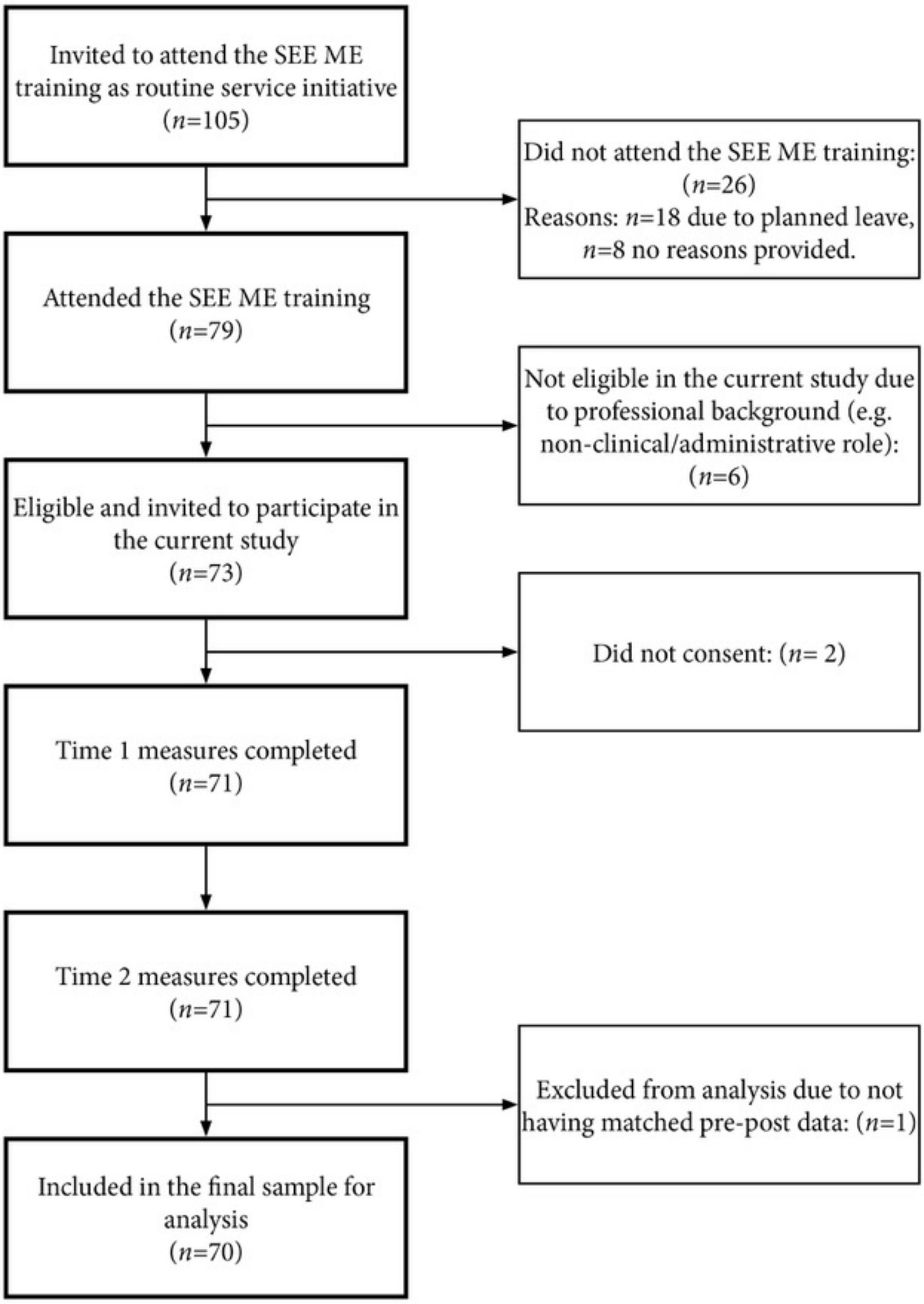
3.1. Descriptives

3.1.1. Training Attendance, Recruitment, and Attrition Rates

See Figure 1 for the study flow chart. Seventy-nine professionals attended the ‘SEE ME’ training in total, of those six were ineligible due to not meeting inclusion criteria (administrative roles) and two did not consent to taking part in the study. Seventy-one participants completed pre and post training questionnaires, however one participant was excluded from the final analysis due to not completing matched pre and post data. There were no dropouts from the study.

Figure 1

Study Flow Chart.



3.1.2. Demographics

Participant descriptive information is provided in Table 1. The sample was predominantly female, n= 55 (78.6%), with an average age of 40.06 years (SD= 11.5). Participants' experience of working in mental health services ranged from 1 to 40 years. Professionals identified as a range of ethnicities, with the overall White and Black ethnic groups comprising each about 40% of the total sample. These ethnic groupings consisted of predominantly Black African (33%) and White British (31%) participants. Participants had a range of professional backgrounds, with Community Psychiatric Nursing being the most common, followed by Psychology. These figures of professional's roles are representative of EIP, except for the number of psychiatrists across the teams which is slightly under-represented in the current sample.

Table 1

Participant Demographics (n=70).

Demographic	Statistic
Age M(SD)	40.06 (11.5)
Range	23-66 years
Gender Identity (n)	
Female	55 (78.6%)
Male	14 (20.0%)
Non-binary	1 (1.4%)
Ethnicity (n)	
Black	29 (41.4%)
Black African	23 (32.9%)
Black British	5 (7.1%)
Black British Caribbean	1 (1.43%)
White	27 (38.6%)
White British	22 (31.4%)
White European	3 (4.3%)
White Irish	2 (2.9%)
Other	14 (20%)
Asian/ Asian Bangladeshi/ Asian British	12 (17.1%)
Chinese	1 (1.4%)
Middle Eastern Arab	1 (1.4%)
Professional role/ discipline[a] (n)	
Community Psychiatric Nurses	28 (40%)
Psychology Provision	21 (30%)
Other professions (Social worker, OT)	15 (21.4%)
Psychiatrists	6 (8.6%)
Years working in mental health services	
M(SD)	10.66 (8.57)
Range of years	1-40 years

[a] Psychology provision; Assistant Psychologist/ Research Assistant (n=6), CBT Therapist/ Clinical Psychologist (n=8), Family Intervention Practitioner (n=2), Trainee Clinical Psychologist (n=5)
Other Professions; Occupational Therapist (n=4), Social Worker (n=3), Support Worker (n=6)

3.2. Associations Between Variables

Prior to investigating the study aims, a correlation table of all variables involved in the study is presented below to explore if implicit and explicit variables were associated, and in particular to ascertain if the vignette task looking at recommendation of restrictive practices was associated with validated measures.

As can be seen on Table 2, the race IAT was not significantly associated with any of the other variables. Previous research has shown either no significant associations (Castillo et al., 2007) or small significant associations (White-Means et al., 2009) between the race

IAT and cultural competence. Additionally, no significant associations between the race IAT and other explicit measures such as implicit imitative tendencies, perspective taking, emotion recognition, and explicit traits related to empathy except for a positive correlation with positive emotional empathy have been reported in prior research (Pennington et al., 2023).

The decision to recommend more restrictive practices was negatively and significantly associated with reduced cultural competence as measured by the CCAT (Papadopoulos, 2001). The RFQ_C and RFQ_U subscales measuring hyper and hypo mentalising respectively were negatively correlated as expected (Fonagy et al., 2016). Finally higher commitment to addressing racial inequalities was associated with reduced certainty about mental states as measured by the RFQ_C (Fonagy et al., 2016).

Table 2

Correlations Between the Baseline Variables.

Variable	IAT T1	CCAT Overall	RFQ_C	RFQ_U	Restrictive practices vignette T1	Commitment T1
IAT	—	—				
CCAT overall scores	-0.13	—				
RFQ_C	-0.05 [a]	0.03	—			
RFQ_U	0.07	-0.15	-0.40***	—		
Restrictive practices vignette	0.15	-0.46***	0.04 [a]	0.00	—	
Commitment	-0.12	0.12	0.28*	0.15	-0.07	—

Note. IAT= Implicit association test (Greenwald et al., 1998), CCAT= Cultural Competence Assessment Tool (Papadopoulos, 2001), RFQ_C = Reflective Functioning Certainty Scale, RFQ_U = Reflective Functioning Certainty Scale (Fonagy, 2016), * p <0.05, **p<0.005, ***p<0.001

[a] Pearson's r correlation coefficient, all other variables used Spearmans rho

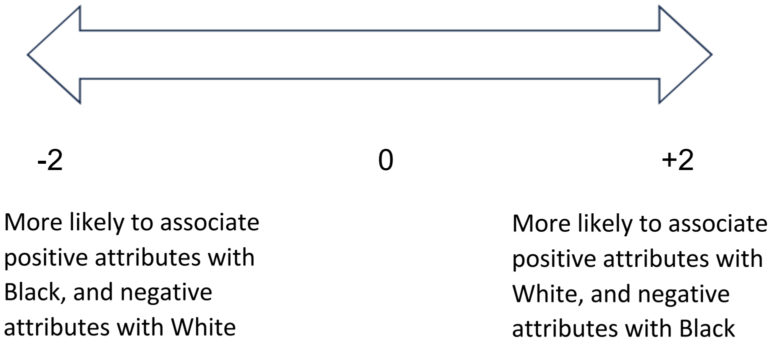
3.2 Evaluating the Impact of SEE ME Training

3.2.1. Unconscious bias: Are mental health professionals more likely to associate positive attributes with White and Negative attributes with Black at baseline? (Hypothesis 1)

IAT d-scores for mental health professionals who participated in the study indicated participants were more likely to associate positive attributes with White and negative attributes with Black at baseline showing support for hypothesis 1, (M= 0.15, SD= 0.43), t(65)= -2.656, p=0.010, Cohen's *d*= -0.327. See Figure 2 for the range of values indicating the meaning of IAT scores. The IAT D mean indicated that was in the slight pro-White/ anti-Black bias range (Maina et al., 2018). Previous studies that examined implicit bias amongst healthcare professionals at baseline reported d-score means of 0.35 (Sabin et al., 2008) and 0.44 (Liu et al., 2022), suggesting that the current sample implicit preference towards White was not as strong these samples.

Figure 2.

IAT D-scores.



3.2.2. Did the “SEE ME” training improve mental health professionals’ implicit bias towards Black people, cultural competence, and reflective capacity? (Hypothesis 2, 3 and 4)

Descriptive statistics pre-training and post-training for the IAT (Greenwald et al., 1998), CCAT (Papadopoulos, 2001), and RFQ (Fonagy, 2016) are provided in Table 2. Mental health professionals’ cultural awareness as assessed by the CCAT(Papadopoulos, 2001), suggested a significant improvement after the “SEE ME” training, as indicated by medium effect sizes. Other aspects of cultural competence did not significantly change (i.e. cultural knowledge, sensitivity, and practice). This showed partial support for hypothesis 3. Hypotheses 2 and 3 predicted that mental health professionals’ unconscious racial bias towards Black (IAT; Greenwald et al., 1998) and reflective functioning (RFQ; Fonagy et al., 2016) would improve post-training, however as shown in Table 2 this was not supported by the data.

Table 2.

Pre and Post Training Descriptives of Implicit Bias, Cultural Competence and Reflective Functioning and Repeated Measures Tests.

Variable	Measure/ subscale		Pre-training		Post-training					
		n	Mean	SD	Mean	SD	Statistic	df	p	Effect size
Pro-White/ anti Black implicit bias	IAT	66	0.15	0.43	0.23	0.41	1.568[a]	65	0.122	0.193[c]
Cultural competence	CCAT Awareness	69	8.77	1.27	9.20	1.12	132.000[b]	68	0.004*	-0.556[d]
	CCAT Knowledge	69	9.16	1.02	9.28	0.86	197.500[b]	68	0.305	-0.204[d]
	CCAT Sensitivity	69	8.64	1.55	8.68	1.33	359.500[b]	68	0.875	-0.030[d]
	CCAT Practice	68	9.75	0.56	9.75	0.61	84.000[b]	67	0.964	-0.018[d]
Reflective functioning	RFQ_C	67	8.37	4.49	7.85	4.56	0.632[a]	66	0.529	0.077[c]
	RFQ_U	67	1.82	2.07	1.82	2.22	332.500[b]	66	0.776	-0.054[d]

Note. IAT= Implicit association test (Greenwald et al., 1998), CCAT= Cultural Competence Assessment Tool (Papadopoulos, 2001), RFQ_C = Reflective Functioning Certainty Scale, RFQ_U = Reflective Functioning Certainty Scale (Fonagy, 2016), ** p <0.005

[a] t statistic for parametric test; [b] z statistic for non-parametric Wilcoxon signed rank test; [c] Cohen’s *d*; [d] Matched rank biserial correlation (r)

3.2.3. Differences in cultural competence (CCAT) categorisation

The categorisation in terms of the participants' CCAT ratings pre and post the 'SEE ME' training is presented in Table 4 below. Post-training seven participants progressed from the 'culturally aware' category to the 'culturally safe' category, the number of participants in the culturally competent category remained the same. A chi-square test of independence indicated that these changes were not statistically significant (X^2 (2, n = 69) = 1.7, p = 0.44)[2]. No participants scored within the culturally incompetent category before or after the training.

