Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology, September 2024

Doctoral Thesis

Identity and discrimination: Black people's experiences of navigating Mental Health systems

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Word count

Thesis Section	Main Text	Appendices (including tables, figures, and references)	Total
Thesis Abstract	233	-	233
Literature Review	7991	5485	13,476
Research Paper	7999	6679	14,678
Critical Appraisal	3881	380	4,261
Ethics	4,175	11,563	15,738
Total	24,279	24,107	48,386

Thesis Abstract

This thesis focuses on the experiences of managing psychological wellbeing for Black people. The literature review explored the role of masculinity within the management of mental health and help seeking for Black males. The empirical paper focuses on the experience of inpatient mental health care for Black patients.

Section one details the systematic search of literature across four databases: PsycINFO, MEDLINE, CINAHL, Academic Search Ultimate; the search returned five eligible studies for inclusion. This paper highlighted the pressure to conform to masculine norms and the fractured relationship with Black communities and healthcare professionals. Future research should focus on developing these relationships to encourage engagement with healthcare professionals and services.

Section two outlines an empirical study which aimed to explore the role of racial discrimination within the experience of inpatient mental health care for Black patients. Six individuals took part in semi-structured interviews and data was analysed using Interpretative Phenomenological Analysis. Four themes were identified: (1) Loss of freedom and getting stuck; (2) The clash of spirituality, religion and mental health – suppressed by medication and losing identity; (3) The relationship with staff, and (4) Being Black changes things. Findings suggest that restriction, relationships with staff, conflicting agendas, and race and ethnicity were salient factors. This research contributes to literature exploring the experiences of detention for Black people.

Section three critically appraises sections one and two, including personal reflections, limitations, and clinical implications.

Declaration

This thesis contains research undertaken for the Doctorate in Clinical Psychology at the Division for Health Research, Lancaster University. The work presented here is the author's own, except where due reference is made. This work has not been submitted for any other academic award.

Name: Mary-Maria Johnson

Date: 16/09/2024

Acknowledgements

Firstly, I would like to thank the six individuals who kindly gave up their time to participate in this project. It was a privilege to hear your experiences.

I would also like to thank my supervisory research team – Dr Suzanne Hodge, Dr James Kelly, and Dr Suzanne Heffernan. Thank you for guiding me throughout this project, sharing your knowledge, expertise, and extending encouraging words during this process.

I extend a very big thank you to my dearest friends, both old and new found during my time training. Without your continuous support throughout these three years, I quite simply would not have got through this. You have been my crutch, holding me up during times of woe, reminding me that I am capable and deserving to have got here. Thank you for laughing with me and comforting my tears, I am so lucky to have you in my life. I look forward to being able to champion all of you in your endeavours in the way that you have supported me.

Finally, to my family – my dearest mother and my brother. I cannot thank you enough for everything you have done for me, it has not gone unnoticed. Mum, your love and unwavering support has been the foundation of my resilience. Your prayers have provided me with moments of solace and your words of encouragement have inspired me to keep going in pursuit of my dreams. I am eternally grateful for all that you have done for me that has helped me get to this point. Gabriel, your humour, realism and your chill nature has kept me grounded. Thank you for every phone call and facetime, being so far away from home they have really given me moments of joy and I am so grateful.

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Section One: Systematic Literature Review

Exploring the role of masculinity within Black men's mental health

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Prepared for submission to: The Journal of Mental Health (see appendix 1-D for author guidelines)

Abstract

There is a high prevalence of mental illness among Black men, yet low rates of service utilisation. Race and masculinity have been identified as significant factors preventing black men seeking mental health support. The aim of this review was to identify and synthesise qualitative research exploring Black men's experiences of navigating mental health and masculinity in order to understand the role as a barrier to help-seeking. PsychINFO, MEDLINE, CINAHL, and Academic Search Ultimate were searched systematically for eligible studies, using terms relating to Black males, masculinity, and mental health. Qualitative studies that explored masculinity within Black men's mental health were included, five studies were included in the final review. Studies were analysed using Britten et al.'s (2002) approach to Noblit and Hare's (1988) meta-ethnographic method of meta-synthesis. The findings provide some insight into the nuances of masculinity for Black men and the importance of fostering relationships with communities to shift existing narratives that are perpetuating stigmas that are keeping healthcare professionals at a distance from the Black community, and subsequently perpetuating reasons why Black men do not access healthcare services.

Keywords: Black males; Masculinity; Mental Health

Introduction

Mental health is an issue posing significant concern to public health (Al-Sharifi, 2015). Since 2018, there has been a significant increase in the rates of suicide, primarily among males, with rates at their highest in 2023, since 1999 (Office of National Statistics [ONS], 2024). Research has revealed that on average men are less knowledgeable about mental health, hold more negative attitudes about mental health, and are less likely than women to seek support when feeling worried or low in mood (Addis & Mahalik, 2003; Mind, 2020; National Institute of Mental Health [NIMH], 2020). This finding has been observed across the globe and across differing racial and ethnic groups (Addis & Mahalik, 2003; Richardson et al., 2021). Consequently, over recent years there has been an increased focus on outreach to males that experience mental health difficulties to encourage their engagement with services and to prevent suicide.

Healthcare disparities for individuals from minority ethnic groups have been highlighted by global events. For example, during the COVID-19 pandemic, the Black populations in some countries were noted to have infection and death rates between three and six times than those of predominantly White communities (Andraska et al., 2021). The pandemic exposed and exacerbated pre-existing racial and socio-economic disparities that affect health outcomes for individuals of minority ethnic groups (Keys et al., 2021; Marmot, 2020). Additionally, the Black Lives Matter (BLM) social movement also drew attention to the wider disparities across multiple sectors and public services, and the discrimination present within social communities.

Several studies have explored disparities within mental health. A systematic review of UK studies revealed that there is a particularly high prevalence of mental illness among Black populations in the UK, with higher rates of psychosis compared to the reference population in

England (Halvorsrud et al., 2019) and formal psychiatric treatment detained under the Mental Health Act (MHA) for Black people (Barnett et al., 2019; NHS Digital, 2019). However, the use of outpatient mental health services is significantly lower for Black men than Black women, and compared to men of other races (Neighbors et al., 2007; Sellers et al., 2009; Williams & Cabrera-Nguyhen, 2016), and studies report that only 26.4% of Black men are likely to seek support when exhibiting symptoms of psychological distress (Blumberg et al., 2015). However, their rates of detention under the MHA are amongst the highest (Barnett et al., 2019) with Black males being four times more likely to be detained than their White counterparts (Singh et al., 2007). This is concerning, as access to outpatient services might prevent the need for detention and the development of more serious mental health difficulties.

Research has identified inequalities in access to resources and services for individuals from minority ethnic groups (Bhui et al., 2007; Memon et al., 2016; Singh et al., 2007). Multiple factors have been identified that act as barriers to this group accessing support, including socioeconomic status, racism, religious beliefs, masculinity, and a lack of awareness of the need for support (Cheatham et al., 2008). There have been various initiatives to address these issues. For example, the United Kingdom (UK) has implemented a national commitment to prioritise suicide prevention as part of the National Health Service (NHS) long-term plan, which includes a focus on improving access and outcomes for people from minority ethnic groups (NHS, 2019). Additionally, in 2020, NHS England launched the Race and Health Observatory, aiming to address the health inequalities for patients and communities (Hunt et al., 2021). Therefore, it is important to understand the nuances of factors within these communities that constrain or impede engagement with services.

It is argued that not feeling able to access these community or outpatient resources when problems arise is not only problematic for the individual needing support, but can also result in an additional burden being placed on an already overstretched and pressured healthcare system when escalated care and resources are then required (White et al., 2011; Yousaf et al., 2015). In 2021, the UK Government acknowledged the systemic issues within the wider mental healthcare system and committed to reforming the MHA to overcome these inequalities and disparities affecting Black men; however, unfortunately these have been on hold. Despite this, it is of the utmost importance that conversations continue to encourage supporting Black males to engage with services for their mental health so that there is opportunity for early intervention and prevention of escalation in symptoms, distress, risk and subsequent detention.

Exploring the concept of masculinity allows the researcher to vicariously investigate other influencing factors such as socioeconomic resource and limited awareness via the lens of masculinity to obtain a rich perspective Black men's experiences. It has been argued that for males, societal pressures and expectations to conform to masculine norms make help-seeking difficult (Moller-Leimkuhler, 2002). There is a commonly-held perception that if a man needs support to manage his wellbeing, then he lacks masculinity, which is prominent belief among men of all races; however, this is often more prevalent within minority groups (Cadaret & Speight, 2018; Ward & Besson, 2013).

'Masculinity' is a social construct, defined by Levant et al. (2013) as, "Beliefs about the importance of men adhering to traditional norms for male behaviour (p. 393)". However, it has been argued that societal perceptions of masculinity are based on a set of norms associated with White, heterosexual and able-bodied men (Coleman-Kirumba et al., 2023; Luisi et al., 2020). Characteristics of masculinity include physical control, heterosexuality, emotional stoicism, avoidance of femininity, occupational success, and being a family provider and protector (Cofield, 2023; Coleman-Kirumba et al., 2023; Hooks, 2004). However, these characteristics do not fully reflect the experiences for those of different cultures or racial ethnicities where the concept of masculinity may hold additional definitions and responsibilities. This is particularly true for Black men, whose understanding of masculinity contends with hegemonic masculinity due to anti-Black social norms (Young, 2021), and as such, these experiences have been conceptualised by social theorists as 'Black masculinity' (Mutua, 2000; Ferber, 2006). The construct of Black masculinity means navigating both expectations within the community, and against stereotypes outside the community.

Previous research has identified race and masculinity as significant factors relating to Black men seeking mental health support that need to be explored further to understand why or how they act as barriers to help-seeking (Cofield, 2023; Coleman-Kirumba et al., 2023; Shannon, 2023). Although some attention has been given to these concerns, there is a need to obtain a richer understanding that can be used to adapt services to better meet the needs of the population they mean to serve.

The aim of this review is to identify and synthesise qualitative research exploring Black men's experiences of navigating mental health and masculinity in order to understand the role of masculinity and the nuances within this construct for this group, as a barrier to help-seeking. The findings of studies that explore these experiences will enable the identification of key learning points for healthcare professionals working with this population and provide recommendations for further research in this area.

Materials and Method

Design

This is a systematic review and meta-synthesis of qualitative research with the aim of exploring the role of Black masculinity within mental health**.** The review followed the

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines to ensure a thorough methodological process (Figure 1).

Search Strategy

An initial scoping of the literature was conducted using OneSearch to support the development and refinement of the research question for the review, and sculpt the research aims. The process of defining appropriately sensitive search terms was assisted by an academic faculty librarian; search terms were chosen were key words relating to masculinity, Black males and psychological functioning, and subject headings were also explored to identify additional search terms that could be included to refine the search for relevant papers. In order to find all the literature that could relate to the research question, the search terms were clustered and where appropriate, truncated, using the Boolean operators "OR" and "AND". Separate searches for each string were conducted initially before being combined using the 'AND' Boolean operator, to find all relevant literature. No limiters were set within the search (Appendix 1-A). Searches were carried out in December 2023 using EBSCOHost (including PsychINFO, MEDLINE, CINAHL, and Academic Search Ultimate); these databases were selected following guidance from the academic faculty librarian, and felt to be appropriate sources for literature pertaining to the topic and relevant healthcare research. Search results were exported to Endnote for deduplication and initial screening. In total, 945 results were generated by database searches. Following screening and selection, five studies met the criteria.