Table 4.

Categorisation of Cultural Competence Ratings Pre and Post the Training (n=69).

Category	Pre-training	Post-training
Culturally competent	9 (13.04%)	9 (13.04%)
Culturally safety	23 (33.33%)	30 (43.48%)
Culturally aware	37 (53.62%)	30 (43.48%)
Culturally incompetent	None	None

Note. Cultural competence categorisations: Culturally competent = score of 40 in total; culturally safe = score of five or more in the cultural awareness section, and the four generic statements across the other sections are correct), 'culturally aware' (score of 5 or more in cultural awareness section, regardless of the four generic statements in the other sections being accurate), and 'culturally incompetent' (score of less than five in the cultural awareness section, regardless of scores across the other sections).

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[2] A 2x3 analysis was carried out due to a '0' cell count in the culturally incompetent category

3.2.4. Clinical decision making on restrictive practices (Hypothesis 5 and 6)

A mixed ANOVA was performed to evaluate the effects of time and the vignette protagonists' race on recommended restrictive practice clinical decision-making scores. Scores were added from 0-700 (higher scores indicating more restrictive practice recommendations). The descriptive statistics are presented in Table 5 below.

Table 5

Means and Standard Deviations for Restrictive Practice Decision-Making as Function of a 2 (Vignette Protagonist Race) x 2 (Time) Design.

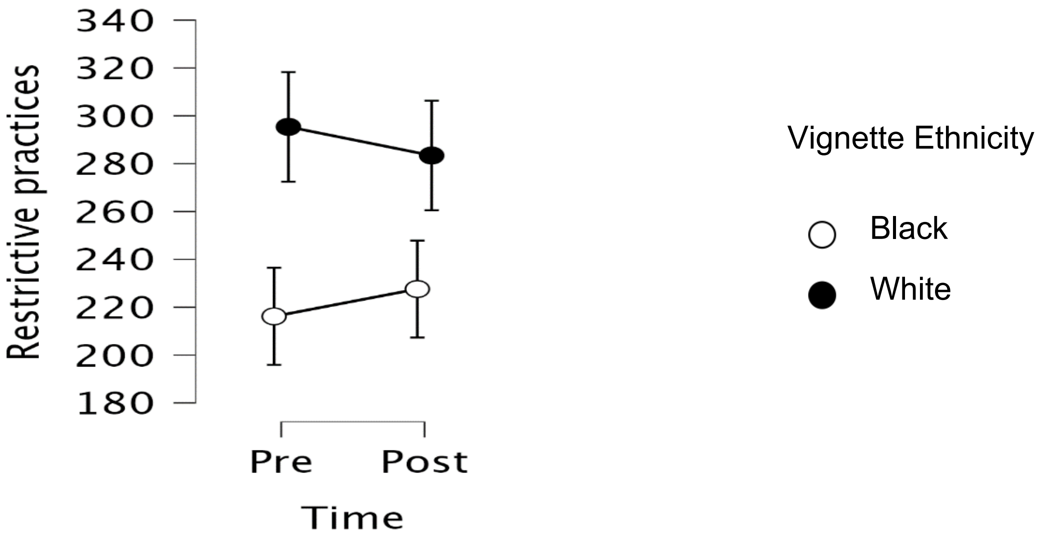
		Time			
		Pre-training		Post-training	
Race of vignette protagonist	N	M	SD	M	SD
Black	35	216.17	78.80	227.60	83.01
White	35	295.40	95.77	283.40	89.81

Note. M and *SD* represent mean and standard deviation, respectively. Higher scores indicate higher recommendation of restrictive practices

Levene's test indicated homogeneity of variance for all the repeated measures variables ($p>0.05$). The results indicated no statistically significant interaction between the timepoints and the race of the vignette protagonist, $F(1, 68) = 1.211$, $p=0.275$, $\eta2=0.004$ and no statistically significant main effect for time, $F(1, 68) = 7.202e-4$, $p=0.979$, $\eta2=2.389e-6$. There was a statistically significant main effect for the race of the vignette protagonist, $F(1, 68) = 14.244$, $p=<0.001$, $\eta2=0.133$. Hypotheses 5 and 6 were both not supported by the data. The findings indicated that pre-training participants were more likely to recommend restrictive practices for the White vignette protagonist compared to the version with the Black protagonist. This is the opposite of what was predicted in hypothesis 5. Additionally, the findings did not suggest an interaction effect, post-training the White vignette protagonist continued to have higher restrictive practices recommended to her than the Black vignette protagonist as shown in Figure 3.

Figure 3

Descriptive Plot.



3.2.5. Commitment to addressing inequalities (Hypothesis 7)

See Table 6 for the descriptive statistics related to mental health professionals' commitment to addressing inequalities pre and post the training. There was a statistically significant improvement on all items with large effect sizes, except for the items related to feeling 'discomfort when talking about the inequalities Black people face' and being 'aware of the impact of participants own ethnicity/ identity when working with Black people'.

Table 6

Commitment to Addressing Inequalities Pre and Post Training for Individual Items.

Item		Pre-training		Post-training					
	n	*M*	*SD*	*M*	*SD*	*z*	*df*	*p*	Effect size Matched rank biserial correlation (r)
I understand the impact of existing inequalities on Black people in EIP	68	5.18	1.39	5.81	1.20	148.50	67	<0.001***	-0.638
I feel confident talking about the inequalities black people face	68	5.07	1.25	5.53	1.30	208.00	67	0.002**	-0.539
I feel discomfort when discussing existing inequalities that black service users face	68	6.12	1.56	6.06	1.73	562.50	67	0.811	0.041
I am aware of the impact of my own ethnicity/ identity when working with Black people	68	5.53	1.34	5.82	1.26	326.50	67	0.103	-0.277
I have a rich view of Black service users with psychosis in EIP	68	4.91	1.29	5.46	1.17	294.00	67	0.002**	-0.500
I feel confident in how to create a supportive experience for Black people with psychosis	68	5.09	1.13	5.63	0.91	141.00	67	<0.001***	-0.656
I am committed to addressing inequalities for Black service users in EIP	68	6.06	1.06	6.35	0.91	112.50	67	0.010*	-0.516

Note. * $p < 0.05$, ** $p < 0.005$, *** $p < 0.001$

3.3. Is Social Desirability Associated with the Outcome Variables?

The correlations between the SDRS-5 and the primary and secondary outcomes completed by participants are presented in Table 7 below. There were no significant associations between social desirability and unconscious bias scores measured by the IAT. At baseline higher social desirability (SDR-5) was significantly associated with reporting *more* ‘commitment to addressing inequalities’’, *more* ‘certainty about mental states’ (RFQ_C) and *less* ‘cultural competence’ (CCAT) and Uncertainty about Mental States (RFQ_U). Post-training, higher social desirability scores were only significantly associated with reporting *more* ‘commitment to addressing inequalities’’ and a *higher* likelihood of recommending restrictive practice overall. In sum, there was evidence that participants’ performance on explicit tasks as expected was linked to attempts to present in a socially desirable manner.

Table 7

Correlations Between the SDRS and Other Variables.

Variable	IAT	CCAT Overall	RFQ_C	RFQ_U	Restrictive practices vignette T1	Commitment T1
SDRS-5 with T1 VARIABLES	-0.07	-0.31 [a] *	0.48***	-0.27*	0.23	0.36**
SDRS-5 with T2 VARIABLES	0.14	-0.18 [a]	0.02	-0.19 [a]	0.30*	0.29 [a] *

Note. IAT= Implicit association test (Greenwald et al., 2003), CCAT= Cultural Competence Assessment Tool (Papadopoulos, 2001), RFQ_C = Reflective Functioning Certainty Scale, RFQ_U = Reflective Functioning Certainty Scale (Fonagy, 2016), * p <0.05, **p<0.005, ***p<0.001

[a] Spearmans rho was used all data violated normality, for all other variables Pearson’s r correlation coefficient was performed

3.4 Exploratory Analysis: Does Mental Health Professional Ethnicity Influence the Impact of the SEE ME Training?

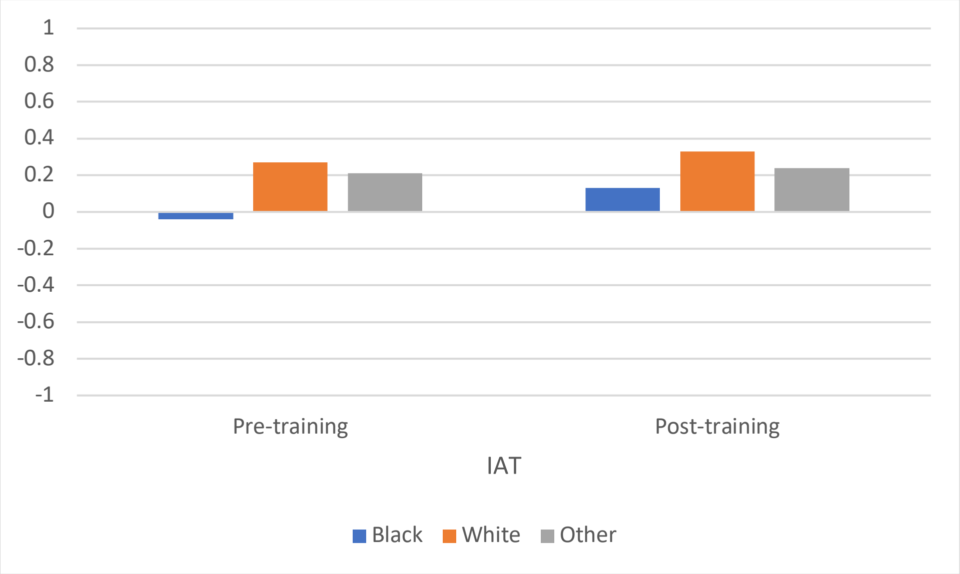
As presented in Table 1 the sample comprised of Black n=29 (41%), White n=27 (39%) and Other (predominantly from Asian ethnic backgrounds) n=14 (20%) mental health professionals.

Unconscious Bias

Inspection of the IAT indicated clear differences in unconscious bias scores depending on participants ethnicity (see Figure 4). Black participants had no racial bias before and after the training (range for no racial bias is between -0.14 and +0.14 (Maina et al., 2018)), although Black participants remained in the no racial bias their unconscious scores increased. White and Other participants' unconscious bias scores showed a slight pro-White bias that was similar before and after the training, with White participants exhibiting stronger pro-White unconscious bias scores than Other participants.

Figure 4

Pre-post IAT Scores Classified by Participant Ethnicity.

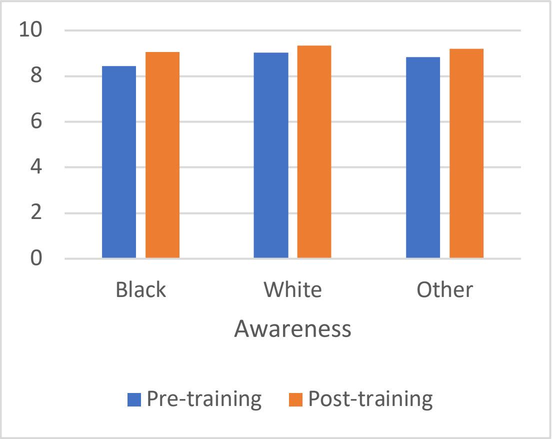


Note. Black (n=25), White (n=27), Other (n=14)

Cultural Competence

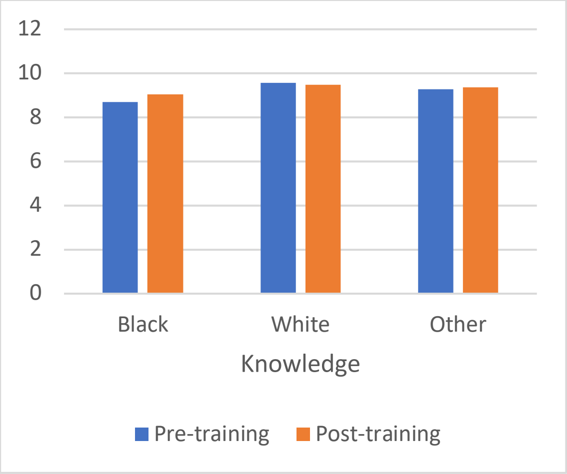
Participants showed similar trends across all cultural competence subscales (see Figures 5a, 5b, 5c, 5d), with practice subscale scores appearing to be almost identical (see Figure 5d). The cultural competence awareness subscale suggested an increase in scores for all participants post-training (see Figure 5a), however the remaining subscales suggested no marked differences in trends before and after the training.

Figure 5a. *Pre-post CCAT Awareness Scores Classified By Participant Ethnicity.*



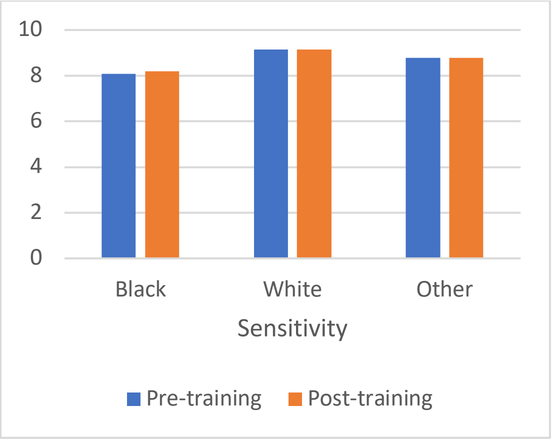
Note. Black (n=28), White (n=27), Other (n=14)

Figure 5b. *Pre-post CCAT Knowledge Scores Classified by Participant Ethnicity.*



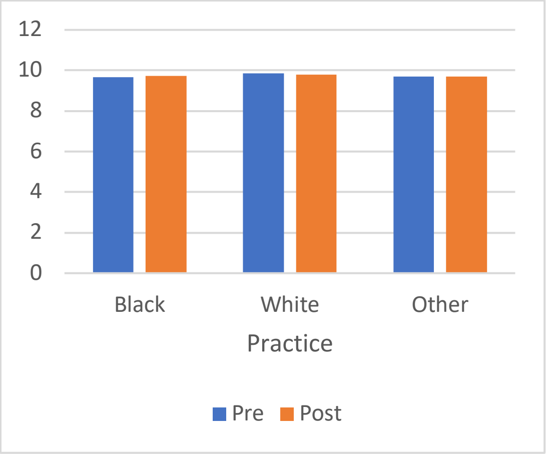
Note. Black (n=28), White (n=27), Other (n=14

Figure 5c. *Pre-post CCAT Sensitivity Scores Classified by Participant Ethnicity.*



Note. Black (n=28), White (n=27), Other (n=14).

Figure 5d. *Pre-post CCAT Practice Scores Classified by Participant Ethnicity.*

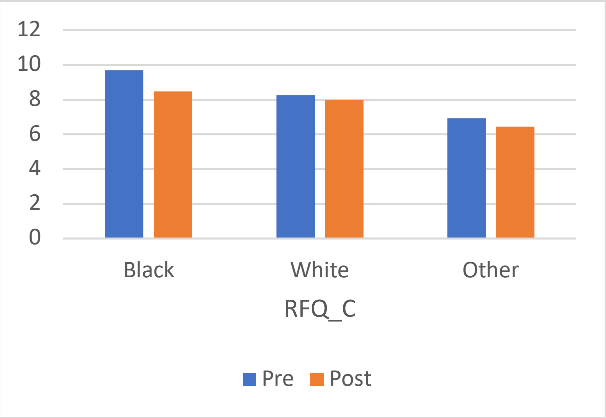


Note. Black (n=28), White (n=27), Other (n=14)

Mentalising

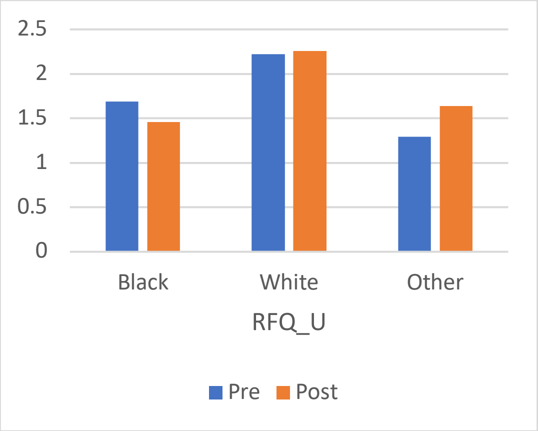
Black participants had the highest RFQ_C (hyper-mentalising) scores pre- training, and after the training these scores reduced suggesting that they were more genuinely mentalising (see Figure 6a). White participants RFQ_C scores were similar before and after the training. Other participants had the lowest hyper mentalising scores which reduced after the training suggesting more genuine mentalising. Scores from the RFQ_U subscale (see Figure 6b) indicated that White participants had the highest scores for hypo-mentalising which suggesting that they had the most reduced capacity in attributing mental states compared to the other ethnicities. Black participants RFQ_U scores reduced after the training, suggesting that their mentalising scores had improved. Other participants had the lowest RFQ_U scores before the training, these scores increased after the training suggesting they were less genuinely mentalising following the training.

Figure 6a. *Pre-post RFQ_C (Hyper-mentalising) Classified by Participant Ethnicity,*



Note. Black (n=26), White (n=27), Other (n=14) Lower scores indicate more genuine mentalising

Figure 6b. *Pre-post RFQ_U (Hypo-mentalising) Classified by Participant Ethnicity.*



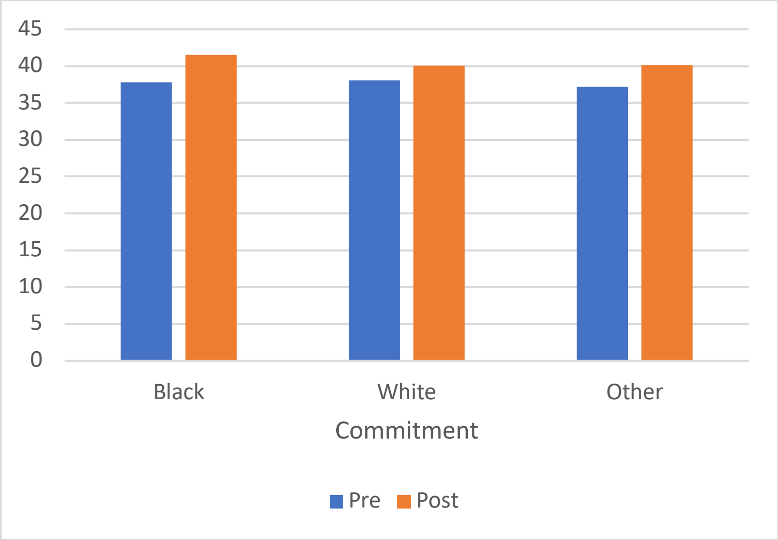
Note. Black (n=26), White (n=27), Other (n=14) Lower scores indicate more genuine mentalising

Commitment to Addressing Inequalities

The trends seen in pre, and post training commitment scores were similar across groups, with an improvement in all participants commitment to addressing racial inequalities (see Figure 11).

Figure 7

Pre-post Addressing Inequalities Commitment Classified by Participant Ethnicity.

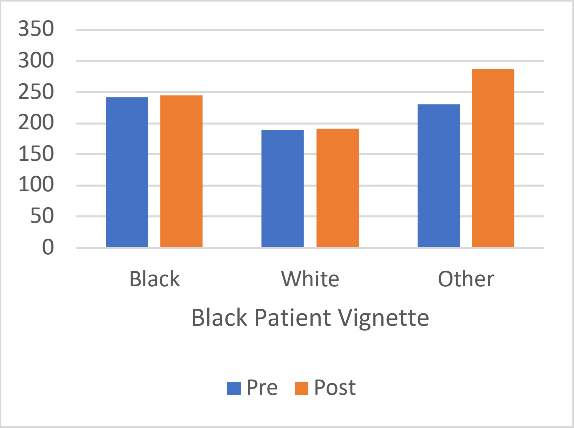


Note. Black (n=27), White (n=27), Other (n=14)

Restrictive Practice Recommendations

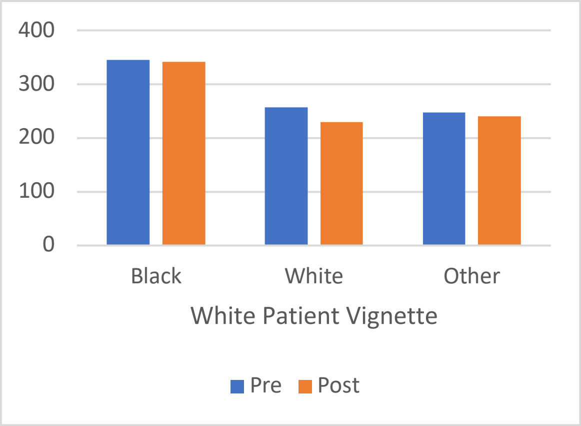
Black and Other ethnic groups seemed more likely to recommend restrictive practice pre-training, compared to White professionals for the Black vignette protagonist (see Figure 8a). Post-training there were no apparent changes amongst Black or White professionals, however professionals from the ‘Other’ ethnicity (predominantly from Asian ethnic backgrounds) seemed to have increased scores for recommending restrictive practices for the Black patient in the vignette. Inspection of the White vignette protagonist suggested that Black professionals recommended more restrictive practices for the White patient pre and post the training, compared to White and Other professionals.

Figure 8a. *Pre-post Black Patient Vignette Classified by Participant Ethnicity.*



Note. Black (n=13), White (n=16), Other (n=6).

Figure 8b. *Pre-post White Patient Vignette Classified by Participant Ethnicity.*



Note. Black (n=16), White (n=11), Other (n=8)

4. Discussion

The present study aimed to quantitively evaluate the impact of the 'SEE ME' training on mental health professionals working in EIP. The training was co-produced with EbE's and mental health professionals to address the racial inequalities Black service users with psychosis experience. The hypothesised variables used to evaluate the impact of the 'SEE ME' training on professionals' clinical practice were unconscious racial bias, cultural competence, mentalising capacity, clinical decision making and commitment to addressing inequalities for Black service users with psychosis in EIP. Seventy mental health professionals with diverse ethnic backgrounds and varying professional roles participated in the study. The sample comprised 41% Black, 39% White, 18% Asian, 1% Chinese, and 1% Middle Eastern participants. The sample evaluated in this study represents a notable strength, particularly considering the scarcity of anti-racism interventions conducted in healthcare settings within the existing literature (Hassen et al., 2021). Additionally, in the context of examining implicit bias among healthcare workers, mental health professionals are a group that have received limited attention (Liu et al., 2022; Maina et al., 2018).

Overall, the findings indicated that the ‘SEE ME’ training is significantly beneficial for improving cultural competence awareness, and commitment to addressing racial inequalities. Additionally, participants’ hyper-mentalising scores reduced indicating that they were more genuinely mentalising following the training, however this finding was not statistically significant. There was no significant improvement for professionals’ unconscious racial bias or clinical decision making related to restrictive practice recommendations. Socially desirable responding was associated with a range of explicit measures, suggesting that these findings should be interpreted with caution.

4.1. ‘SEE ME’ training improved cultural awareness and increased commitment to addressing racial inequalities.

A significant improvement was found on participants’ cultural awareness scores from pre-post the ‘SEE ME’ training. There was also an improvement in professionals’ cultural knowledge and cultural sensitivity scores, however these changes were not statistically significant, and no change was found on cultural practice scores. Following the training, 10% of the sample progressed from the ‘culturally safe’ to the ‘culturally competent’ category (Papadopoulos, 2001). This is an important finding given that higher levels of cultural competence amongst professionals are associated with a reduction in racial disparities and experiences of discrimination in healthcare (Betancourt et al., 2003; Eken et al., 2021). The CCATool used in the present study is based on Papadopoulos, Tilki and Taylor (1998) model for developing cultural competence (Papadopoulos et al., 1998). The model pertains to the clinician’s ability to deliver effective healthcare that accounts for individuals’ cultural beliefs, behaviours and needs. The model encompasses four key elements of cultural competence including cultural awareness, cultural knowledge, cultural sensitivity, and cultural practice. The initial stage in the model is cultural awareness, where individuals examine their personal values and beliefs, raising self-awareness regarding their cultural identity's formation. Recognising how one's cultural background shapes values and beliefs, which in turn influence health beliefs and practices, is crucial. The authors argue that cultural awareness is the essential first step towards cultural competence and that without experiencing this stage it is difficult to move towards cultural sensitivity and competence. (Papadopoulos et al., 1998, 2004). Furthermore, without cultural self-awareness, healthcare providers may engage in cultural imposition which involves imposing their own values and beliefs on others (Campinha-Bacote, 2002). This typically results in inequalities and disempowerment within marginalised cultural groups (Almutairi et al., 2015; Koskinen et al., 2012).