Screening and Selection

Screening and selection were completed using a stepped process according to PRISMA guidelines. Results were filtered by excluding papers that were not relevant to the review. Papers were considered suitable if they met the following inclusion criteria:

- Participants were Black male adults
- Qualitative primary research papers, written in English
- Explored the concept of masculinity from the participants perspective within the research
- Included discussions of mental health, psychological functioning and wellbeing.

Further filtration was conducted by screening titles and abstracts before proceeding to full text. References of the relevant literature were also screened for any additionally relevant literature to be included within the review.

The inclusion criteria for research within this review required that the literature was analysed using qualitative methods, exploring Black masculinity. If studies did not exclusively focus on the demographic of interest, they were still included if data within the findings relating to the topic were appropriately distinguishable. Qualitative research was sought as the researcher aims to explore individuals experiences, and this method of research will allow for a richer form of data to be analysed.

The exclusion criteria for this screening process disregarded literature that referred to physical health rather than mental health. Research that was quantitative was also excluded.

Final included papers for the review included studies that used exploratory research designs such as the use of semi-structured interviews and focus groups, qualitatively analysed to draw out themes. The limited research available serves to highlight that despite awareness of the concerns, this topic remains scarcely under-researched. The majority of the research used populations from the United States (US). Due to the small number of eligible studies, the author included dissertations that also met the inclusion criteria. Two of the sample of papers fell within this category but were not published, highlighting the limited research into this under-researched population.

[Insert table 1.1]

Quality Appraisal

Following the completion of the screening and selection process, the final five included studies were appraised using the Critical Skills Appraisal Programme (CASP) tool (Critical Appraisal Programme, 2018) to support the evaluation of strengths and weaknesses of identified literature by reviewing the credibility, rigour, and relevance of the research. These principles are seen as underpinning the quality of qualitative research (Spencer & Ritchie, 2012).

This checklist is the most commonly used for reviews using meta-synthesis within healthcare research (Sattar et al., 2021). Additionally, the CASP tool is a recommended critical appraisal tool for qualitative studies and recommended for novel qualitative researchers. The CASP checklists consists of ten questions; the first two are screening questions to ensure the studies meet the basic criteria for inclusion. The following eight questions are then scored across three sections: ‘Are the results valid?’, ‘What are the results?’, and ‘Will the results help locally?’ The questions are answered as ‘Yes’, ‘No’, or ‘Can’t tell’. A three-point scoring system introduced by Duggleby et al. (2010) was assigned to the responses, 1 – indicating weak; 2 – indicating moderate; 3 – indicating strong. Scores were then totalled for each study, where a maximum possible score was 24 (Duggleby et al., 2010). Dissertations included may have scored higher that the published articles, as it was possible that information from some of the articles had been removed to adhere to journal formatting and word limits, thus not available for quality assessment. No papers were excluded from this review based on the CASP ratings. Rather, the ratings provided a basis to consider the strengths and limitations of the findings, methodology and ethical considerations, subsequently influencing how much weight the findings of the papers contributed to the development of the themes. A summary of the CASP ratings of the five studies is provided in Table 1.2.

[Insert Table 1.2]

Synthesis

The findings from the five included studies were analysed using Britten et al.'s (2002) approach to Noblit and Hare's (1988) meta-ethnographic method of meta-synthesis. Meta-synthesis was chosen as the approach can enable the researcher to unveil themes across papers that are not identified within individual studies and thus has the potential to yield new information and interpretation within the research topic. Noblit and Hare's method is a meta-ethnography approach for synthesising qualitative studies; it aims to enable the researcher to identify, interpret, compare and synthesise a range of concepts whilst preserving the relationship and meaning between them through the seven stages of analysis (Britten et al., 2002): deciding what is relevant; reading the studies; determining how the studies are related; translating the studies into one another; synthesising the translations; and expressing the synthesis. Britten et al.'s approach was applied to support the development of first and second order constructs with the aim of allowing the researcher to better identify constructs within each paper. Data included in the synthesis was that reported as either 'findings' or 'results' within the identified articles. If the research did not exclusively address the aims of the review, only elements of the findings that did relate to the aims of the review, and met the inclusion criteria, were used.

The meta-ethnography collated the experiences of 88 participants as stated within the five studies. All five studies were read, and re-read, to identify first and second order constructs, in line with Britten et al.'s (2002) approach. First order constructs are defined as direct quotes from the participants within the study, and second order constructs as the author's interpretations of the data. Both first and second order constructs were analysed together to support the stage of translating the studies into one another. Third order constructs were developed by the reviewer as a representation of the first and second order constructs from the included research papers in the review. The interpretations were continuously revised as each paper was reviewed in order to stay true to the language and expressions of the original papers. All first and second order constructs were logged in an Excel spreadsheet and were then grouped together by concept and amalgamated to form the basis of the third order constructs (see Appendix 1-C). Four themes were generated through the analysis: The rules and expectations of masculinity; Mental health is not discussed in the Black community; The need to feel safe (through connection); and Coping strategies that help, but hinder.

Reflexivity

This synthesis specifically attends to the research exploring qualitative experiences of mental health for Black men, focussing on the role of Black masculinity. It was conducted by a Trainee Clinical Psychologist who identifies with parts of the literature, and has relationships to individuals who may have had similar experiences to participants within the studies. Therefore, it is possible that the aspect of the researcher's identity has informed the way the data were analysed; this review should be interpreted critically in light of this. See the critical appraisal paper for further discussion around this.

Results

Theme 1: The rules and expectations of masculinity.

This theme related to the power of the construct of 'masculinity'. Men across the included research expressed that masculinity was a social construct with rigid expectations that carried responsibilities, but also afforded them power and influence. However, conformity to masculine ideals had consequences.

Black males in Robinson-Perez (2019)'s study described the expectation that they bear the role of provider and protector for their families. They acknowledged how the expectation to take up this role was assigned to them at birth because they were born male. "It's like the stigma when you're born, being the man of the house, being the provider" (Page 133). Participants in Watts & Bentley (2021)'s study expressed similar family roles that were expected of them as males.

> The way masculinity has been ingrained or indoctrinated in us is that you're strong. You exert leadership. You're a protector. You're a provider. You're supposed to have a family... care for your family. You're supposed to leave a legacy for that family... it's what each person has been taught throughout their childhood (Page 159-160).

Participants across studies reported that the social construct of masculinity expects men to be responsible leaders and act "tough" and "macho" at all times (Watts & Bentley, 2021). "You have to be strong. You have to be the man of the house, you can't really show weakness" (Williams et al., 2022, p. 1169).

Men expressed how these stereotypes provided them with a sense of safety in how they can navigate the world with ease, compared to female counterparts. "Society is a little easier on me" (Brassel et al., 2022, p. 334). However, Black men within Brassel et al.'s (2020) study felt there were limitations to this due to their race; expressing that they experienced these benefits only in comparison with Black women, not White women. This could be thought of as a racially gendered hierarchy where White men dominate, followed by White women, then Black men, and finally, Black women.

Participants also expressed how they enjoyed taking on responsibilities and being relied upon by others, as it made them feel respected and provided positive personal outcomes such as growth and maturity: “I like responsibility… you can do nothin' but grow from that” (Brassel et al., 2020, p.332). However, along with the positive benefits of masculinity, participants also described negative consequences. Men spoke of the expectation that they *must* remain strong and able to provide for and take care of others at all times, despite the associated costs: “As a man you take care of business, no matter what that may entail or how much you don't want to” (Brassel et al., 2020, p. 332). Black men specifically discussed how their responsibility for others extended beyond their immediate family, to their communities. This then increased the pressure of needing to ensure they acted ‘appropriately’, because the consequences of not doing so had a wider impact.

> So once you, as a man, try to deny your manhood... you letting down not only yourself but all the other people around you in the sphere of your influence... you have a lot of power and if you abuse that power it's gonna trickle down and affect the lives of other people whether you realise it or not (Brassel et al., 2020, p.332).

Behaviours were said to be ‘policed’ by others as a means of measuring whether men were indeed behaving in accordance with the ‘rules’ of masculinity. If it was perceived that they were not, they felt at risk of being devalued, viewed as weak, and not respected by others.

> We're always told that Black men can't be vulnerable. Men can't express and we can't want love. We want love. Men want love and so because of how we're taught by society, we think that you can't want those things. If you do want those things then you look weak, and so you can't show any emotions (Cofield, 2022, p. 64).

These rules meant that men across the studies felt unable to engage in emotional expression or seek help for any experienced stressors.

This theme highlights that the automatic assignment of societal expectations for males to be 'masculine' and take on responsibilities for others, constrains them. These expectations encourage the supressing of their needs and do not permit emotional expression without the threat of losing social capital i.e. theoretical and physical resources to enable successful functioning in society. It recognises the societal pressures that are constraining men and the juxtaposition of men being perceived as powerful members of society, whilst essentially being powerless to the construct of masculinity. It also highlights that for Black men there is an additional pressure to represent the Black community, therefore, perhaps the threat to social capital is greater due to the fear of further oppression in addition to race.

Theme 2: Mental health is not discussed in the Black community.

This theme represented Black men's perspectives about conversations relating to mental health within their community and the societal attitudes that exist in relation to expressing their worries or struggles.

Men highlighted that mental health is not a topic of conversation within their households or amongst friends. One participant in William et al.'s (2022) study acknowledged that stigma about mental health still exists within the Black community.

> I just feel like there's a stigma when it comes to Black men showing their emotions. I feel like the second something like mental health comes up, everybody kind of shies away from speaking up. So, I don't think... I feel like these types of conversations don't really come up in the Black, male community (page 1169).

Participants described how the stigma reinforces the narrative to "keep it in, and man up", dissuading males from feeling able to discuss their worries due to fears of appearing weak (Williams et al., 2022). Men noted this to be the primary reason emotions are not expressed.

> You've got to be a man about it or you gotta man up. That's one of the things that stops people from showing emotion, because it's emasculating, I guess and you'll be viewed less of a man. And in their head, they won't have as much respect if you show emotion (Williams et al., 2022, p. 1169).

Others attributed the difficulties for men being due to the lack of modelling of how to appropriately express emotion and be vulnerable.

Most Black men don't usually have a father figure or a father figure that teaches them how to be vulnerable, because it's seen as feminine so talking about your feelings equates to being feminine… Not having that figure to show you healthy coping of how to discuss certain topics... it's hard" (Robinson-Perez, 2019, p. 133).

Expressing emotions was seen as a feminine trait, that if Black men show emotion they are deemed less of a man and are at risk of losing the respect of other members in their community. Men spoke of how acting anything outside of the expected behaviour of a Black man would jeopardise how they are seen by Black women.

> You show anything that's not like hyper strong, hyper tough, hyper emotionless then you're not a man. That's feminine (…) When Black men tend to exude things that society has deemed to be feminine or Black women deem to be feminine you really get talked about to the point where you get shamed for doing it. He can't ask for help. His struggles must be kept secret (Cofield, 2022, p.64)

Some males highlighted that they felt the lack of conversation about mental health was a result of cultural and generational expectations within their families:

> There’s no discussions. Mainly for me, within family, I can't speak the same for a lot of Africans, but I'm from Ghana, and with the old generation, mental health doesn't really exist, because they just say 'my parents pushed through it' so they use that as a basis like, 'if we can do it, you shouldn't be having these problems' but it doesn't work like that for everybody (Williams et al., 2022, p. 1169).