Furthermore, the ‘SEE ME’ training resulted in significant improvements in participants commitment to addressing inequalities, particularly pertaining to their commitment on the following items: ‘understanding’, ‘confidence’, ‘having a rich view’, ‘creating a supportive experience’ and ‘committed to addressing inequalities’. These improvements in commitment can be directly linked to the theory of planned behaviour, a psychological model, that states intention is an important determinant of behaviour change that is influenced by attitudes, subjective norms, and perceived behavioural control (Ajzen, 1991). Thus in line with this model, a stronger commitment to addressing racial inequalities, driven by the ‘SEE ME’ training, may be associated with a higher likelihood of actively engaging in the intended behaviour. Additionally, the critical race theory aims to understand and transform the connection between race, racism, and power and highlights the role of acknowledging individuals and institutions involvement in perpetuating racial disparities, with commitment to social justice being important aspect of the framework (Delgado & Stefancic, 2023; Solorzano et al., 2000). Based on these models, cultural awareness and commitment are important first steps for addressing racial inequalities. However, these findings should be interpreted with caution as responses on commitment and cultural awareness were significantly associated with social desirability (associated with less cultural competence, at baseline only, and for commitment the associations were less strong post-training).

4.2. Understanding what the SEE ME training did not change

The ‘SEE ME’ training did not reduce clinicians’ implicit racial bias (primary outcome measure) as assessed by the Race IAT (Greenwald et al., 1998). The training also did not change discomfort around addressing inequalities, self-reflection about the role of one’s own ethnicity, general reflective capacity, or the likelihood of recommending restrictive practices. Possible explanations for these findings are discussed below.

4.2.1. Mixed ethnicity sample and reduced evidence of racial biases at baseline

IAT Overall participants had a slight pro-White/ anti-Black implicit bias at baseline on the IAT (Greenwald et al., 1998) however this racial bias was lower than other studies (Liu et al., 2022; Sabin et al., 2008) . The present sample was more ethnically diverse, with the sample being 41% Black, 38% White and 29% Other (predominantly Asian British/South Asian), than previous research. A systematic review of 35 studies explored implicit racial bias among healthcare professionals, primarily composed of White and Asian participants, with only 9% being Black and 3% Hispanic. Findings indicated that they exhibited implicit bias, ranging from slight to strong, favouring White individuals over Black individuals (Maina et al., 2018). Moreover, the exploratory analysis which categorised participants’ unconscious bias scores by ethnicity suggested that Black participants exhibited no racial bias before and after the training, indicating there was no unconscious bias to address in 41% of the sample. These findings of no racial bias exhibited among Black participants are comparable to previous research (Sabin et al., 2009; Weinstock, 2012). The remaining White and Other participants however had a slight pro-White/ anti-Black bias pre and post the training, which is consistent with previous findings indicating slight to moderate implicit racial bias amongst these racial groups in healthcare professionals (Cooper et al., 2012; Haider et al., 2015; Maina et al., 2018; Sabin et al., 2009).

Restrictive practices vignette The clinical vignettes were developed with Black EbE's with psychosis, under the care of NELFT EIP, and with mental health professionals who were on the staff addressing inequalities steering group and worked in EIP services. The vignettes were piloted with Trainee Clinical Psychologists. The current study showed that participants were more likely to recommend restrictive practices for the White vignette protagonist than the Black vignette protagonist and this did not change following the 'SEE ME' training. This opposes the original hypothesis and existing literature that employs clinical vignettes to examine the influence of ethnicity on professionals' clinical decision-making (Bogart et al., 2001; Green et al., 2007; Lewis et al., 1990; Sabin & Greenwald, 2012). Social desirability was associated with task performance post training and can therefore account for this unexpected finding, but there was no significant correlation between vignette performance and social desirability at baseline. Participants might have had heightened awareness of the study's intent given they were informed the training was designed to addressing inequalities for Black people with psychosis and, consciously or unconsciously, adjusted their recommendations to counteract these disparities. Similarly, a previous study found no association between medical students' clinical assessments and vignette ethnicity and suggested this might be explained by their awareness of the study's intent and concerns related to social desirability (Haider et al., 2011). An exploratory analysis indicated that Black professionals may have been more likely to recommend restrictive practices for the White patient in the vignette than professionals from White and Other ethnic backgrounds. In the current study Black professionals were more likely to have a nursing background which follows a medical model, whereas other disciplines such as psychology were predominantly White and are more likely to generally favour less invasive interventions. Professional role might have been a factor as at baseline, Black participants were perhaps more likely to recommend restrictive practice across Black and White participant vignettes, but the higher recommendation for sectioning for White patients could potentially be linked to ethnicity. The complexity of biases and their impact on the interactions between mental health staff and individuals is noteworthy. Beyond considerations of racism, the influence of the medical model on medical and nursing staff adds another layer of complexity to the dynamics. Exploring these various influences is crucial for a comprehensive understanding of the factors shaping healthcare interactions.

Further research is needed to ascertain the role of social desirability and the impact of ethnicity matching. It is important to evaluate the predictive validity of the study's clinical vignettes i.e. do they predict the likelihood of restrictive practices in real clinical settings? An important finding of the current study was that higher restrictive practice vignette recommendations were significantly associated with reduced cultural competence. Given previous research linking cultural competence and clinical practice (Brach & Fraserirector, 2000; Holden et al., 2014), this data tentatively suggests that perhaps a more robust improvement in cultural competence (beyond cultural awareness as achieved with the SEE ME training, but also improving cultural knowledge and competence practice) might be more likely to mediate shifts in vignette exercises but also in clinical practice.

4.2.2 One hour and 30 minutes to change lifetime exposure to negative stereotypes of Black people

The 'SEE ME' training was 1hr 30 minutes in total, the race IAT might have shown if it was carried out for a longer period of time over multiple sessions. Devine's habit-breaking analysis of prejudice reduction proposes that dismantling prejudice is a prolonged journey demanding significant commitment towards achieving a nonprejudiced objective (Devine, 1989; Devine et al., 1991, 2012). This model draws parallels between implicit biases and deeply ingrained habits cultivated during socialisation experiences. To "break the habit" of implicit bias, individuals must gain insight into the situations that trigger bias and learn how to substitute biased reactions with responses aligned with their nonprejudiced aspirations (Devine et al., 2012). Hence, single-session interventions are confronted with the difficulty of challenging well-established patterns of associative learning, making it improbable for them to generate alterations in the implicit system. Effective interventions tend to be of an extended duration, allowing for emotional content processing between sessions (Velde & Wittman, 2001). Additionally, the training content may not be suitable to changing clinician's racial attitudes. Developmental psychology research suggests that implicit preferences, including racial biases, tend to develop in the first year of infancy (Aboud & Steele, 2017; Baron, 2013), at the age of three White children show a pro-White racial bias that remains comparatively consistent throughout development (Dunham et al., 2013; Gonzalez et al., 2017, 2021). This stability may be influenced by consistent exposure to cultural messages that reinforce these biases (Baron, 2015). Therefore based on this literature, 'The SEE ME' training could be enhanced through the implementation of a more extensive and multifaceted intervention approach, involving a series of sessions spaced over time. This approach facilitates in-depth exploration, processing of emotional content, more opportunities to challenge deeply ingrained unconscious racial biases and stereotypes, consistent reinforcement, and incorporation in routine clinical practice.

4.2.3 Discomfort and addressing inequalities work

Exposure to conversations about racism is associated with increased levels of discomfort and anxiety (Sue, 2013). This is supported by the lack of significant changes in 'discomfort' and awareness of the impact of participants' 'own ethnicity/identity' measured by the Commitment to Addressing Inequalities scale and the lack of significant changes in mentalising. This could have potentially affected the impact of SEE ME, given research showing that heightened arousal can hinder mentalising and empathy (Decety & Svetlova, 2012; Luyten & Fonagy, 2015). Personal distress is a self-focused response that depletes an individual's attention and cognitive resources (Decety & Svetlova, 2012; Eisenberg & Eggum, 2009). It is often associated with the wish to relieve one's own distress, making it challenging to focus on others. Bloom (2017) argues that empathy can often lead to irrational and biased decision-making due to it being emotionally driven. The author highlights that people often empathise more towards those they are similar to and not towards those they perceive to be dissimilar, proposing a need for more measured, critical, and rational form of compassion that takes into account the broader implications of actions and decisions. This could be linked to the exploratory analysis findings, which revealed that Black participants hyper and hypo mentalising scores had reduced post-training indicating they were more genuinely mentalising after the training. Moreover, previous studies that have effectively immediately reduced implicit racial bias included high participant involvement by making participants active members of the scenario, such as imagining being part of a situation that challenged biases (Lai et al., 2014). The 'SEE ME' training potentially did not do enough to put the professional in the client's perspective, for example the use of Virtual Reality (VR) has been demonstrated as being an effective technique for challenging implicit racial bias (Kishore et al., 2019).

Furthermore, the exposure of challenging and difficult narratives in the film that may have resulted in negative valence among participants, despite participant findings showing they were more committed to addressing racial inequalities following the training. This negative valence, in turn, could have impacted their associations in the IAT, making them more likely to associate negative words like "agony" or "terrible" with the Black target group in the IAT (see appendix I for the full list of IAT items). The pairings in words were based on previous research (Nosek et al., 2007) , and not the 'SEE ME' training, this may have also impacted the IAT results. Moreover, it has been proposed that cognitive stressors, such as time pressures and high caseloads, can lead to heightened implicit racial bias and produce worse outcomes for Black people (Fitzgerald & Hurst, 2017; Hall et al., 2015; Johnson et al., 2016; Sabin et al., 2009; Stepanikova, 2012). It is possible that cognitive stressors could have impacted their IAT scores, particularly given the COVID- 19 pandemic and current National Health Service (NHS) crisis (e.g. staff shortages, long waitlists, higher demand than available funds) has significantly impacted healthcare professionals' psychological wellbeing and increased their levels of burn out (Gillen et al., 2022). These explanations may also be plausible for the exploratory analysis. Although participants who were classified as in the Black, White and Other ethnic groups remained in the same IAT categories pre and post the training, their unconscious racial bias scores worsened after the training.

Moreover, participants were not provided with IAT feedback which may have benefitted the reduction of racial bias by promoting further awareness of the biases they implicitly hold. Previous studies that have similarly engaged participants, in a self-reflective task, have provided IAT feedback to motivate professionals to address their implicit biases (Devine et al., 2012; Gonzalez et al., 2014; Teal et al., 2010; Van Ryn et al., 2015; Zestcott et al., 2016). The rationale for not feeding back the IAT results was due to the possibility of it eliciting defensiveness, which may result in a denial of their bias or result in participants challenging the disparity (Zestcott et al., 2016). A study that explored this with physicians and nurses found the majority of participants reported their experience of completing the IAT and obtaining feedback of their result as either, neutral, positive or interesting (Sukhera et al., 2018), therefore this may have been beneficial in the current study.

4.3. Strengths and Limitations

This was the first quantitative study to evaluate the impact of the 'SEE ME' training on mental health professionals, a service development initiative that was co-produced with EbEs and experts by profession, to improve the care of Black people with psychosis in EIP services. The study employed a variety of implicit and explicit measures, and a notable strength lies in the substantial involvement of PPI in the selection and development of these questionnaires. Additionally, it was conducted in a naturalistic, real-life setting enhancing the ecological validity of the findings. Furthermore, a notable strength of this study is the high participation rate (90%) among mental health professionals who attended the 'SEE ME' training, with the sample representing diverse ethnic and professional backgrounds.

Several limitations are important to consider. Firstly, the post-intervention assessments were collected on the same day as the intervention. The lack of a delayed post-assessment may hinder the ability to ascertain sustained effects or identify potential delayed responses to the intervention. Furthermore, it could lead to an overestimation of the intervention's effectiveness, as short-term effects may not be indicative of long-term outcomes. Improvement to the training investigation could involve conducting post-intervention assessments on subsequent days or over an extended period to capture long-term effects, and implementing follow-up assessments at intervals to track changes and assess the sustainability of observed effects. A second limitation is the absence of a control group or intervention control condition. Without a control group, it becomes challenging to ascertain whether the observed changes in participants' outcome variables were a direct result of the training or due to other factors. Additionally, given the small sample for the vignettes, the study may be underpowered in this specific aspect. The lack of observed differences may be attributed to the limited sample size, making it challenging to draw definitive conclusions. Consequently, caution is advised when interpreting the findings for the clinical vignettes.

Furthermore, the researcher was actively involved in the development of the training and subsequently conducted the evaluation for the current study. Given this dual role, there was a potential for experimenter bias, where the researcher's personal investment in the training could influence data collection, analysis, or interpretation (Rosenthal & Fode, 1963; Šimundić, 2013). To ameliorate the impact of bias the analysis was pre-planned, and a wide range of self-reported explicit and implicit measures were selected for data collection. It is important to note that the researcher did not directly facilitate the training sessions. Moreover, participants varied in terms of the years of experience they had working in mental health services which ranged from 1 to 40 years. Existing literature suggests that interventions aimed at addressing racial inequalities and reducing racial bias are most effective when implemented early in professionals' training or careers (Hall et al., 2015). Furthermore, the secondary outcomes were self-report questionnaires, which pose inherent limitations, such as social desirability bias and subjective interpretation. These limitations should be taken into account when interpreting the results related to these self-report measures.

In addition, the Commitment in Addressing Racial Inequalities Questionnaire was created specifically for this study and was not a validated questionnaire. This raises concerns about the questionnaire's reliability and validity in accurately measuring participants' commitment to the training. The clinical vignettes were co-produced and piloted; however this measure was not validated, and task performance did not reveal social desirability biases at baseline. It was observed in the current study that the clinical vignettes were negatively associated with cultural competence, as anticipated. This suggests a potential connection between performance on the vignette task and the related theoretical concept of cultural competence. The RFQ (Fonagy et al., 2016) was used to assess mentalising however, this questionnaire was created to evaluate impairments in mentalizing commonly observed in clients with borderline personality disorder characteristics. It was deemed appropriate for the current study due to its short length to reduce respondent burden, however a mentalising questionnaire validated on health professionals may have been more sensitive to change. Additionally, participants were not asked if they had prior experience completing the Implicit Association Test (IAT). While the IAT is known to be resistant to faking responses, individuals with concrete instructions or previous experience with the IAT may produce different results (Fiedler & Bluemke, 2005; Kim, 2003; Lai et al., 2016).

4.4. Future Research and Clinical Implications

The ‘SEE ME’ training effectively improved cultural awareness and 'commitment to addressing inequalities in mental health professionals in EIP services. The long-term impact of addressing inequalities trainings necessitates a plan for embedding and sustaining interventions and evaluations. The feedback gathered as part of the wider service development project will be analysed and reported separately to shape future implementation and evaluation of the training. The 'SEE ME' training is recommended for professionals in all mental health services, particularly professionals working in inpatient settings, where Black individuals often experience elevated rates of restrictive practices (Barnett et al., 2019; Halvorsrud et al., 2018; Weich et al., 2017), and for clinicians who are involved in recommendations for sectioning under the Mental Health Act. Furthermore, it is recommended in primary care and Improving Access to Psychological Therapies, given that untreated depression is often a precursor of first episode of psychosis (Basu et al., 2020). It is also advised for professionals in training or in the early years post-qualification, as individuals in these stages are less likely to have developed entrenched unconscious racial biases (Hall et al., 2015).

The measures utilised in this study examined the immediate impact of the training on hypothesised variables related to clinical decision-making and behaviour. Subsequent research should extend its focus to assess real-world behaviours, such as sectioning rates. Qualitative research should also be considered to explore Black service users’ experiences in EIP services. Additionally, different methods for addressing racial inequalities and implicit racial bias should be investigated that are more immersive and enable perspective changing manipulations, such as VR. Furthermore, it is important not to privilege the voices of professionals and instead privilege lived experience (Bhui et al., 2018) therefore, Black individuals with lived experience should work in teams and with service users, for example as peer support workers.

Additionally, further research is required with EIP professionals, but also with other mental health systems given that many adverse experiences occur at the point of sectioning assessments and during hospital admissions. To gain a deeper understanding of the training's impact, future research should investigate the impact of the ‘SEE ME’ training on professionals who are still in training or in their earlier years of post-qualification. Furthermore, administrators attended the ‘SEE ME’ training, however they did not participate in the study due to not meeting the inclusion criteria. Future addressing racial inequalities trainings should extend to non-clinical staff and all professionals who service users encounter, particularly administrators who are a key point of contact and frequently the first contact service users have with services. Moreover, providing participants with feedback about their unconscious bias scores and evaluation is important for future research. This feedback mechanism can potentially enhance self-awareness and promote a more conscious effort to reduce implicit biases, ultimately improving the quality of care provided to Black individuals. Additionally, future research could use different IAT word pairings that are linked to the 'SEE ME' film, for example using words such as "powerful" and "hope" and examine whether this impacts participants' implicit bias. Additionally, based on previous research, emotional and cognitive stressors can impact racial bias, therefore future research related to the 'SEE ME' training should evaluate the impact of cognitive stressors, such as stress or burn out.

Previous research has highlighted the complexity of deeply rooted implicit bias in cognitive processes, especially resistant to change with short-term interventions (Lai et al., 2016) . There is a necessity to re-evaluate intervention strategies, their duration, and intensity, and advocate for long-term assessments to uncover latent changes over time. Some interventions may not produce immediate bias reductions, but they can lead to subsequent attitude and behaviour shifts, underscoring the importance of comprehensive evaluation of effective bias reduction strategies (Lai et al., 2016). Furthermore, conducting a long-term follow-up is essential to assess the sustainability and longer terms effect of the 'SEE ME' training. This short term study suggests the need for interventions that bring about unconscious bias changes that have long-lasting effects and that are embedded in routine NHS practice to address the racial disparities that Black people encounter.

"*If you get it right with me, you've got it right with my whole family*" (EbE, 'SEE ME' film).

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Part 3: Critical Appraisal

Overview

This section will offer a critical appraisal of my experiences of conducting the empirical research for this thesis, focussing on five main areas. Firstly, I will reflect on my rationale for choosing this research project. Secondly, I will consider the complexities of categorising 'Black' Individuals in Mental Health Research. Thirdly, I will reflect on the importance of co-production within the context of this project. I will then discuss my involvement in the ‘SEE ME’ training and I will provide reflections on my experience of this process. Finally, I will reflect on the challenges that came up for me whilst carrying out the research.

Rationale for choosing this research project

From the very outset, I was immediately drawn to this project, and it ignited a profound sense of duty and a passionate commitment within me to carry it out. The decision to embark on the journey of conducting a doctoral thesis on the impact of a training aimed at reducing racial inequalities for Black service users with psychosis was deeply rooted in both personal and professional motivations.

As a Black trainee clinical psychologist, living in the UK I have been exposed to the persistent racial disparities in access to, quality of, and outcomes within mental health services. This has shaped my perspective and driven my interest in addressing racial disparities within mental health care. Throughout my academic and clinical training, these disparities continued to be a recurrent theme. These ongoing disparities with a lack of action to address them have continuously served as both a source of motivation and frustration for me. It was the *doing something* aspect of the project that really interested me. At that point, I had grown increasingly disheartened by the unsettling statistics and the distressing stories of racial discrimination reported in the media. Engaging in meaningful action felt like a powerful way to address these issues, moving beyond conversations and statistics. Additionally, being involved in a project that allowed for an opportunity of co-production felt really meaningful to me.

From a professional perspective, the selection of this research topic aligned with my aspirations as a current trainee and future clinical psychologist. Prior to selecting this research topic, I had experience of working with service users with psychosis in an NHS team in London. I witnessed the discriminatory practices and racism Black people face in mental health services, first-hand. What was immediately obvious to me was that White people were being referred to psychology and that Black people were not. It really angered me and within this context, as a new trainee, I did what I could which was creating a psychological group that everyone in that community setting could access. It was highly attended for my whole placement, primarily by people from Black and Minority Backgrounds (BME). Due to this the group was embedded within the service, beyond my tenure. Within my career, I would like to take actions to create systemic change as much as I can, which again is what drew me to this project.

The Complexities of Categorising 'Black' Individuals in Mental Health Research

In the context of my research project focused on reducing racial disparities within mental health services for individuals of Black African, Black Caribbean, and Black British backgrounds, I encountered a significant challenge related to the categorisation of participants as 'Black.' While this term was inclusive to some extent, it raised important questions about the diverse and nuanced experiences within this group. While 'Black' is commonly employed as a broad categorisation, it may inadvertently disregard the distinct ethnic, cultural, and national identities that exist within the diverse African and Caribbean communities (Aspinall, 2002). Furthermore, the experiences of Black individuals who were born and raised in the UK may significantly differ from those who have migrated to the UK. This was a limitation of included studies in the systematic review, studies generally did not report whether participants had migrated to the UK or whether they were born and raised in the UK, making it challenging to distinguish between first, second and third generation migrants. Migration histories, language, and cultural norms profoundly influence individuals' experiences of mental health, access to healthcare, and exposure to racism and discrimination. As a result, there was a risk that the research might not fully capture these distinctions. Moreover, the term 'Black' in research, though practical for demographic categorisation, doesn't account for the intersectionality of identities. Black individuals may also identify with other characteristics, such as gender, religion, or socioeconomic status, each of which can intersect with their experiences of mental health and healthcare access. These intersections introduce unique challenges and experiences. Throughout the research project, I reflected on the importance of adopting a more nuanced and intersectional approach. Recognising the heterogeneity within the 'Black' community is essential, and collecting detailed demographic and contextual information can help facilitate a more accurate understanding of experiences and disparities. It also allows for the identification of culturally responsive and tailored interventions that better serve the unique needs of different subgroups within the 'Black' category. Reflecting on these complexities, I have come to appreciate the significance of considering diversity and intersectionality in mental health research, as this can ultimately lead to more equitable and effective interventions.

Co-production and its importance within the context of this project

Co-production is a collaborative approach that involves the active participation of service users, or EbEs, in the development, design, and delivery of services, interventions, or research initiatives (Verschuere et al., 2012). It is based on the fundamental principle that individuals with lived experience possess unique insights and expertise that are invaluable in shaping and improving services or projects. The emphasis on co-production in this project is a direct result of the belief in the importance of including the voices and experiences of Black individuals in shaping interventions and services. The decision to co-produce a film and training with Black experts by experience was rooted in the recognition that those with lived experience possess invaluable insights that can inform meaningful change.

Co-production empowers service users by giving them a voice and an active role in decisions that directly affect their lives (Turnhout et al., 2020). In the case of this project, Black individuals with psychosis, the EbEs, were co-creators of the film and in the selection of the outcome measures and in the co-production of the vignettes and the 'commitment to addressing inequalities' questionnaire**.** This approach gave them the platform to tell their stories in the way they wanted it to be told, for mental health professionals to hear directly from them ways that racial inequalities could be addressed directly honouring and acknowledging their expertise, and also measuring targets they felt were important to capture. Additionally, co-production ensures that services, interventions, or research projects are relevant and effective (Bell et al., 2023). The active involvement of those who had directly experience racial disparities within mental health setting have resulted in this project being so meaningful. They played a pivotal role in shaping the training's content, preferred delivery style, and tone, and sharing their stories making it attuned to the needs of Black individuals with psychosis. Co-production aligns with the principles of equity and inclusivity. It challenges traditional power dynamics and acknowledges that everyone, regardless of their background or mental health status, should have an equal say in decisions that affect them. This inclusive approach was the foundation of our project, aimed at addressing racial disparities and promoting more equitable mental health services. Co-production fosters trust and strong relationships between service providers, researchers, and service users (Filipe et al., 2017). This project really felt like the power imbalance that often exists had really reduced, we all felt like we were one team working together, the service users, research team, mental health professionals and the film production crew. There was a sense of partnership and mutual respect. This trust was a critical component of our project's success, facilitating open dialogue and the sharing of personal narratives.

My role in developing the ‘SEE ME’ training

The empirical study evaluated the impact of the ‘SEE ME’ training, although developing the training was a component of a broader service development initiative, it represented a substantial and pivotal part of my doctoral journey. The training was created through a collaboration involving myself, three peer trainee clinical psychologists, two research supervisors, five Experts by Experience (EbEs) who were Black service users with lived experience of psychosis, and mental health professionals. My role in supporting the development of the film emerged as a multifaceted and deeply meaningful journey. From the inception of the project to the creation of the final product, my involvement extended through various phases, and offered me profound opportunities both personally and professionally for learning and development. We met the EbEs through the Early Intervention in Psychosis NELFT EbE group and established a meaningful relationship with them, maintaining continuous communication right from the outset of this project.They played a central role in shaping the intervention right from the beginning, from brainstorming its initial concept to sharing their personal stories and key messages in the film. Throughout the project, they took an active part in continuous discussions and workshops, providing invaluable input into the training's content and how it should be presented in the film.

The heart of this co-production lay in the workshops that were conducted with the EBEs. In these sessions the EBEs shared their stories, expressed their emotions, shaped the narrative of the film, discussed how they wanted the film to look, the tone of the film along with the types of music that they wanted to be used to portray these tones. It was during these workshops and at filming days that I witnessed the profound impact of their narratives. Hearing their stories first hand was so powerful and moving and evoked so many emotions in me; sadness, anger, and hope for change. It was a privilege to be entrusted with their stories, and the responsibility to do justice to their experiences was deeply felt and alongside ensuring that they were the storytellers of their own stories and an enduring commitment to ensure that their stories were heard in the manner they wished. “Creativity does not just reflect our experience, but actively shapes it; hence it comes with great responsibility to self and others" (Clennon, Bradley, Afuape & Horgan, 2015). These authors state that creativity is most rewarding when it liberates us from oppressive notions, rather than perpetuating them.