Men felt that the older generation remained dismissive of mental health and the idea of seeking therapy: “The older generation, the older Black generation especially, I think they still think therapy just means you're crazy” (Cofield, 2022, p. 69). Participants described beliefs that therapy is not accessible for them, and that difficulties should be kept ‘in house’, explaining how seeking therapy was not encouraged and the consequences of how they would be perceived and treated by the community if they did.

> Therapy was never an option for me (…) If you're a Black man and you're raised by Black parents and you're in a Black community it almost seems like something's wrong with you. Like something not right in your mind that caused you to want to go to therapy and people treat you differently because you choose to go to therapy (Cofield, 2022, p.68).

This theme highlights the narratives that are presented within families and the wider cultural scripts that lead to the perpetuation of Black men feeling unable to step outside these expectations without the fear of being judged. Additionally, men also did not know how to express their emotions because they had also not been given safe spaces to understand the spectrum of emotions “Emotional language isn't something [Black] men are encouraged nor do we get so we don't know how to express ourselves. It's either rage or love” (Cofield, 2022, p.65). This demonstrates the constricted ways men feel able to express themselves that does not put them at risk of devaluation. This theme also provides some insight into the perceptions of mental health for older generations, and the resistance that remains as the stigma shifts beyond their experiences and generation. As society increases its efforts to reduce the stigma associated with mental health, there may be additional efforts required to support generations that have endured difficult experiences without the acceptance from others of being able to discuss these. Additionally, It could be suggested that therapy is somewhat of a taboo topic within the Black community; one participant highlighted that therapy, as a source of help was never discussed "Nobody ever mentioned therapy growing up. Ever. For a lot of my life, it wasn't even a thought" (Cofield, 2022, p.69). These conversations, or lack of, perpetuate the belief that matters should be managed within their internal systems. "We feel like we're all family and we can support each other. We're all we got. We don't need anybody from the outside" (Cofield, 2022, p. 68). They have trust within their families and community, whereas there is little evidence of trusting healthcare professionals to be able to support them appropriately and fairly, and thus to be of any help.

Theme 3: The need to feel safe (through connection)

This theme reflects Black men's need to feel safe, and have connection with others who can relate to them, so that they can feel supported.

Men highlighted that they can often be one of a few Black people in spaces and how this can be anxiety provoking for them, feeling as though they "stick out". Participants in the Robinson-Perez (2019) study discussed how they would be conscious of their interactions with others and their environment:

> I was the only person of colour when I joined, so it's like that kind of thing in every space that I've started out in, yeah like, every space that I've wanted to be in. I've had to be like the 'only' person of colour... so I've been very aware of my surroundings... not like wanting to say the wrong thing or go the wrong way. (Page 96)

These feelings instilled a desire to connect with others who they could relate to as this enabled them to feel safe and validated.

> The community of campus that I've joined, friend groups, have been nothing but supportive, we have no other choice to be supportive of each other. In the grand scheme of things, when I am with my group, I don't feel like I stick out. (Robinson-Perez., 2019, p. 96)

Becoming part of a community provided a space for individuals to feel supported by people who perhaps shared an understanding of their experiences. However, participants expressed that support felt limited to the realms of their community:

> I still feel I've been supported that leaves me better off than most. But it's only in the Black community that I feel the most support, so in that I still feel that though… I am kind of a successful student I still feel that I am limited to just my community, so when I step away from people of colour, I still feel that no one supports me in that realm, in the way. (Robinson-Perez, 2019, p. 100-101)

This speaks to Black men's concerns that outside of the Black community there is no support, which may influence their motivation to seek support outside of their community.

Black men had an awareness that therapists are predominantly White, Black men in Watts & Bentley (2021)'s study noted that it was difficult to feel comfortable in situations where the person they had approached for help did not understand their experiences with respect to their identity:

> I've had a few therapy sessions where I've definitely had to walk them through what it means to navigate this life of being a Black male and then on top of that a gay Black male, and that's not their fault. But at the same time, it's not my fault if I'm seeking help to go to a person who doesn't really know how to help me (Page 165)

Participants described unhelpful experiences with White therapists, leading to a racial distrust: “I don't want a White man. I've done that, I done it twice, it was terrible both times, or not terrible but just not helpful” (Cofield, p. 72). One man expressed that he did not feel understood by White therapists and this resulted in disengagement.

> I came there open but it was just reminders to stay in your place boy, 'I'm big you're small. I'm right you're wrong. White is right and Black is wack'(...) I just was like, you don't get it. You don't get me, you don't get us and I think that's why it impacted my decision to not continue therapy (Cofield, 2022, p. 76).

Black men highlighted that racism contributes to some of their problems and how the need to explain these experiences and the impact was also a deterrent for therapy.

> Racism has definitely contributed a lot to the stress that I have (...) If I'm trying to talk about my mental health and things that are stressing me but then I also have to explain or feel like I have to explain what racism feels like then I feel like what's the point (Cofield, 2022, p. 74).

Racial difference in therapists appeared to be a significant factor affecting the decision to engage in therapy. Participants emphasised a desire to see representation, and a preference for engaging with someone who may be likely to understand their concerns: “Representation does matter whether they're white-washed or not (…) a lot of times its easier coming from somebody who looks like you” (Cofield, 2022, p. 87). This suggests that the lack of representation in healthcare professionals may be acting as a barrier for Black men to seek support and feel safe enough to share their experiences and feel understood.

Theme 4: Coping Strategies that help, but hinder

This theme identifies the coping strategies that Black men have employed to manage their concerns or worries, and the resources they utilise for support as opposed to emotional expression.

Coping mechanisms varied across participants, some men described avoiding or denying acknowledgement of any concerns relating to their mental health by masking e.g. minimising their mood if others asked, and presenting with a pleasant demeanour: "I feel like no matter what's going on, you might put on a bright face, but you deal with it internally, so you won't really show it physically" (Williams et al., 2022, p. 1171). One participant shared that their reason for masking was to maintain a sense of pride: "Sometimes I put a smile on my face when I go out, but internally I just feel depressed and I don't want to say that I'm sad, because of probably pride, and that's not good" (Williams et al (2022), Page 1171). In Robinson-Perez (2019)'s study, one participant spoke of becoming detached but trying to rationalise and empathise with the behaviour of others as a means of protecting themselves and managing emotions from stressors, "I kind of detach myself and go into the third person perspective and think about what led them up to this point, kind of thinking about that and trying to rationalise what they are even doing and then you almost start feeling sorry for them" (Page 143).

Men described a sense of helplessness and hopelessness about their stressors, and feeling as though there would be little point in sharing their problems because nothing could be done to change the situation, "I keep it (feelings) bottled up because I feel like there is nothing, I can do to change it." (Robinson-Perez., 2019, p. 144). A similar thread was highlighted in Cofield (2022): "we're not set up or taught or it's not made acceptable to ask for help or to look out for help. We just deal with it and keep pushing just because we've had to do that since we got here, pretty much" (Page 67). Men also expressed a lack of being modelled how to communicate emotions as a strategy for coping with adversities.

> There's never been a point in my life where I have actively practiced just being open and just open communication about my emotions, my feels [or] my thoughts. Never in my life and I think that ties into like my perception of growing up of Black masculinity. I've never witnessed my uncles and never witnessed any male figures in my life just like openly communicating about their emotional wellbeing [or] their feelings. It was never, never a thing (Cofield, 2022, p. 67).

Participants often sought help through the church and prayer, and referenced leaning on their faith to eliminate their problems: "Growing up in church all my life it was just like you pray, you leave it at the altar [and] you let God worry about it" (Cofield, 2022, p. 68). Similar views were expressed in Robinson-Perez (2019): "I mean I guess in terms of coping mechanism a lot of them are similar to me, but my faith is really important to me, so prayer, believing that God would take care of everything" (Page 151).

Participants in Robinson-Perez (2019)'s study discussed their use of self-care to manage their mental wellbeing: "I'm more self-motivated, sometimes I like to go to the gym, or I go play ball or I go hang out with friends which is basically my thing" (Page 151). Participants also highlighted positive affirmations and managing appearances as a strategy to maintain their wellbeing.

> I'd say positive affirmations are really good you know, being as intentional as you can as you know filling your mind with positive thoughts you know what you think is what you become I'd say. I try to do as much as I can trying to like dress nice, like if you feel good, you look good trying to kind of manifest that on myself (Robinson-Perez., 2019, p. 151).

This theme represents the alternative strategies men are employing to manage their mental wellbeing without the use of emotional expression. Many of the mechanisms discussed demonstrate the concept that problems are not shared with others, and men feel they are left to manage their distress themselves. One participant stated, “it's up to myself to take care of myself in a way that I know is beneficial for me physically and mentally” (Robinson-Perez., 2019, p.151). This theme highlights that despite the limited emotional language and expression utilised by men, there is some degree to which they are attuned to the state of their mental wellbeing. Despite the constraints by the norms of Black masculinity and it acting as a barrier to emotional expression and help-seeking, these strategies appear to fit with the cultural expectations of Black masculinity and offer some practical coping strategies. However, for those that ignore, avoid or suppress their feelings, there remains a concern about how long they are able to continue in that way before their mental state worsens.

Discussion

This review synthesised five studies, developing four themes representing the experience of Black masculinity as a barrier to help-seeking for Black men. The first theme shows how Black men understand the social construct of masculinity and starts to highlight some of the differences between masculinity and Black masculinity. Black men emphasised their additional load of responsibility to be a man who protects and provides not only for his family, but also acts as a role model and leader to younger generations of the Black community. Men also emphasised the pressure that comes with conforming to masculine traits and the threat that they face if their masculinity is not recognised by others, with a perception that this would devalue their identity and come at a cost to their social capital, limiting their ability to be successful.

In the second theme, Black men highlighted the lack of conversation about mental health within the Black community and a discomfort for others when difficulties relating to mental health came up. It was noted that people would tend to distance themselves from those facing difficulties rather than be drawn in to support. Lack of social support has been shown to be an important factor in the development of mental health difficulties (Brewin et al., 2000; Harandi et al., 2017; Turner & Brown, 2010). Reasons for this were not identified within this current review, but it could be hypothesised that there is a lack of understanding within the community if mental health is not openly discussed, and therefore people do not know how to appropriately support someone, and so, disengage. Alternatively, as participants expressed, others may be enacting their fears by perceiving the individual as 'lesser than', and not wanting to associate with them. It could be suggested that the enactment of this behaviour also contributes to Black men not feeling able to discuss their mental health challenges amongst their community due to fear that disclosure would push people away and they would subsequently be left or feel rejected.

Participants within the review also commented that there remains stigma about mental health within their communities, and that it is particularly recognisable within the older generations. It was suggested that struggle and difficulties are seen as an inevitable experience among the Black community because of what previous generations have endured. This is likely a reference to experiences of racism and discrimination and therefore may hold expectations that life will have hardships and one must 'get on with it' because they did and got through it with limited support. Men discussed having limited modelling from their elders and peers of being vulnerable and using emotional language to express themselves and their difficulties, which again reinforced the narrative that Black men should be able to tolerate any distress and suppress their feelings. It is important to reflect on the need for men not only to see emotional vulnerability expressed by the males around them but also to see emotional vulnerability being accepted by others within their community without fear of judgement, depreciation, shame or rejection.

What is emphasised throughout the review is that Black men feel limited by the constraints of masculinity. The construct of Black masculinity does not permit emotional vulnerability and encourages emotional stoicism, encouraging the sentiment "man up", which is ultimately silencing of men's struggles. Feeling vulnerable may be incongruent with their expectations of themselves, thus is a threat to their self-image and identity. It is important to hold in mind that in a world where Black people have experienced oppression, even the possibility of being relegated may feel even more threatening, the fear of losing respect or status from others because they have had to work harder to get it in the first instance. Respect could be perceived as a social currency that allows Black men to navigate spaces with some equity that enables them to have opportunities to be successful, and as a moderator to experiencing further oppression.

Black men described how they could often be one of few Black people in spaces, driving a need to find their community within these spaces to feel validated. This links to the theme of 'needing to feel safe' as Black men feel that they do not fit in, and this was a valuable resource to navigate those spaces. Thinking about this in terms of evolutionary responses, humans are programmed to enhance their chances of survival, and do so by living in groups as a source of safety and support (Van Vugt & Schaller, 2008). This could be seen as an adopted tactic by this group of people, in order to survive daily life, living in a world where people that look like them have historically been oppressed and dismissed, void of opportunities to progress. In that way, Black men are trying to connect with others, join groups to keep themselves safe from the potential threats faced by others. It may be of benefit for services to consider group settings where Black men are able to manufacture connections with others that will allow them to feel a sense of safety and support, in particular when they are expected to step into unfamiliar territory of emotional expression.

Black men in this study discussed employing strategies for coping that do not involve emotional expression such as avoidance, suppression and detachment. Such strategies can help individuals feel objectively distant from situations and reduce psychological distress (Beck et al., 1979). Although these appear to have been functional to some degree, they have also been shown to mediate poor health outcomes like burnout (John & Gross, 2003, 2004). It could be understood that these strategies are also a demonstration of emotional stoicism that is encouraged within the construct of Black masculinity, however it has been suggested that in order to overcome stressors, it is necessary to talk to people about the experiences (Lepore et al, 2000). Nevertheless, as participants described, they have not felt welcome to communicate their emotions with others or to a community that appears less accepting of psychological distress. Additionally, society holds expectations that men should be able capable of functioning regardless of stressors and without being emotional and thus men have learnt to place similar expectations on themselves.

Some individuals described the church as their resource for support which was more accepted and encouraged to utilise within the Black community and did not pose a threat to their masculinity. This appeared to be a more tolerable form of help-seeking that also did not go against the community script of 'keeping things in house' that participants referred to. Currently Black men feel that therapy is not an available resource to them, and that it favours White men and women. Under-representation of Black men, both utilising therapy and as therapists, was a prevalent view expressed by participants. Men acknowledged the need for a shift in attitudes that goes beyond their community and extends to wider society and the way Black men are depicted in these contexts.

Clinical Implications

In terms of clinical implications, this review highlights that there are barriers for this group in even accessing services therefore it is more appropriate to consider the overall strategies as this is the current stage. As the studies included within this research are not UK populations, it is first imperative that researchers explore these experiences with Black men in the UK, this can then provide contextually and culturally relevant information and identify the needs to inform clinical implications and strategies to support this population. Professionals may approach this issue by considering methods of co-production, such as consulting with local communities then ensure the views are represented in the development of research and subsequent services, initiatives and policies, to build connection and trust between Black men and healthcare professionals. Additionally, some of the matters discussed speak to some deep-rooted social justice issues for people who are not accessing formal support and services, clinical psychologists could lean into community psychology approaches to tend to the underlying social issues.

Strengths and Limitations of the Review

The majority of the research included comes from unpublished dissertations and therefore is considered as grey literature, which could hold biases or incomplete information as it has not yet gone through the stringent editing and peer-reviewing process that published research has. The population within the literature is from the US, which limits the ability to generalise these perspectives as an international experience amongst Black men. For example, race relations that exist in the US may be considerably different to those of other countries and therefore may have influenced the intensity of some of the experiences discussed within the findings. Furthermore, healthcare provision in the US is different to other counties and should also be considered as a factor that may influence an individual's ability to engage with healthcare professionals compared to individuals in countries where access to the healthcare system is not constrained to financial ability.

Future Research

Future research could explore what resources Black men in the UK are using in order to inform contextually and culturally relevant strategies to support this population. Additionally, participants within the review described a lack of conversations and acknowledgment of mental health and difficulties within the Black community. This demonstrates a need for future research to investigate mental health education and promotion that is specifically directed to Black communities.

Black men within these studies also referred to a lack of Black male role models demonstrating emotional expression. The employment of mentorship programmes could serve as an intervention that researchers could pilot and evaluate to identify whether this has the potential to act as a mediator that can promote the importance of mental health and psychological wellbeing. Positioning Black male healthcare professionals in these spaces could serve as a starting point for relationship building and subsequently change the perspectives that are preventing men from utilising services for help-seeking.

It is also possible that as narratives relating to gender in society continue to progress and become more fluid, existing social constructs and expectations around Black masculinity may change, subsequently impacting on pressures to conform. It would therefore be useful for researchers to review this again in future years, to identify whether attitudes and behaviours explored within this review have changed.

Conclusion

This review provides some insight into the nuances of Black masculinity and how this acts as a barrier to help-seeking in Black men. A significant finding was the pressure to conform to masculine 'norms' and the threat of losing masculine identity. There is a need to relieve the perceived threat and to support men to engage in emotional expression without the detrimental consequence for their social capital, however much work is required. Healthcare professionals should consider collaborating with the communities when developing any strategies to improve utilisation of healthcare services for mental health and wellbeing, as it is clear that there are relational barriers perpetuating a mistrust of healthcare professionals and services. A commitment to coproduction to reduce stigma and increase awareness of mental health and community support for Black men is needed.

Acknowledgements

The authors thank the librarians at Lancaster University for their support with the searches for this paper.

Declaration of Interest

The authors report there are no competing interests to declare.

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Appendices

Appendix 1-A

Example of Search Strategy for APA PsychINFO

Item	Search Terms	Results
S1	(DE "Racial and Ethnic Groups" OR DE "African Cultural Groups" OR DE "Asians" OR DE "Blacks" OR DE "Caribbean Cultural Groups" OR DE "European Cultural Groups" OR DE "Indigenous Populations" OR DE "Latinos/Latinas" OR DE "Middle Eastern and North African Cultural Groups" OR DE "Multiracial" OR DE "People of Color" OR DE "Romanies" OR DE "Whites" OR DE "African Cultural Groups" OR DE "Minority Groups" OR DE "Sexual Minority Groups" OR DE "Blacks") OR TI (blacks OR people of col* OR person of col* OR individual of col*) OR AB (blacks OR people of col* OR person of col* OR individual of col*)	371,014
S2	((DE "Mental Health Services" OR DE "Mental Health" OR DE "Athlete Mental Health" OR DE "Youth Mental Health" OR DE "Youth Mental Health" OR DE "Mental Health Disparities" OR DE "Preventive Mental Health Services" OR DE "Mental Health Programs" OR DE "Crisis Intervention Services" OR DE "Deinstitutionalization" OR DE "Home Visiting Programs" OR DE "Hot Line Services" OR DE "Suicide Prevention Centers" OR DE "Mental Health (Attitudes Toward)" OR DE "Mental Health Stigma" OR DE "Global Mental Health" OR DE "Mental Health Stigma") OR (DE "Well Being" OR DE "Employee Well Being" OR DE "Spiritual Well Being" OR DE "Subjective Well Being")) OR TI (psychological functioning OR mental state OR well-being OR wellbeing OR well being) OR AB (psychological functioning OR mental state OR well-being OR wellbeing OR well being)	413,867
S3	(DE "Psychology of Men" OR DE "Gender Role Attitudes" OR DE "Transgender (Attitudes Toward)" OR DE "Gender Roles" OR DE "Masculinity") OR TI (masculin* OR machismo OR machoism OR manhood OR maleness OR manliness) OR AB (masculin* OR machismo OR machoism OR manhood OR maleness OR manliness)	27,753
S4	S1 AND S2 AND S3	343

Appendix 1-B

Questions contained within the CASP qualitative checklist

	Question (Q)
Q1	Was there a clear statement of the aims of the research?
Q2	Is a qualitative methodology appropriate?
Q3	Was the research design appropriate to address the aims of the research?
Q4	Was the recruitment strategy appropriate to the aims of the research?
Q5	Was the data collected in a way that addressed the research issue?
Q6	Has the relationship between researcher and participants been adequately considered?
Q7	Have the ethical issues been taken into consideration?
Q8	Was the data analysis sufficiently rigorous?
Q9	Is there a clear statement of findings?
Q10	How valuable is the research?

Appendix 1-C

Example Data Analysis Table (Cofield, 2022)

Concept	First Order Constructs	Second Order Constructs	Third Order Constructs
The rules and expectations of masculinity	"you have to be twice as good" "My idea of a [Black] man is somebody who's ale to protect and provide. Unfortunately." "Being a black man is hard because you're not able to express emotionally everything that you're feeling when you feel it. (...) you're not allowed to have feelings. how dare you." "They want to see a [black] masculine man be this kind of way regardless if he fucked up on the inside or not" "we're always told that Black men can't be vulnerable. Men can't express and we can't want love. We want love. Men want love and so because of how we're taught by society, we think that you can't want those things. If you do want those things then you look weak, and so you can't show any emotions." "Masculinity is a performance (…) and when I think of masculinity I think of a straight person, a straight man, not because that is what is masculine but that is what the idea of masculinity is. I don't agree with that"	Many participants acknowledged that Black masculinity will always be different from masculinity because of the difference in expectations for white men and black men. Participants also discussed the added pressure to be more hypermasculine. Black men have been taught to be emotionless although that is not always the case. However, if they show it, they are wrong and looked down upon. Emotional expression is equated to weakness and lacking the strength required of Black masculinity. Seeking help, expressing emotions, and going to therapy are foreign concepts to Black men who were never taught to never want to need help.	Men agreed that there are expectations and power placed on them by society that are required in order to be perceived as masculine. In particular Black men expressed valuing the amount of respect that is given by others when one takes on responsibilities. However having broader responsibilities also meant that there was more at stake to lose if their role was jeopardised by their behaviour or how they were perceived by others.
Means of coping	"I mean I guess in terms of coping mechanism a lot of them are similar to me, but my faith is really important to me, so prayer, believing that God would take care of everything."	Many participants described the impact their family and childhood environments had on their beliefs about asking for help and seeking therapy. Some acknowledged common	Rather than approach external services or spaces for support. Men employed strategies deemed more in keeping with

	“ I'd say positive affirmations are really good you know being as intentional as you can as you know filling your mind with positive thoughts you know what you think is what you become I’d say, I try to do as much as I can trying to like dress nice, like if you feel good, you look good trying to kind of manifest that on myself" "It's a lot more on myself to go find people that I can confide in and it's up to myself to take care of myself in a way that I know is beneficial for me physically and mentally."	thinking among Black people when it comes to therapy and seeking help through the church and prayer. Participants shared experiences confirming the normalised thinking that emotional healing through prayer was the only necessary treatment for any emotional issues among Black people. The concept of keeping things in house and within the Black community was an important lesson that many Black people learn in their youth.	existing beliefs within the community and social constructs. Participants described strategies for managing emotions such as avoidance/denial, and minimisation/suppression, or engaging in activities as a means of distraction, positive affirmations, and leaning on their faith/the church for emotional healing through prayer. Participants discussed the notion to keep things 'in house' was instilled within them from young ages.