Engaging in a creative project outside the traditional clinical setting provided a unique perspective on the transformative power of creative expression. Being on film sets and collaborating with professionals from the film industry introduced me to an entirely different realm of creativity. I had the opportunity to learn about directing, cameras, lighting, and the nuances of filmmaking. This expanded my understanding of how creativity and storytelling can be harnessed as tools for change. I also assumed a practical in arranging and supporting filming days, addressing logistical considerations, ensuring the EBEs were immediately paid, and ensuring the comfort and safety of the EBEs, including transportation support**.** Attending filming on weekends allowed me to offer continued emotional support with a face that the EBEs were familiar with and had already built a relationship with.

In essence, my role in supporting the development of the 'SEE ME' film was a profound journey that transcended the boundaries of traditional clinical psychology. It emphasised the transformative potential of creative collaboration and reinforced my commitment to addressing racial disparities in mental health through innovative and inclusive means.

Challenges and reflections that came up whilst undertaking the research

Carrying out my research project whilst also supporting in the co-production of the film often required an intense level of multitasking that was both demanding and challenging. I found myself juggling a multitude of responsibilities simultaneously, including tasks of involving EbEs and attending filming days. Concurrently, I remained in regular communication with the film company supporting them with practical tasks. In addition, I was engaged in extensive literature searches identifying outcome measures that aligned with the training targets for my research project. Simultaneously, I carried out a literature search to gain insights into the creation of vignettes and the critical factors that should be considered. At this time, I also co-produced the vignettes with EbEs and mental health professionals and piloted them with trainee clinical psychologists. Multitasking all these tasks, whilst also meeting the demands of the doctorate that included placement, teaching, exams, and assignments was undeniably challenging, at times I found it hard to keep up and it was exhausting. However, it was driven by a deep-seated desire to do justice to the topic and ensure that the voices and experiences of those involved were heard and represented accurately.

Another challenge that came up for me during data collection was separating the service development project from my empirical study. Although I emphasised to staff that participating in my study was optional, I often wondered if they really viewed it as optional because attending the 'SEE ME' trainings was mandatory as part of routine service development. When it came to the completion of the questionnaires, despite my repeated emphasis on participation being optional and their right to withdrawal at any time, I frequently reflected on whether staff members felt obliged to participate because of being aware that the DClin Trainees supported with leading in the development of the 'SEE ME' training that was a service development project under NELFT. They therefore may have participated out of gratitude or politeness which triggered feelings of discomfort and, at times, a sense of guilt on my part. I grappled with the awareness that some of the staff might have engaged in the process due to professional expectations rather than a genuine interest in the research. These reflections have underscored the delicate balance between the necessity of mandatory participation for certain aspects of the project and the desire to maintain the voluntariness of engagement. It has also deepened my appreciation for the ethical considerations that underpin research participation, emphasising the need to ensure that participants feel a sense of agency and autonomy in their involvement.

In the film, one of the EbEs described what being Black meant to him "the colour black it absorbs things. I absorbed a lot through my race, through my culture, through my history…”. This quote really resonated with me, and I have found myself reflecting on it a lot. During the data collection period of my empirical paper I felt like I was absorbing so much. In my personal context, a war started in my home country of origin, Sudan. I attended the ‘SEE ME’ trainings and administered outcome measures whilst at the same time I was constantly worrying about my family members safety. The lack of media coverage about this ongoing war made me feel so angry and upset about how Black people are treated and how unjust the world is to those who do not deserve it. This connected me even more to the project because it was an attempt to actually do something to tackle racial injustice. Like the service users in the systematic review highlighted, I think context is so important, and my personal context at this time felt important to include.

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Appendices

Appendix A: ‘SEE ME’ Film Link

[redacted]

Please do not share this film link. The link will be removed for the final submission. Thank you.

Appendix B: 'SEE ME' Reflective Tasks

UCL

SEE ME

The Danger of a Single Story

NELFT NHS
NHS Foundation Trust

TASK 1 - Individual

- ☐ What stood out to you? What did you take away from the film?

- ☐ Why do you think these things stand out to you (or not)?
    - *Consider your own personal or professional identities and experiences.*
    - *Think about parts of your identities that may be more or less visible to others, and parts of yourselves that you choose to share and others you tend to keep quiet.*

- ☐ How do these reflections link to your values or hopes in the work that you do?

TASK 2 – Small groups (2-3 people)

- ☐ What parts of your client's stories did you pay attention to most and least?

- ☐ What might your client have wanted you to know, or hold in mind about them?

- ☐ What else might you (and/or your team) have wanted to hear about this client's stories to help move work forward?

- ☐ What could we learn from the film that could help?

TASK 3 – Larger groups (4-6 people)

- ☐ What's one learning point or take away message you will take from today?

- ☐ What will you and your team do to ensure that client's stories are brought into your everyday work? – *Try to think of specific examples*

- ☐ What would be the first steps (as an individual or as a team) to take forward what you have thought about from today?

- ☐ How can your team keep this conversation going – what is the next step?

Appendix C: Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE OF THE VICE-PROVOST (RESEARCH, INNOVATION & GLOBAL ENGAGEMENT)

24th March 2023

Dr Miriam Fornells-Ambrojo
Research Department of Clinical, Educational and Health Psychology
UCL

Cc: Michaela Eells, Lori Bain, Mishka Mahdi & Chelsea Gardener

Dear Dr Fornells-Ambrojo

Notification of Ethics Approval with Provisos
Project ID/Title: 24629/001: Addressing inequalities in the care of Black people with psychosis

Further to your satisfactory responses to the Committee's feedback, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **31st December 2024.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
https://www.ucl.ac.uk/research-ethics/responsibilities-after-approval

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

Appendix D: Study Advert

Recruitment poster; Version 1.0
Date (25.03.2022)

NELFT NHS
NHS Foundation Trust

UCL

This study has been approved by the UCL Research Ethics Committee, Approval ID number: 24629/001. Principal Investigator: Dr Miriam Fornells- Ambrojo

Study title: Addressing inequalities in the care of Black people with psychosis: sharing testimonials. Evaluating the impact of 'SEE ME' film training on mental health professionals.

Are you employed by NELFT?
Do you work in an Early Intervention in Psychosis service?
Have you attended 'SEE ME' training event?

If you answered **'yes'** to all the questions above and you would like to take part in this study, **we would like to hear from you**.

What is this research about?

We want to evaluate whether the racial inequalities training event, 'SEE ME', has an impact on mental health professionals' clinical practice.

Who can take part?

Any EIP professional who attended the 'SEE ME' training event.

What is involved?

You will be asked to complete two online surveys on the day of the training event (one prior to the training, and one following the training). Each survey will last approximately 30 minutes.

Each EIP team will receive **£50** for taking part in the research.

If you are interested in participating or would like to find out more, please contact **Mishka Mahdi** (Trainee Clinical Psychologist) at *study email address* (*study tel. number)

Appendix E: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

UCL Research Ethics Committee Approval ID number: 24629/001

Title of Study: Addressing inequalities in the care of Black people with psychosis: Evaluating the impact of the 'SEE ME' film training on mental health professionals and an exploration of professional experiences, reflections, and views

Department: Research Department of Clinical, Educational and Health Psychology

Researchers: Trainee Clinical Psychologists, Mishka Mahdi [redacted] Lori Bain [redacted]

Principal Researcher: Dr Miriam Fornells-Ambrojo, Clinical Psychologist [redacted]

You are being invited to take part in a research project. Before you decided it is important for you to understand why the research us being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

1. What is the purpose of the study?

There are two parts to this study. You are welcome to be involved in both parts of the study, or in just one part.

Part a: We would like you to complete online questionnaires and tasks before and after the 'SEE ME' film training event so that we can evaluate the impact of the training on your clinical practice.

Part b: We would like to interview you about your experience of the 'SEE ME' film training event. We would like to hear whether there was anything particularly helpful/ unhelpful, whether you have learnt anything new, and the impact this may or may not have on your clinical practice. We would also like to hear your views and ideas for future training. We would like to interview between 15-20 people. If many more people would like to be interviewed, we would decide who to interview by selecting people from range of professional roles and ethnicities.

2. Why have I been invited to take part?

We have invited people to take part in this research who are:

Employed by North East London Foundation Trust (NELFT) working within the Early Intervention Psychosis (EIP) services in a clinical role and

Attend the 'SEE ME' training event

Who cannot take part in the study?

Unfortunately, we must ask you to not participate if you:

…did not attend the 'SEE ME' training event

…are not an employee of NELFT

…were actively involved in the co-production and development of the SEE ME' training event (i.e., contributed to the film development)

3. Do I have to participate?

You do not have to take part in this study. It is up to you to decide whether you wish to participate or not. If you decide to take part, we will ask your permission to use your anonymised responses in our doctoral thesis. We also plan to share our findings in research publications and/or presentations. You are free to withdraw at any time, without having to give a reason for doing so, and this will not have effect on your employment or role.

4. What will happen if I decide to take part in the study?

Part (a): If you agree to participate you will be asked to complete two online surveys on the day of the training, one prior to the training and one following the training. You will not be asked to provide your name, or any other identifiable information and all your data will remain anonymous and confidential. Each survey will last approximately 30 minutes. The online surveys will include questionnaires, clinical vignettes and demographic (non-identifiable) questions and a short feedback form about the training event. You will require a device with a keyboard, e.g., laptop or computer, to complete the online questionnaires.

The online survey will include questionnaires, clinical vignettes and demographic (non-identifiable) questions and a short feedback form about the training event. The questionnaires will look at cultural competence, reflexivity, and clinical decision-making.

Part b: If you decide that you would like to take part in this part of the study, the researcher will contact you to arrange a date and time for the interview. The interview will last between 45-60mins and will take place at a convenient NELFT site or online via MS Teams (depending on your preference). The researcher will ask you about your experience of attending the 'SEE ME' training event, and about the impact of this on you professionally and personally. The interview will be recorded so that the researcher can transcribe the conversation once you have finished talking. The researcher will remove any personally identifiable information so that the conversation will be anonymised. The researcher will identify key themes that arise during the interview and will choose some direct quotations to show examples of these themes in the final report.

Please note you can decide to take part in both parts (a) and (b), only one of them, or neither of them.

5. Will I be recorded and how will the audio recording will be used?

The interview session is audio recorded so that the researcher can transcribe the conversation after you have finished talking. If you do not consent to being recorded, you unfortunately will not be able to take part in the study as we will need to analyse the interview transcripts. The audio recording will be stored on an encrypted device and will be deleted as soon as the interview is transcribed. Transcriptions will be written by the researcher that conducted your interview and the researcher will remove any personal identifiable information so that the conversation will be completely anonymised. The researcher will identify key themes that arise during the interview and will choose some direct quotations to show examples of these themes in the final report.

6. Additional opportunity to offer consultation to the research team:

We will also invite participants to meet with the researcher to comment on their interpretation of the main themes emerging from your interview, including any anonymised quotations used. If you are interested in being involved in this additional part of the project, you will be invited to attend a second meeting around March-April 2023, when the researcher will show you the summary of themes that have been identified and you will be asked about your feedback to ensure you feel they accurately represent your view.

7. Will I be compensated?

Part a: If you complete the pre-post questionnaires on the day of the ‘SEE ME’ training event you will be entered into a prize draw for £50. The prize draw will be conducted 1 week after the date of measure completion. You will be informed of the outcome via email and receive payment with via voucher or cask, depending on your preference. Additionally, each of the 4 NELFT EIS teams will receive £50 to thank you for participating in this part of the study irrespective of your individual decision to take part.

Part b: Yes, if you take part in the interviews, you will receive £15 in compensation for your time. This will be in the form of a gift voucher or cash, depending on your preference. Additionally, if you are also interested in contributing to checking the credibility of the analysis (i.e., has the researcher interpreted and understood the interviews accurately), you will be contacted to review the themes emerging from the interview and will receive an additional £10 for your time.

8. What will happen to the results of the research study?

You will be offered the opportunity to receive a summary of the findings of the study. The results of the study will contribute to part of a dissertation thesis and be sent to an academic journal for publication, but you will not be identifiable. Your participation in the study will, of course, not be disclosed.

9.What are the possible disadvantages and risks of participating in this study?

Talking and thinking about racially inequalities can, understandably, evoke challenging emotions in some people. There is a chance that it could be distressing for you to reflect on, and think about, the factors that can influence the care of Black individuals with psychosis. This may be particularly difficult if you have lived experience of being a service user or carer.

The researchers are training to be clinical psychologists and have experience in managing distress. Whilst doing the questionnaires if at any time you find their contents to be distressing, please contact the researcher so that you can be supported, you will be signposted to local support services if required. You can withdraw from completing the questionnaires at any time without providing a reason. Support organisations will be provided at the end of this participant information sheet and at the end of the survey.

Whilst doing the interview if at any time you feel upset, you can let the interviewer know so she can help you to manage your distress. You can ask the interviewer to move on to another subject or terminate the interview at any time. You do not need to discuss anything that you do not want to, and you should discuss only the things which you wish to share. If you experience distress at the end of the interview, the researcher will remain with you until you feel better and will discuss with you where you can get additional support.

10. What are the possible benefits of taking part?

We hope that you will find it a positive experience to share your experience of the training event. By evaluating the impact of the training, we can determine whether this training is helpful for addressing racial inequalities for mental health professionals. Furthermore, by understanding how the racial inequalities training is experienced by professionals, we can learn how to improve the training and tailor it to the needs of mental health professionals. We aim to share important and relevant information with key stakeholders to enable many people to learn from the feedback that you have provided. We hope that this research can contribute to the improvement in care for Black service users with psychosis.

11. What if there is a problem?

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated by the research team, the National Health Service or UCL complaints mechanisms are available to you. Please ask the researcher 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. UCL's insurance provides indemnity in case of an adverse event or if a claim was made. The insurance policy provides two types of cover for all studies: Cover for claims against UCL for negligence by research participants and others. Cover for non-negligent harm to study participants, that is compensation to participants where negligence cannot be, or is not proven.

If you suspect that the harm is the result of the Sponsor's (University College London) negligence, then you may be able to claim compensation. Please make the claim in writing to Dr Miriam Fornells-Ambrojo who is the Chief Investigator for the research and is based at 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. If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions, contact details are at the end of the document.

If the information above has interested you and you are considering participation, please read the additional information before making a decision.

12. What will happen if I don't want to carry on with the study?

You are free to withdraw from the study up to 3 weeks after completion. If you withdraw from the study without your right being affected. After 3 weeks, we will keep the information about you that we have already obtained but please be aware that to safeguard your rights, we will use the minimum personally-identifiable information possible.

13. Will my participation be kept confidential? (Privacy notice)

The controller for this project will be University College London (UCL). This means that we are responsible for looking after your information and using it properly. UCL will keep identifiable information about you for 10 years after the study has finished. The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data and can be contacted at data-protection@ucl.ac.uk. This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in health and care research studies, please visit this web page for further information https://www.ucl.ac.uk/legal-services/privacy/ucl-general-privacy-notice-participants-and-researchers-health-and-care-research-studies. The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data is: 'Public task' for personal data and 'research purposes' will be the lawful basis for processing special category data. Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk

We follow ethical and legal practices and all information about you will be handled in confidence. The information about your participation in this study will usually be kept confidential. The only exception is if you tell us something that leads us to believe that you may be at risk of harming yourself or somebody else, or that you are at risk of harm from somebody. In this case, we will need to inform your line manager to ensure that you receive the relevant support. We will keep you informed about this. We will only use your personal information to contact you if you have agreed to be contacted for participation in this study.

Only the lead researchers on the project will have access to your personal information and this will be kept separate from the data collected. Only researchers involved in this study and regulatory authorities will have access to the data. Data will be stored in locked offices and on password-protected databases at University College London. All information that is collected during the course of the research will be kept strictly confidential according to the General Data Protection Regulation (GDPR) and Data Protection Act 2018. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

North East London Foundation Trust will keep your name and contact details confidential and will not pass this information to UCL. North East London Foundation Trust will use this information as needed to contact you about the research study. Certain individuals from UCL and regulatory organisations may look at your research records to check the accuracy of the research study. UCL will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

UCL will collect information about you for this research study from NELFT. NELFT will not provide any identifying information about you to UCL.

14. Who has reviewed this study?

This study has been reviewed and approved by the UCL Research Ethics Committee: Project ID number: 24629/001

15. Who is organising and funding this study?

This study has been organised by UCL and funded by UCL DClinPsy.

16. How have patients and the public been involved in this study?

Service user involvement and professional involvement was an important part of the study preparation, particularly in developing the interview schedule. Three Experts-by-Experience and two mental health professionals were consulted for the selection of the questionnaires and for the development of the vignettes and the interview schedule. The experts-by-experience were black service users and carers who co-created the ‘SEE ME’ training event. The mental health professionals who provided their input both worked in NELFT and would have been eligible to take part in the research study. They provided feedback on the recruitment poster, information sheet, consent form, questionnaires and interview schedule. Their feedback helped shape the final wordings of questions, to ensure that they were clear, felt relevant, and sensitively addressed difficult topics.

17. You may find the following resources/services helpful in relation to obtaining information and support:

The Samaritans: 116 123. A free 24/7 helpline for anybody experiencing distress.

Support line for NHS staff: 0800 06 96 222 (7am to 11pm, 7 days a week).

Shout Text service: NHS and other health and social care staff can text ‘frontline’ to 85258 for support.

Project5: provides NHS staff free access to support sessions via an online booking system: www.project5.org

Black Minds Matter UK – a charity supporting Black people to access mental health care services. www.blackmindsmatter.com

The Black, African and Asian Therapy Network – a network offering resources relating to wellbeing and mental health. www.baatn.org.uk

You can access mental health and wellbeing apps such as Headspace, Unmind, Sleepio, Daylight and Liberate for free.

Your General Practitioner (GP) can signpost you to additional services if you experience emotional distress.

18. Contact details:

[redacted]

Thank you for your interest in this study and for taking the time to read this information. If you agree to part in the study, you will be given a copy of this information sheet and a copy of the signed consent form to keep.

Data Protection privacy notice	**If I have any questions, who can I ask?**
UCL's Data Protection Officer is Alex Potts and he can be contacted at data-protection@ucl.ac.uk. You can read UCL's privacy notice at: https://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care- research-privacy-notice and details of your rights at:https://ico.org.uk/for-organisations/data-protection-reform/overview-of- the-gdpr/individuals-rights/ Your personal data (name, contact details, gender, ethnicity) will be processed as described in this information sheet. The legal basis for data processing is to "perform a task in the public interest"	[redacted] If you are unhappy about the study at any stage, please contact the researchers on the email address above. If you would like to complain further, you can email ethics@ucl.ac.uk.

Appendix F: Consent Form

UCL Research Ethics Committee Approval ID number: 24629/001

Title of Study: Addressing inequalities in the care of Black people with psychosis: Evaluating the impact of the 'SEE ME' film training on mental health professionals and an exploration of professional experiences, reflections, and views
Department: Research Department of Clinical, Educational and Health Psychology
Researchers: Trainee Clinical Psychologists, Mishka Mahdi [redacted] and Lori Bain [redacted]
Principal Researcher: Dr Miriam Fornells-Ambrojo, Clinical Psychologist [redacted]

Thank you for considering taking part in this study. Please complete this form after you have read the Information Sheet and listened to an explanation of the study. If you have any questions arising from the Information Sheet or the explanation given to you, please ask the researcher before deciding whether to take part. You will be given a copy of this consent form to keep and refer to any time.

I confirm that I understand that by ticking each box below I am consenting to participating in this study. I understand it will be assumed that unticked boxes means that I DO NOT consent to participating in this study. I understand that by not giving consent to any one element that I may be deemed ineligible for the study.

1. I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw within 3 weeks of completing the study without giving a reason, without my employment or legal rights being affected.	
3. I understand that 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 anonymised information.	
4. I consent to the processing of my information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the UK Data Protection Act 2018 and General Data Protection Regulation 2018.	
5. **Part (a) of the study:** I agree to take part in the above study involving the completion of questionnaires and tasks before and after the 'SEE ME' training event to evaluate the impact of training	
5.1 I understand that require a device with a keyboard (e.g., laptop or computer) to complete the questionnaires.	
5.2 I agree to be entered into an individual prize draw for £50 for taking part in part (a) of the study. Please note that additionally to the individual prize draw, each of the 4 NELFT EIS teams will be allocated £50 irrespective of your individual participation to use as they wish (e.g., as part of away day).	
6. **Part (b) of the study:** I agree to take part in an interview about my experience of the 'SEE ME' training	
6.1 I give consent for the research interview conducted post training to be audio recorded for the purpose of later analysis of the discussion to achieve the aims of the study.	
6.2 I give consent for anonymous quotations to be extracted from the audio recordings for use in future publications. I understand that direct quotes from the interview that I participate in will be included in the final report and publication from the study, but that my information will be anonymized, so that nobody can tell it was me that said it.	
6.3 I understand that I will be offered a £15 gift voucher as a thank you for my participation. I understand that there are no other direct benefits, financial or otherwise, of my participation.	
7. I understand that my information will be stored safely and securely at University College London. I agree that if I agree to take part in the interviews, the researcher will delete the audio recording, once transcription is completed. I agree that the written version of our conversation will be stored for 5 years. Questionnaire data with no identifiable personal information will be kept indefinitely on a anonymised database.	
8. I agree to be contacted at a later date to be involved in the data analysis process, by checking themes identified by the researcher for accuracy (optional).	
9. I would like to be sent a copy of the final written report (optional).	
10. I would like information about follow-up studies related to this topic (optional).	
11. I have been provided with contact information for further support if required	

Participant name Signature Date

Researcher name Signature Date

Appendix G: Debrief Sheet

Study title: Addressing inequalities in the care of Black people with psychosis: sharing testimonials. Evaluating the impact of 'The Dangers of a Single Story' film training on mental health professionals

Debrief sheet

Thank you for taking part in this study. This document explains why we set up the study and what we hope to achieve from the data that we collect during the interviews.

If you know of anyone that will be participating in this study, we request that you not discuss it with them until after they have had the opportunity to participate. Prior knowledge of questions asked during the study can invalidate the results. We greatly appreciate your cooperation.

Study rationale

It is well documented that there are racial inequalities in the care of Black service users with psychosis. There have been a few interventions and training programmes targeted at addressing racial inequalities with the aim of improving the care of Black service users within mental health services. There has been limited research that has focused on evaluating the impact of anti-racism interventions on mental health professionals.

This study aimed to evaluate the impact of this training on mental health professionals' attitudes, beliefs and clinical practise. We hope that this evaluation will allow us to determine whether this training is useful for tackling racial inequalities in services.

What if you have been adversely affected by taking part?

The research was not designed to cause distress and reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation, or its after-effects, may have been distressing or challenging in some way. If you have been affected in anyway, you may find the following resources/ services to be helpful in terms of obtaining support and information:

- The Samaritans: 116 123. A free 24/7 helpline for anybody experiencing distress.
- Support line for NHS staff: 0800 06 96 222 (7am to 11pm, 7 days a week).
- Shout Text service: NHS and other health and social care staff can text 'frontline' to 85258 for support.
- Project5: provides NHS staff free access to support sessions via an online booking system: www.project5.org.
- Black Minds Matter UK – a charity supporting Black people to access mental health care services. www.blackmindsmatter.com
- The Black, African and Asian Therapy Network – a network offering resources relating to wellbeing and mental health. www.baatn.org.uk
- You can access mental health and wellbeing apps such as Headspace, Unmind, Sleepio, Daylight and Liberate for free.
- Your General Practitioner (GP) can signpost you to additional services if you experience emotional distress.

Contact details

If you would like further information or have any questions or concerns regarding this study, please feel free to contact the researcher:

Name: Mishka Mahdi
Email: [redacted]

Appendix H: Demographic Information Sheet

Study title: Addressing inequalities in the care of Black people with psychosis: sharing testimonials. Evaluating the impact of 'The Dangers of a Single Story' film training on mental health professionals and an exploration of professional experiences, reflections, and views.

Demographic characteristics

1. **What is your age?**

2. **What is your gender identity?**
   [] Female
   [ ] Male
   [ ] Non-Binary
   [ ] Prefer to self-describe _____ _____________
   [ ] Prefer not to say
3. **What ethnicity do you identify as?** (e.g., Asian, Asian British, *Black African, Black Caribbean, Black British, Black other,* White British, White European, *etc)*

4. **What country were you born in?**
   - *If not born in the U.K.:* How long have you been living in the U.K.?
5. **Do you follow a faith or belief system?**
   - If yes, what faith/belief system do you identify with?
6. **What is your highest level of education?** *(e.g., GCSE, NVQ, Apprenticeship, Degree/Higher Degree)?*

7. **What is your professional role?** *(Your full and specific job title)*

8. **How many years have you been working in mental health services for?**

9. **What country did you train in for your professional role?**

10. **Do you have lived experience of psychosis as a service user or carer?**

    - Yes/ No/ Prefer not to say

11. **Have you attended any previous training in the sphere of cultural humility/cultural competence/ a training/ project that seeks to address racial disparities?**

    - If yes, what was the name and duration of the training(s)?