Appendix 1-D

Author Guidelines for the Journal of Mental Health

About the Journal

Journal of Mental Health is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Journal of Mental Health accepts the following types of article:

- Original Articles; Research and Evaluation Articles
- Review article
- Book and Web Reviews

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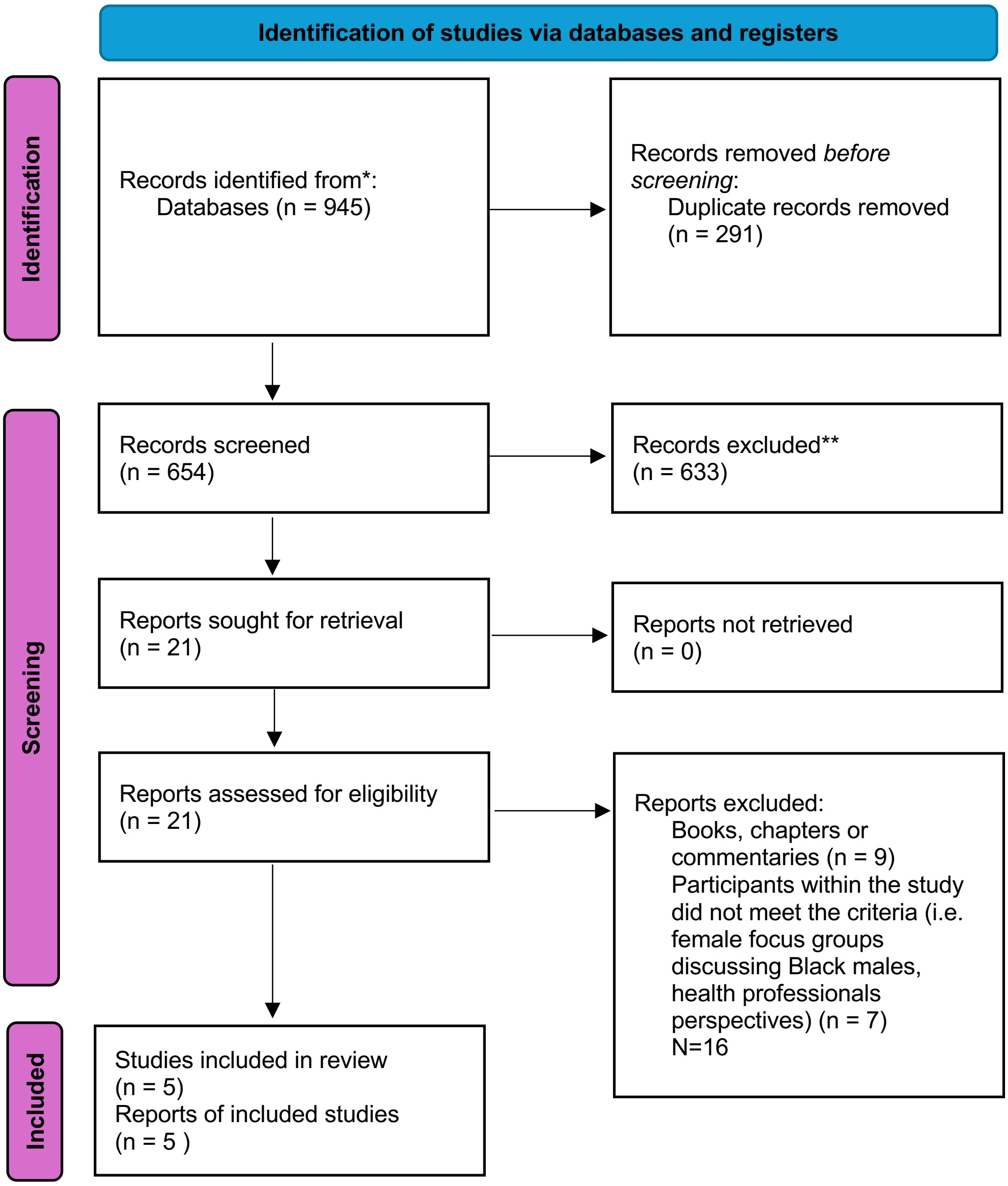
Figure 1-1

PRISMA Flow Diagram



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From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmi

Table 1-1

Study Characteristics

Study	Date/country	Study Aim	Sample	Methods	Analysis
Watts & Bentley, 2021	2023 USA	To understand the experience and perceptions of masculinity, and it impacts their mental health and wellbeing.	N = 17	Focus groups	Descriptive phenomenological analysis
Brassel et al., 2020	2020 USA	Exploring the role of race and power and shaping men's experiences of manhood.	N = 23, 11 Black men, 12 White men	Focus groups (same race)	Phenomenological methodology
Williams et al., 2022	2023 USA	To identify social and contextual factors influencing mental health risk for Black men	N = 20	Focus groups	Thematic analysis
Robinson-Perez, 2019	2019 USA	An intersectional analysis to examine Black men's understanding of their mental health	N = 24	Focus groups (9 females, 5 males) & In-depth semi-structured (10 males)	Heuristic phenomenology

		and explore the impact of gendered racial microaggressions			
Cofield, 2022	2022 USA	Exploring the influence of social constructs on millennial Black men’s decisions about seeking mental health treatment	N = 16	Semi-structured interviews	Moustakas’s phenomenological analysis

Table 1-2

CASP Quality Appraisal Summary

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total
(Brassel et al, 2020)	Can't tell	Yes	2	2	2	3	1	3	3	3	19
(Williams et al, 2022)	Yes	Yes	1	3	3	1	3	3	3	3	20
(Robinson-Perez, 2019)	Yes	Yes	3	3	3	3	1	2	3	3	21
(Watts & Bentley, 2021)	Yes	Yes	3	3	3	1	1	2	3	3	19
(Cofield, 2022)	Yes	Yes	3	1	2	2	3	3	3	3	21

Section Two: Research Paper

An exploration of the experiences of inpatient mental health care for Black patients in the North West of England, UK.

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Prepared for submission to: The Journal of Mental Health (see appendix 2-D for author guidelines)

Abstract

There is an over-representation of Black people under NHS inpatient treatment, or ‘sectioned’ under the Mental Health Act (MHA) compared to their White counterparts, with Black people four times as likely to be detained. Discrimination has been posed as an explanation for these disparities, and experiences of detention for Black people have been identified as racialised and racist. This study aimed to explore the experiences of inpatient mental health care for Black people and understand the impact of racial discrimination within these experiences. Interpretative phenomenological analysis (IPA) was used to analyse data collected via semi-structured interviews with six participants who were recruited from NHS inpatient services. Four group experiential themes were constructed from the data: 1) Loss of freedom and getting stuck; 2) The clash of spirituality, religion and mental health – suppressed by medication and losing identity; 3) The relationship with staff, and 4) Being Black changes things. Findings unveiled loss and restriction, relationships with staff, conflicting agendas and differential treatment because of race and ethnicity were central factors of experiences of inpatient mental health care for Black patients. This study contributes to existing research exploring the experiences of detention for Black people and provides clinical implications for healthcare professionals.

Keywords: Black ethnicity, Mental health, Inpatient care

Introduction

Inpatient treatment is the term often used to describe the delivery of care for a prolonged period of time in a hospital setting. In regards to mental health treatment, people may be hospitalised for treatment formally, or informally. Formal hospitalisation may include detention under the Mental Health Act (MHA) (1983) for psychiatric treatment and is sometimes referred to as a patient ‘being sectioned’. Informal treatment may include treatment given within a hospital setting however the patient has the autonomy to withdraw from services and leave without consequence of law or authority requiring intervention. Historically, mental health detention has been criticised within theories of social control, describing institutions as convenient places to rid society of inconvenient people (Scull, 1980), and for subjecting them to isolation, loss of connection from the outside world, mistreatment, and constant surveillance (Barton, 1976).

It has been long established that there has been an over-representation of individuals of minority ethnic backgrounds detained under the Mental Health Act; in particular, people from Black- African/Caribbean/British ethnic backgrounds (Ineichen, 1986; Department of Health & Social Care [DHSC], 2018). National Health Service (NHS) data highlighted a continued increase in the proportion of Black ethnic people detained compared to White people. In 2017/18 it was recorded that Black people were over four times more likely to be detained than White people (Singh et al., 2007). Recent statistics still show this to be the case, with Black African identified as having the highest rates, followed by Black Caribbean (NHS Digital, 2024a; 2024b). When comparing ethnic groups and compulsory detentions, Barnett et al. (2019) identified that studies in the UK had higher rates of Black minority ethnic detentions. The authors argued the reasons for this were “multifactorial, involving longstanding experiences of discrimination and deprivation” (DHSC, 2018, p. 20).

Exploration into the experiences of detention for people of Black ethnicity is sparse, however the research that is available acknowledges that the experiences for these groups of people are unique with factors of their experience influenced by their race (Solanki et al., 2023). Solanki et al.'s (2023) recent exploration of detention for Black adults concluded that the experience is racialised and racist. Solanki and colleagues conducted a thematic analysis to explore the experiences of Black adults detained under the MHA, and unveiled four themes from the data: Help is decided by others, not tailored to me; I am not a person – I am a Black patient; Mistreated or neglected instead of cared for; and Sectioning can be a space for sanctuary and support. They established that people of Black ethnic backgrounds experience racism in inpatient settings in addition to systemic challenges, and call for these to be addressed across mental health care (Solanki et al., 2023).

Discrimination has been defined as negative actions, unjust or prejudicial treatment of others on the basis of their social status memberships, sex, age, race, or any other socially defined characteristics (Dovidio & Gaertner, 1986). It has been well-established as a chronic stressor for individuals of the global majority, in particular Black adults (Barksdale, 2009). The relationship between racial discrimination and negative social and psychological outcomes is well documented, studies observe that it exacerbates psychological distress (Ong et al., 2009; Sellers et al., 2006; Sellers & Shelton, 2003). It is understood that the discriminatory experiences exacerbate symptoms of depression and anxiety, and research has established the relationship between these disorders and morbid ideation, suggesting that the experience may subsequently lead to a person having thoughts to harm themselves (Cheref et al., 2019). Walker et al. (2014) explicitly identified that perceived discrimination is related to increased suicide ideation in Black adults. Brooks et al. (2020) explored the effects of perceived discrimination as a provocative event influencing an individual's capability for suicide, and noted an increased capability for suicide in Black adults, although no association was present amongst White adults (Brooks et al., 2020).