12. **Have you been involved in restrictive practices such as sectioning or restraining within your role?**

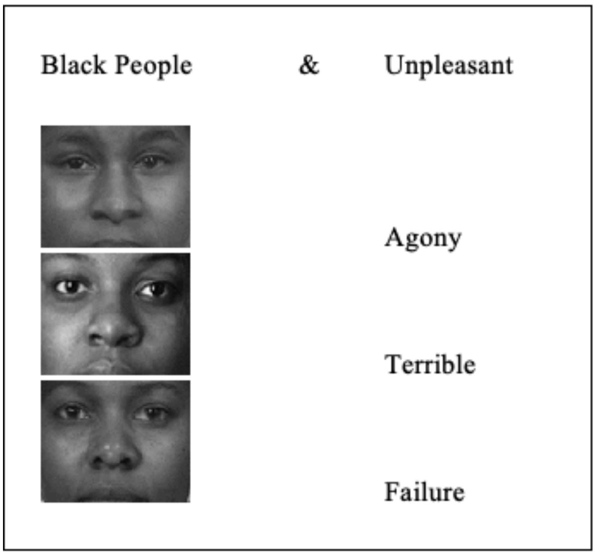
13. **What do you aim to achieve from taking part in the addressing racial inequalities 'The Dangers of a Single Story' training project?**

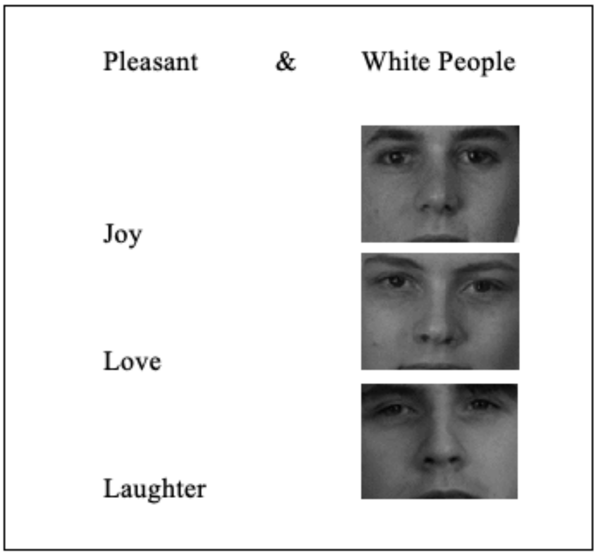
Appendix I: Race Implicit Association Test Stimuli

CATEGORY	**ITEMS**
PLEASANT	Joy, Love, Peace, Wonderful, Pleasure, Glorious, Laughter, Happy
UNPLEASANT	Agony, Terrible, Horrible, Nasty, Evil, Awful, Failure, Hurt
BLACK PEOPLE	Faces of Black People
WHITE PEOPLE	Faces of White People

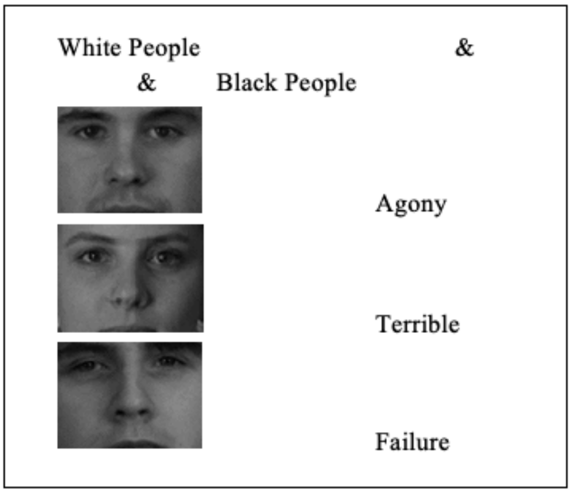
Example of pairings using the Race IAT:

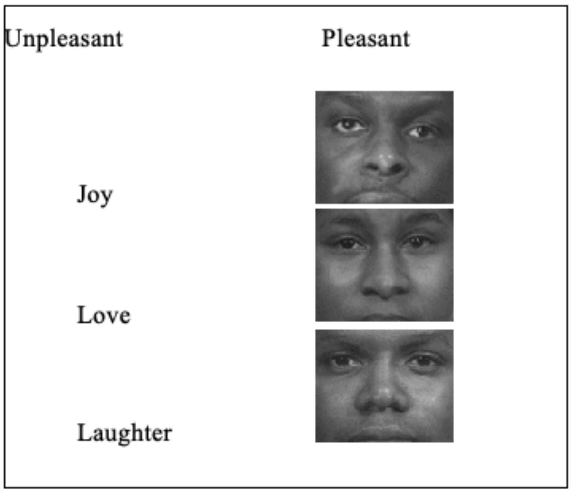
When there is an implicit preference for whites on the race attitude IAT, the response to these pairings is faster:





than the response to these pairings:





Appendix J: Cultural Competence Assessment Tool

A) Assessing Cultural Awareness

For office use only ☐

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	[redacted]				
2	[redacted]				
3	[redacted]				
4	[redacted]				
5	[redacted]				
6	[redacted]				
7	[redacted]				
8	[redacted]				
9	[redacted]				
10	[redacted]				

B) Assessing Cultural knowledge

For office use only ☐

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	[redacted]				
2	[redacted]				
3	[redacted]				
4	[redacted]				
5	[redacted]				
6	[redacted]				
7	[redacted]				
8	[redacted]				
9	[redacted]				
10	[redacted]				

C) Assessing Cultural Sensitivity

For office use only ☐

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	[redacted]				
2	[redacted]				
3	[redacted]				
4	[redacted]				
5	[redacted]				
6	[redacted]				
7	[redacted]				
8	[redacted]				
9	[redacted]				
10	[redacted]				

D) Assessing Cultural Practice

For office use only ☐

	Statements	Strongly agree	Agree	Disagree	Strongly disagree
1	[redacted]				
2	[redacted]				
3	[redacted]				
4	[redacted]				
5	[redacted]				
6	[redacted]				
7	[redacted]				
8	[redacted]				
9	[redacted]				
10	[redacted]				

Appendix K: The Reflective Function Questionnaire

Please work through the next 8 statements. For each statement, choose a number between 1 and 7 to say how much you disagree or agree with the statement, and write it beside the statement. Do not think too much about it – your initial responses are usually the best. Thank you.

Use the following scale from 1 to 7:

Strongly	1	2	3	4	5	6	7	Strongly
disagree								agree

1. __ People’s thoughts are a mystery to me **(original item 1)**

2. __ I don’t always know why I do what I do **(original item 17)**

3. __ When I get angry I say things without really knowing why I am saying them **(original item 22)**

4. __ When I get angry I say things that I later regret **(original item 29)**

5. __ If I feel insecure I can behave in ways that put others’ backs up **(original item 35)**

6. __ Sometimes I do things without really knowing why **(original item 36)**

7. __ I always know what I feel **(original item 8)**

8. __ Strong feelings often cloud my thinking **(original item 27)**

Appendix L: Clinical Decision-Making Vignettes

Start of Block: Default Question Block

You will be presented with two short vignettes, depicting experiences of service users who engage with mental health services. After reading the vignettes, please rate the extent to which you agree/ disagree with the questions that follow (from a scale of 0-100). Please try to answer in a way that you feel genuinely reflects how you would act in practice, rather than how you believe one should ideally act or how others might act.

Please note, the researcher's goal is to understand decision-making of groups as a whole and not to evaluate those of individuals.

There are no right or wrong responses to these vignettes. Please try to not overthink your answers and respond quickly choosing what feels “right” in the moment. All your responses will be anonymised.

End of Block: Default Question Block

Start of Block: Clinical Decision-Making Vignettes

Clinical Decision-Making
A 21-year-old Black woman has been hearing voices that others can’t hear for the last 6 months. She believes that strangers on the street can hear her thoughts and that they try to manipulate her and always want her to be upset. Her family describe her as irritable and report that she doesn’t leave her room and that they can often hear her talking to herself. Recently, while her family were watching TV, she unplugged the TV and would not let her family turn it back on. She reported that people on TV track her every move. She attended an assessment at the early intervention in psychosis service, whilst in the waiting room she noticed someone looking at her for a long period of time from the other side of the room. She stood up where she was and asked them to please stop. Staff tried to speak to her in the waiting room, however she abruptly left setting off the fire alarm on her exit. Staff then called the police and a van of 4 police officers arrived.

Please rate from 0-100 the extent to which you agree/disagree with the following statements:

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

0 10 20 30 40 50 60 70 80 90 100

I agree with mental health professionals' decision to call the police in this scenario	
I think that this person should be sectioned under the mental health act and admitted to hospital for assessment	
I think this person would agree to be voluntarily admitted (i.e., she would agree to go into hospital) for assessment	
This person is a risk to themselves	
This person is a risk to others	
This person is frightened	
It will be very distressing for this person to be involuntarily admitted to hospital under section	
It will be very distressing for this person to have police involvement in their sectioning process	

End of Block: Clinical Decision-Making Vignettes

Start of Block: Vignette 2

Clinical Decision-Making
A 21-year-old White woman has been hearing voices that others can’t hear for the last 6 months. She is not sure where the voices are coming from, but feels they are very powerful and spiritual. Her family report that she has been walking around the house, looking irritated and mumbling to herself. Recently, she has been struggling to sleep at night, seems paranoid and has stopped eating food prepared by her family. Last week, she told her parents that she knew what they had planned and started emptying the cupboards, fridge, and bins onto the floor. She left the family home saying that she was in danger and returned late at night. She was being assessed at home by the early intervention in psychosis service after her parents contacted the GP. Staff tried to speak to her in her bedroom and she abruptly left pushing past one of the mental health professionals. They called the police for support and a van of 4 police officers arrived.

Please rate from 0-100 the extent to which you agree/disagree with the following statements:

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree

0 10 20 30 40 50 60 70 80 90 100

I agree with mental health professionals' decision to call the police in this scenario	
I think that this person should be sectioned under the mental health act and admitted to hospital for assessment	
I think this person would agree to be voluntarily admitted (i.e., she would agree to go into hospital) for assessment	
This person is a risk to themselves	
This person is a risk to others	
This person is frightened	
It will be very distressing for this person to be involuntarily admitted to hospital under section	
It will be very distressing for this person to have police involvement in their sectioning process	

End of Block: Vignette 2

Appendix M: Commitment to Addressing Inequalities

Please answer how much you agree or disagree with the statements below:

	Strongly disagree (1)	Disagree (2)	Somewhat disagree (3)	Neither agree nor disagree (4)	Somewhat agree (5)	Agree (6)	Strongly agree (7)
I understand the impact of existing inequalities on Black people in EIS (1)	○	○	○	○	○	○	○
I feel confident talking about the inequalities black people face (2)	○	○	○	○	○	○	○
I feel discomfort when discussing existing inequalities that black service users face (3)	○	○	○	○	○	○	○
I am aware of the impact of my own ethnicity/ identity when working with Black people (4)	○	○	○	○	○	○	○
I have a rich view of Black service users with psychosis in EIS (5)	○	○	○	○	○	○	○

I feel confident in how to create a supportive experience for Black people with psychosis (6)	○	○	○	○	○	○	○
I am committed to addressing inequalities for Black service users in EIS (7)	○	○	○	○	○	○	○

End of Block: Addressing Inequalities Experiences Questionnaire

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Appendix N: Normality Testing of Key Variables

Variable	Skewness Z score	Kurtosis Z score	Shapiro-Wilk Test (*p*)
Pre “SEE ME” Training			
IAT	0.580	-0.838	0.196
CCAT			
Awareness	-3.156	0.140	<.001
Knowledge	-4.073	1.767	<.001
Sensitivity	-3.689	0.532	<.001
Practice	-7.609	6.812	<.001
RFQ			
RFQ_C	-0.901	-1.849	0.008
RFQ_U	6.437	7.521	<.001
EIP	-1.230	0.178	0.595
SDRS-5	1.159	-1.892	<.001
Vignettes			
Black protagonist	2.83	0.956	0.002
White protagonist	1.656	-0.012	0.079
Post “SEE ME” Training			
IAT	1.715	0.064	0.340
CCAT			
Awareness	-5.474	4.302	<.001
Knowledge	-4.481	3.700	<.001
Sensitivity	-3.048	-0.079	<.001
Practice	-14.561	38.384	<.001
RFQ			
RFQ_C	-0.751	-1.476	0.061
RFQ_U	11.727	31.301	<0.001
EIP	-3.048	2.418	0.004
Vignettes			
Black protagonist	0.226	-1.397	0.248
White protagonist	0.648	-0.174	0.754