There remains a need to further explore the impact of experiences of racial discrimination on mental health for different groups of people. Research exploring the nuances of these culturally specific experiences, and how they relate to risk related behaviour, is minimal, and is predominantly quantitative. In addition, current research that has explored this topic has generally been conducted with populations in the United States (US). Research demonstrates that discrimination has an impact on mental health, including suicide risk in Black adults, however, more knowledge is required to understand the nuanced experiences behind this finding. In order to better understand the relationship between perceived discrimination and an individual's distress and risk related behaviours, qualitative research within a clinical setting is necessary. Solanki et al. (2023) has explored this within the UK nonetheless there remains a need to keep collecting data and expand on the knowledge and information that is available. More qualitative research exploring this topic with this population is needed, in addition to exploring different contexts, geographical locations and utilising different methodological approaches to obtain rich and nuanced information. Thus, this research aims to provide some additional context for individuals in the UK by exploring the experiences of psychiatric inpatient care for Black[1] people with a particular focus on understanding the role of racial discrimination within these experiences. This study will capture the voices of participants live experiences navigating mental health care systems in the UK and serves to provide rich qualitative information to support healthcare professionals understanding of the nuanced experiences for Black adults within inpatient mental health settings. This information could have implications for psychologists in clinical practice as it

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[1] This paper refers to Black people as those having Black British, Black African, Caribbean or Black other ethnic heritage.

could improve therapeutic relationships, risk assessments and contribute to National Institute for Health and Care Excellence (NICE) standards and strategies for suicide prevention to provide cultural sensitivity.

Materials and Methods

Study Design

A qualitative phenomenological approach was employed using semi-structured interviews to explore the experiences of inpatient care for Black patients, with an interest in the role of discrimination within their experience. Interpretive Phenomenological Analysis (IPA) has been applied to analyse the data of this research project as it was felt to be the best-suited methodology as it focuses on how people make sense of their experiences (Smith et al., 2022). Its double hermeneutic process supports the researcher to understand the perspective of the participant as much as possible, and the meaning placed on such experiences; and it's person centred approach enables participant to tell their story the way they want. Additionally, IPA is consistent with the epistemological position of the research, and supports the aims of research in clinical psychology – to develop an understanding of people's perceptions of significant life events – in particular where experiences are emotionally laden (Smith & Eatough, 2015). Whilst there are no specific requirements for sample size within IPA, recommendations have been made for doctoral studies to range between six to ten participants (Smith & Eatough, 2015). Nonetheless, IPA can favour smaller sample sizes because of its idiographic focus, which allows the researcher to understand the perspectives of the person, as much as possible. (Smith et al., 2022). Semi-structured interviews are the most common form of data collection in IPA research, it allows the researcher to develop a rapport with the participant, supporting the hermeneutic roots of the approach (Smith & Eatough, 2017; Smith et al., 2022). Additionally, it enables the interviews to have a similar structure whilst still facilitating flexibility for the participants to engage, respond and expand in topics meaningfully and relevant to their experience.

Recruitment

In line with Smith et al.'s (2022) guidelines, purposive sampling was employed. Participants were recruited across three mental health services, from one NHS trust located in the North West of England. The researcher and supervisors contacted ward/team managers/members from four inpatient services within the trust. Information regarding the project was shared with staff including ward managers, support workers, assistant psychologists, equality and diversity leads, and nurses. Recruitment packs containing the participant information sheet, consent to be contacted, and demographic questionnaire were distributed via email, and paper copies were also provided to staff who were asked to share information about the study with service users who fitted the inclusion and exclusion criteria. Information regarding the project was also communicated to service users via staff during ward community meetings. Staff were asked to store and disseminate information when a potential participant had been identified or expressed interest, and completed forms were returned to the researcher via secure email. Following receipt of consent to contact and the demographic questionnaire, the researcher contacted participants to offer an opportunity to ask any questions and schedule an interview. All interviews were conducted face-to-face and each participant signed a written consent form prior to the interview commencing.

Although recruitment was also attempted via social media, there was no uptake of eligible participants via this method. One individual did express interest however did not meet the inclusion criteria (Table 2-1) as they were the carer, not the individual that received care within the inpatient service.

Participants

Nine individuals expressed interest in taking part in the study. However, of these participants two were discharged from the inpatient service prior to the interview date, and one changed their mind prior to commencing the interview. Unfortunately, this participant communicated their decision via staff, so the researcher was unable to explore the reason for their withdrawal.

A total of six people were recruited into the research. Some information about the sample characteristics and demographics was self-reported by participants prior to the interview (Table 2-2). The participant sample consisted of three male and three female participants between the ages of 26 and 59. Five participants identified as first-generation immigrants, two participants identified as Black British, the remaining identified as African. Pseudonyms for participants have been used to ensure anonymity.

Data Collection

Data was collected via semi-structured interviews with the participant. The researcher asked questions exploring their experience of inpatient care as a Black patient. The interviews lasted between 26 and 60 minutes. The mean interview time was 36 minutes.

Ethics

NHS REC (23/NW/0344) gave a favourable opinion for this research project. Ethical approval was gained from HRA via IRAS system. See ethics section for further details regarding ethical considerations.

Data Analysis

The data was analysed following the IPA approach as stated by Smith et al. (2022). Following the six interviews, the data was transcribed and analysed. Each individual interview was transcribed, read and re-read whilst re-listening to interviews. “Initial noting” interpretations and annotations were made alongside the transcripts, exploring the content and language used by the participant, which was then reviewed to inform the development of experiential statements (Appendix 2-A). Experiential statements were then reviewed and grouped together where it was perceived they were contextually similar to allow the formation of Personal Experiential Themes (PET) for each participant (Appendix 2-B). PETs across all the participants were then reviewed with the aim of identifying shared and unique experiences. These were then grouped by themes to create Group Experiential Themes (GET) to represent the data collected. Four themes were developed, including four subthemes (Appendix 2-C). Throughout the analysis process, the researcher repeatedly reflected and evaluated their own assumptions, biases and own beliefs, as means of bracketing perceptions to avoid influencing and misrepresenting the participants experiences.

Statement of Positionality

This research is being conducted by a Trainee Clinical psychologist with experience of providing mental health services within various settings, including inpatient. Additionally, the researcher identifies as Black ethnicity, and has personal experiences of racial discrimination. Therefore, it is possible that the aspect of the researcher’s identity has informed the way the data is analysed and therefore should be interpreted critically in light of this. The researcher also acknowledges that their identity does not exclude them from representing the system of which participants are reflecting on their experiences.

Results

The analysis of qualitative data produced 4 GETs representing experiences of participants: 1) Loss of freedom and feeling stuck, 2) The clash of spirituality, religion and mental health – suppressed by medication and losing identity 3) The relationship with staff, and 4) Being Black changes things. These themes are explored in more detail below.

GET 1 – Loss of freedom and feeling stuck

Five participants contributed to this first theme which encompasses patients' experience of feeling stripped of their autonomy, restricted and bound by the ward environment as an inpatient. Participants' comments did not reflect any acknowledgment of requiring an inpatient admission for mental health needs, or an awareness of the reason for their admission. The first subtheme, '*How did I get here and how do I get out?'* captures participants' lack of clarity of their need to be in hospital. The second subtheme *'Trapped and entrapment'* represents participants experiences of feeling restricted – physically and emotionally, with limited resources to escape. Participants expressed a frustration about loss of independence and a lack of clarity about the reason for their admission whilst feeling uncertain about when they would be able to leave.

How did I get here and how do I get out?

When describing their experiences of being detained in hospital, some participants highlighted that they were unsure of the circumstances that led to their admission, and did not have a clear understanding of what was expected or required in order to be discharged. Gabriel described having no indication that there was a need for him to be in hospital:

> I didn't feel bad, I didn't feel bad, I didn't have relapses, I just brought me here to this ward (…) when I gonna get discharge because I'm already six, seven, because November, December, January, February, March, April, May, June, July, ten months is it. Oh sorry (laughs) ten months it's already, and then it's always the same no? They have to, you cannot stay here forever
>
> (Gabriel)

Similarly, Vivienne described having limited awareness of the events leading to her admission and being left out of discussions with healthcare professionals about what was going on, which delayed engagement in treatment. She reported that the information about her was gathered from others and treatment was decided for her:

> For some reason I did not see the warning signs at all, just happened like two days after work (…) So, they're treating people from the start… but they are, all of their information from the well people, people that are well… deemed well, and most are not (…) they didn't really get the questions from me (…) once I was told and as soon as I was told, I started taking my drugs and felt better. I felt like that it took the whole ward too long to let know that at the second stage (…) but in here, I was not asked questions… at all, until I got well, maybe that's the policy I don't know
>
> (Vivienne)

In both cases, the participant described being done to, rather than being worked with, leaving them feeling excluded from their own care and treatment, with no understanding of the pathway to discharge and potentially prolonging their admission.

Trapped and entrapped

Participants described feeling restricted and limited by the nature of being detained in a locked environment "I'm trapped in here, meaning that there's nowhere I can go" (Karl) and likening some of the processes within the experience to imprisonment "It's a prison inside a prison" (Gabriel). Karl described how the emotional impact of these experiences affected his responses : "It's very restraining, it's degrading to my mental health because being sectioned makes me feel trapped and it can make me react irrationally". Participants' distress from the experience was exacerbated in such a way that led to responses where their behaviours were perceived as an escalation of risk and subsequently exposing them to greater controlled conditions. Jermaine described how his responses were met with further restriction and isolation: "Like for example, when I came here, I was, I was, I was engaging with staff.

And then I just, I just switched and then, they put me in seclusion". There was a sense of frustration in the distress felt by participants due to the loss of freedom and agency within their experiences. Esther described how she disliked the loss of autonomy and having to rely on staff: "This is the things I miss about being independent you know (…) I just find it frustrating to have to depend on them for everything".

GET 2 – The clash of spirituality, religion and mental health – suppressed by medication and losing identity

The second theme conceptualises the struggle of navigating religion and mental health as an inpatient. The first subtheme *'it's my identity, not mental health'* includes participants' explanations of their religious, spiritual, or faith-led behaviours that are misconstrued as symptoms of mental illness. The second subtheme *'Needing faith to get through'* reflects the importance of faith for participants as a means of making sense and coping with the experience.

It's my identity, not mental health

Participants described their experiences of the challenges that came with religion and faith within a mental health setting. Gloria believed her expression of faith during a time of distress precipitated her admission:

> So I was really upset I felt like I had been attacked so I prayed from my house to the hospital, and I was confessing the word of God and, that's how this whole thing started, and they thought, they thought I've relapsed.

Some participants reported a sense that there were attempts to suppress their beliefs with medication. Gabriel spoke about his religious identity and described a sense of loss of himself from the experience:

> You will become very meek a person (…) sometimes we- we have something to read and, as Christian we have to feel from God's word, yeah sometimes we have things and some Bible, a little bit of Bible (…) but they don't care about it, they just give tablet.

Similarly, Gloria passionately described how she felt her beliefs were pathologised and medicalised rather than being accepted as being part of her identity, and felt confused as to why she was being treated with medication, as professionals perceived her behaviour as symptoms of mental illness:

> It's been alright but I- I just believe I was misunderstood, erm, I'm a Christian, a born again Christian, and there's a way we feel ourselves, there's a way we talk, there's a way we do our things which is perceived as abnormal to the system. (…)I don't know what the medication is all about, I don't know what they're treating because what I believe is in the scripture, there's evidence of it in the scripture, but they are saying it's mental problem. So what are they treating because… that- the medication can't stop my belief of what is in the Bible, or the way I choose to live my life if they believe, medication can't cure that but they don't seem to see that, but thinking it's, it's mental problem.

Gloria also explained how faith and religion is a part of Black people's identity and felt this needed to be acknowledged by healthcare professionals:

> Yeah I want them to know that we have culture, part of culture faith is one of them, erm and as Black person, most of us will believe in God, and that's something that should be respected and there should be more provision for that. It was of particular importance to Gloria as she felt strongly about her experience and expressed a desire to want to change things so that others benefit from her experience: "I intend to create

> a support- I should be allowed to express how I can help- how my faith can help. (…) I think that would be helpful, more like just for people to hear information that can benefit them”. She described the use of medication as a suppression of identity that she felt and had also observed of others:

> They want to medicate me to keep me quiet, not to talk, not to, not to, not to be outspoken but you can’t do that (…) The problem is identity crisis people want to know who they are, but they keep on packing her with medication, and, telling her she’s sick (…) her personality has been taken away from her.

Needing faith to get through

Participants highlighted the significance of their faith as a means of coping and getting through the inpatient experience. Esther reported “I’m just hoping and pray” when she feels vulnerable as a way of managing her distress. Jermaine referenced faith repeatedly when reflecting on his experience “You have to have faith”, and how he would advise others – religious or not, to adopt a sense of faith as a means of coping: “Even if you are atheist, have faith that you’re going to come through (…) Whatever God you believe in, know that everything’s gonna be in God’s hands”. Similarly, Gloria emphasised how faith was an integral part her recovery and how she managed during her experience: “It’s part of people's life, and it’s what can get people well. Erm, because that’s- that’s what have keep me going, my faith in Christ”. There was a sense that faith mediated the experience of distress somewhat: “We believe God will find us, if suffering he finds us” (Gabriel).

GET 3 – The relationship with staff

The third theme focuses on the interactions with staff throughout their inpatient experience. The majority of participants reported on how staff were involved within their experience. This theme relates to the perceptions and experiences of the ways staff interacted with participants throughout their admission.

Some participants described a perception that they were being tested by staff. Jermaine explained how he perceived this to be part of the process of staff getting to know patients and part of building relationships: “Cause the staff doesn’t know you and the staff and the staff wants to get to know and see what they, they’re trying to test you (…) yeah, so, the relationship, so now you have to build relationship”. He expressed a belief that staff make judgements based on historical information and this can influence their attitude towards patients:

> “Everybody’s came in with different background and some staff most staff can be turned off over that. (…) They’ll see your background and they’ll test you in all different kind of ways, like say, you don’t take your meds, that’s when they’ll be angry with you, if you don’t take your meds they’ll be angry with you, if you don’t clean up after yourself they’ll be angry with you, if they tell you to go out and you don’t come back in, and then they start looking for you, they be angry with you. So, that’s when you have to build trust”

There was an emphasis on coercion rather than improved wellbeing and that the ‘tests’ were measured by behavioural compliance and if ‘failed’ were met with negative emotions from staff. The way staff interacted affected how participants responded to them. Karl spoke about how staff's interactions influenced how he might engage with them: “Sometimes the way they respond to me, might want to make me react”. Similarly to the concept of being tested, Karl described how he sometimes perceived staffs behaviour towards him as an attempt to provoke a negative reaction to give cause for a longer admission:

> You see each other in the morning you say hi, good morning, yeah? She was coming, I was saying hi, good morning, she ignore me, I would try to make conversation (…) cause I like to make conversation to make sure you know me, you know. Then one very good day I was sitting on my own (…) I was sitting on my own, she kept trying to talk to me. In my mind how is it that someone that I been ignoring, yeah? Someone that has been ignoring me is trying to talk to me, and the doctor is asking me to take injection, like, I feel like, they kind of trigger me to keep longer in hospital, so I reacted very badly

This relates to the first theme of feeling entrapped, and led to feelings of distrust of staff. Esther believed that "there were a lot of games being played" by staff which led to her not feeling able to develop a trusting relationship "Well, I don't trust them really". Without trusting relationships with staff, it was difficult for participants to feel able to access support from them during their admission. Gloria explained how she did not feel staff could support her emotional needs: "I don't think they can solve my problem (…) I don't believe in them, I don't even think they know what they are doing".

Participants talked about the ways in which they try to appease staff: "Yeah, you just have to ask in a mannerly way. If you ask in a mannerly way, it's not 100% that they're gonna do it for you, but you have to ask them in a mannerly way" (Jermaine); "I try to please them, even when I go to shop I buy things for them as well" (Gabriel).

Gloria spoke about different experiences with ward staff compared to members of the multidisciplinary team. She described the relationship as being a battle: "My conflict is between the doctors and those in charge of my care". However, when reflecting on her interactions with ward staff she praises their work ethic and delivery of care. Other participants also perceived the relationship with the doctor to be different based on the position and power they had over the care they received: “So, the doctor is the one that is in charge, he’s the boss” (Jermaine), “The doctor is not someone you want to argue with or debate with or talk with. The more you try to do that, contest what the doctor has to say, the more you have… medication” (Karl).

Despite having some difficult relationships with staff, participants also described the efforts staff went to whilst acknowledging the demands of their role:

> I- i- I think the staff, they, the junior staff, they’re really doing well, they’re working hard, so there’s- they’re on their toes and trying to help everybody, trying to make the environment conducive. I think they’re doing fantastic job that’s what I think.
>
> (Gloria)

Vivienne explained that she felt assured by staff and their capability to contain her during her admission:

> So, getting here I think the people here, they know what mental health is all about since that’s the ward. So they were able to like contain the issue, so like, maybe me walking up and down, maybe trying to open doors, they were able to contain that issue. And not just for me as well, for every other person as well

Vivienne highlighted the importance of meaningful connection with staff and the significance it had on her recovery. She explained how she felt more supported by staff of the same ethnicity as her, she noted that they put more effort in to building a rapport, and this enabled her to make sense of her experience:

> People who really asked and generally tried to ask me, even in my abnormal state and all, so your- ‘why are you really here?’ ‘what’s going on?’ are people like me. When I got better, and everyone knew, oh my god this girls getting better, other people started

> asking questions as well. But from the beginning, in fact they are the ones that made me realise somethings wrong. (…) that conversation of trying to be nicer (…) that, that alone helped me to realise, plus the medications I guess.

GET 4 – Being Black changes things

All participants described how their ethnicity influenced their experience of inpatient care. Assumptions and stereotypes were a big part of this experience for Esther, she described how she felt stereotyped and judged as aggressive by staff from the start of her admission:

> Well, when I first come here they had all sorts of assumptions about me (…) Then I was misjudged, if I tried to talk to people I was accused of being confrontational, aggressive, which I was not. (…) You know, they perceive Black people as being aggressive all the time, it's just got this stupid stereotype, you know. Even we can be guilty of that, but still it's just ridiculous you know, you got to get to know the person before you make that judgement. So straight away I was stereotyped

Esther described that feeling stereotyped and judged made it difficult to talk to staff, explaining that she perceived staff would use those stereotypes as reasons to disengage with her which resulted in her pulling away from communicating with some members of staff:

> That's when I stopped talking to particular staff member, because as soon as you try to talk to them 'oh you're being confrontation, oh you duh duh, oh I'm going to disengage now, and duh duh' and I'm thinking well what's wrong with you all I'm trying to do is talk to you

These experiences had an emotional impact and limited the support pool available to Esther during her admission: "it upsets me a little bit if they're not co-operating but it doesn't impact my mental state (…) Well, I just call to people that I think I can speak to, and I approach them yeah”. She discussed that mistreatment was not limited to staff members of differing race and needing to stay positive despite the upset: “they’ve all been at it, you know they’ve all been at it but you know I just remain optimistic”. There was a sense of apathy from participants as though there was no option but to accept the upset from the experiences, perhaps feeling that the distress would not be recognised, acknowledged or validated by others. Gloria described how she was distressed and experienced negative responses from staff members of the same culture:

> Although I was loud, erm… erm, I was loud and it seems like some was not alright to me, and some of them understood, some of them they didn’t especially people from my, from my country, they were reacting bad to me, they were saying negative things like, they saw me behave- I’m deliberating behaving the way I’m behaving, it was not nice from my own people and yes they were staff, yeah (…) but I guess, that’s how it is.

Similarly, Karl discussed that despite generally having an okay relationship with staff during his inpatient experience, he believed that his needs and distress were minimised by staff if they were of the same ethnicity: “Maybe because we’re from the same place, they don’t take me seriously as a patient”. Jermaine and Gabriel both discussed their perception that the differential treatment based on race within an inpatient setting was influenced and representative of wider societal and longstanding racial preferences of Black ethnicities and suggestive of differential implications for being Black that are based on additional aspects such as country of origin and culture, as though there is an ethnicity hierarchy:

> Yes some people, some people are treated different from, like some people are treated different from each other (…) Like some, for example, some staff might not like other foreign people (…) Yeah cause, erm, everybody like Nigerians so, everybody likes

> Nigerians cause erm, after the Jamaicans, after the Caribbean, erm, I think I think, it was Nigerians that were most successful in the UK so, but I still feel that, I still feel that, erm, the, the government and everybody around the community work favours the Nigerians more than the Jamaicans, even though it's supposed to be the other way around, cause the Jamaican's is the first, the Caribbean's is the first ones to come as a slavery
>
> (Jermaine)
>
> "I think for other people things feel better cause they from Nigeria, maybe it's better (…) yeah. Nigeria or whatever, Ghana or whatever"
>
> (Gabriel)

Discussion

The findings indicate that feeling stuck, relationships with staff, disregard of personal beliefs and differential treatment because of being Black were central factors in participants' experiences. This stands alongside existing research that has also explored the experiences of detention for this population and found the experience to be affected by ethnicity, with themes of racial discrimination and mistreatment identified from the study (Solanki et al., 2023). The findings are also supported by research that has reviewed literature exploring the experiences of detention more broadly; where race or ethnicity have not been explicitly examined yet also uncovered restrictions of autonomy, staff relationships, and information and involvement in care as themes significant to the experiences of detention (Akther, 2019; Katsakou & Priebe, 2007; Seed et al., 2016; Staniszewska et al., 2019). Indicating that whilst some of the findings outline experiences that may be common amongst inpatients regardless of ethnicity, there are some nuanced experiences for Black people that have been revealed in this study. This study is unique in that it sought to explore the role of racial discrimination within the inpatient experience; however not all participants felt that this was a significant aspect of their experience to explore, and for those that did, differential treatment was not always linked to negative interactions.

One possible explanation of the differing significance could be a reflection of changing race relations within the UK that has raised awareness of discrimination and racism (Badenoch, 2022; Smith, 2021), thus individuals have more awareness of their actions when interacting with others of differing ethnicities. Furthermore, it could be an indication that services have become more culturally competent with the implementation of policy initiatives such as the Patient and Carer Race Equality Framework (PCREF), supporting services to meet the needs of individuals from diverse ethnicities and improve health service provisions, whereby participants are feeling more fairly treated. Alternatively, it is possible that where participants have experienced racial discrimination frequently outside of the inpatient context, they may have become desensitised to the recognition or detach from the distress of discrimination unless behaviours are directly overt, perhaps because they have endured the experience frequently throughout their life in society (Wong et al., 2022). Some participants that did perceive their experience to have been affected by their race or ethnicity, provided comments that indicated a perception that these experiences were a reflection of wider societal narratives and historical racism. This echoes findings from Solanki et al.'s (2023) study that also noted that the experience of detention may sometimes reflect experiences of racism in wider society.

The findings from this current study demonstrate that participants find the experience of being an inpatient as restrictive, noting that at times they felt trapped and processes within the experience were likened to prison, and mirror findings identified in Akther et al.'s (2019) and Solanki et al.'s (2023) research. This lack of freedom and autonomy is described by participants in this study as experiences that have an emotional toll that exacerbates distress, which is difficult to manage and regulate within a constricted environment, leading to responses of behaviours that within the clinical setting is perceived as an escalation of risk and subsequently used as grounds to extend inpatient treatment, ultimately submerging them in a vicious cycle where they are stuck without resources to break the chain. Additionally, participants discussed a lack of information about the reason for their detention, exclusion from conversations about their care and treatment, limiting their ability to develop knowledge of what to expect and what is required to progress in their recovery. These experiences are also reflected in Akther et al.'s (2019) and Solanki et al.'s (2023) whereby lack of information and involvement was also highlighted in themes. Despite research highlighting these issues, the findings in this study demonstrate that there remains gaps between research and practice.

Some participants described different perspectives in terms of beliefs, and how this felt like a battle to be understood by healthcare professionals as behaviours were perceived as symptoms of mental illness. This is reflected in the theme 'The clash between religion and mental health'. Boyd-Franklin (1990) discussed this topic, noting that experiences for those of Black ethnicity can be misinterpreted and mislabelled by Western models (Boyd-Franklin & Shenouda, 1990), similarly, research has also noted that cultural beliefs can often compete and contrast with medical explanations (Islam et al., 2015). Despite participants not attributing the differences in treatment to racial discrimination, but more to cultural differences and approaches to mental health, this theme still highlights the need for healthcare professionals to be able to consider alternatives to Western psychiatric approaches to appropriately support people of Black ethnicity.

The impact of staff support and relationships was also discussed by participants, echoing previous research exploring experiences of detentions that has also highlighted the significance of staff relationships (Akther et al., 2019; Seed et al., 2016). Participants in this present study described staff as being nice and helpful, noting that they were trying their best, whilst also acknowledging that staff have multiple demands whilst caring for multiple individuals with a range of presentations and complexities. However, participants also described staff as testing, and at times perceived them as neglectful of their needs and dismissive of their requests. It was noted that when participants discussed staff’s ability to meet their needs they often focussed on practical requests and needed prompting to explore attendance to their emotional needs. Despite descriptions indicating positive relationships, participants rarely utilised staff for emotional support, and instead discussed peer relationships on the ward and external social support. This is reflective of findings of previous research that has investigated experiences of people of Black ethnicity in mental health services, which highlights the value of relationships on the ward and shared experiences (Chtereva et al., 2017). Additionally, research has emphasised the importance of connectedness for people of colour and how it can buffer poor health outcomes (Brody et al., 2014; Parhman et al., 2000; Yusuf et al., 2023). This could perhaps in part explain why, for some participants, their connection to faith was of such value and importance within their mental health experience, in particular if they were lacking connectedness from staff or peers. Additionally, research has shown that religious beliefs and practices can mediate the negative effects of racism and racial discrimination on mental health (Bhui et al., 2008; Ellison et al., 2008; Ellison et al. 2017) which emphasises the importance of this being acknowledged by healthcare professionals for Black people.

Some participants discussed their experiences of staff in relation to the staff members ethnicity. One participant highlighted that they felt their concerns were not taken seriously by staff members that shared the same ethnicity as them. Additionally, another participant expressed that they felt they were more negatively perceived by staff of the same cultural identity. However in contrast, some participants did express that they experienced more efforts from staff, when they shared the same ethnicity compared to those that differed. Whilst acknowledging that all staff were nice, those of Black ethnicity responded to them in a way that was perceived as more helpful. The findings from this study suggest that whilst staff of the same ethnicity may be able to relate to Black patients, this does not always lead to better outcomes. This idea has been discussed in previous research, commenting on the uncertainty of improved outcomes when having staff who are ethnically matched to patients (Fernando, 2017; Lovell et al., 2014).

Furthermore, one participant discussed how they felt there was preferential treatment based on ethnic group identity; highlighting that as a Black African, they perceived they were treated better than an individual of Black Caribbean ethnicity. This is suggestive of differential implications for being Black depending on additional elements of identity, such as country of origin or cultural practices, and highlights that the nuanced factors within the Black experience that has the power to influence the quality of their experience when accessing healthcare. Findings of a similar vein were identified in Solanki (2020) study, noting treatment based in accordance to group identity rather than people being seen as individuals. From these findings it could be concluded that a diversely representative staff team does not necessarily mediate experiences of differential treatment or discrimination, and ensure quality care for Black patients.

Clinical Implications

The findings of this research emphasise the need for collaborative relationships between patients and professionals, which has also been highlighted in previous research (Seed et al., 2016; Solanki et al., 2023). This is particularly important when considering the value that is placed on connectedness by Black people (Myers, 2006) and its significance is demonstrated in the findings in relation to when connection is present it promoted the ability to develop insight and engage. It is therefore recommended that patients are included in conversations about their reasons for admission, care and treatment, and that their cultural beliefs and support systems are considered as part of their care plan. This recommendation is also supported by professional guidelines and policies that recommend patient involvement (British Psychological Society, 2017; NHS England, 2017). Additionally, when considering staffing, it is imperative that services do not assume that the presence of Black staff will necessarily address the concerns and provide better care for Black patients, as highlighted from the findings in this present study that it does not mediate feelings of differential treatment and discrimination. Appropriate training should be available to all staff working with individuals of Black ethnicity, and regular reflective practice should be accessible as spaces for professionals to consider intentions and initiatives that can support the experiences of care for people of Black ethnicity.

Medication is the referenced treatment throughout the findings, with little discussion of any other interventions as part of participants experience. NICE guidelines recommend medication in conjunction with psychological treatment however research has highlighted that Black people are more likely to be offered medication over talking therapies (NICE 2014; Baker & Kirk-Wade, 2024; Bansal et., 2022). This has clinical implications for healthcare professionals to provide patients with access to meaningful psychological input for a more holistic approach to recovery.

Strengths and Limitations

Whilst studies have explored experiences of detention amongst this population, these have been predominantly conducted outside the UK (Akther et al., 2019; Barnett et al., 2019; Bignall et al., 2019). The current research is unique in attempting to explore the role of discrimination within the experience of inpatient care for Black patients. Previous research identified discrimination and racism as findings, however, the impact of discrimination within the experience had yet to be investigated. This research adds to the existing literature exploring the experiences of inpatient mental health treatment in the UK for Black individuals (Solanki et al., 2023), additionally adding some insight to understand how perceived discrimination factors into their experience. Although in contrast to some existing literature, this study acknowledges that there were many factors impacting on experiences and that discrimination seems to be a contextual factor, but for some, not an overt issue. It serves to develop an understanding and highlights further avenues for research in this area.

Some participants interviewed expressed a desire to want to contribute to changes and have their voices heard, which speaks to the importance of including perspectives of lived experience within research and this serves to challenge existing arguments that people of the global majority are hard to engage (Campbell et al., 2021; Kalathil, 2013; Liamputtong, 2010; Nevid & Marua, 1999). As participants were all recruited from the same geographical area findings cannot be generalised as a representation of experiences of inpatient care across the UK. It is important to highlight that as the diversity of the population differs across locations, experiences of perceived discrimination may also change in prevalence depending on whether individuals are the majority, or minority ethnic group. This is why it is important to conduct research of this type in different locations to explore convergence and divergence within experiences.

Factors such as the researcher not being based within the services of the participating NHS trust could have hindered recruitment, as the role of recruitment for this research project relied heavily on ward staff who are already working under pressure. Additionally, the struggle in recruitment also speaks to the known existing strained relationship between this population and healthcare professionals because of longstanding systemic discrimination and racism that has perpetuated inequalities within the healthcare system. Thus, there may have additionally been a reluctance to engage, particularly as there was no immediate benefit to the participant from taking part. Researchers have highlighted that this population may have reservations and concerns about confidentiality, perhaps due to mistrust of systems (Campbell et al., 2021; Hines & Boyd-Franklin, 2005; Liamputtong, 2010). Future researchers should prioritise working on developing longstanding relationships within the population community to build a rapport and regain some trust that may support the recruitment of research within these communities.

Future Research

Previous research has explored experiences whilst grouping individuals of Black ethnicity. However, as participants in this study expressed a perceived difference in treatment based on ethnic identity, it may provide further insight for future research to explore the experiences amongst population samples that are more heterogeneous within the Black population. This research did collect some demographic data informing migration status but this information was not included as part of the analysis as it is a small sample with little variance, therefore it is not clear how this affects individuals without making leaps, it may be of interest for future research to explore how this cofounds with these experiences, and highlight the importance of considering other factors that could influence the quality of the experiences of Black people accessing healthcare. The current study explores the role of discrimination within inpatient settings, however these experiences are not limited to institutions and inpatient services and future research could explore this in different services that provide psychiatric treatment for Black people to continue to develop contextual understanding of these experiences across differing provisions. More of this research needs to be conducted across differing geographical locations because context is important, and it is needed in order to understand the experiences and distinguish what is shared, what is different, what is unique, and consider different intersectionality that may also cofound within experiences.

The Black mental health manifesto continues to ask for systemic changes to support Black mental health, of which one suggestion includes an investment in community-led research by, and for Black communities (Black Mental Health Wellbeing Alliance [BMHWA], 2024).

Conclusion

This research aimed to develop an understanding of inpatient experiences for Black patients with a specific interest in the role of discrimination and whether this influences that experience. Findings revealed that loss and restriction, relationships with staff, conflicting agendas and differential treatment because of race and ethnicity were salient factors for Black patients receiving inpatient mental health care. Understanding how Black patients experience mental health services supports our understanding of the nuanced experiences within these contexts that exist for individuals of this group when receiving care and treatment within NHS services, as professionals. This study makes and important contribution to the literature by identifying four themes to develop an understanding of these experiences.

Acknowledgements

The authors thank the six participants who participated in this study.

Declaration of Interest

The authors report there are no competing interests to declare.

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Appendices

Appendix 2-A

Example of Exploratory Noting and Constructing Personal Experiential Statements

Personal Experiential Statements	Interview Transcript	Exploratory Notes
Feeling trapped, restrained and confined to the ward and the system	Karl: It wasn't nice, I felt restrained, even til now I still have some restrain. For instance, I can't have a one to one with a female staff without the company of male staff. That is because of my history in previous mental health hospital whereby I have crisis of writing love poetries to female staffs. It's not something that occurs in this hospital, it's something that is being prevented in this hospital already, so, otherwise, I feel a bit restrained (yawns). Not exactly isolated, because it's not my first time in hospital, otherwise I would feel isolated but it's very restraining, it's degrading to my mental health because being sectioned makes me feel trapped and it can make me react irrationally, ya know, yeah. I: And have you been happy with the care you have received in hospital?	*"Restrained" – physically by environment, or physically by others* *"wasn't" suggesting that things may have changed. Although is using past tense but remains an inpatient at the time of interview, perhaps is distancing himself from the experience* *"even til now" a sense that even though time has passed, he still feels*

Wanting to be treated and valued in the same way as others	Karl: It's decent. It's decent, yeah. (Inaudible/please don't think) hospital standard, it's quite decent I'd say, it could be better though? There are wards less acute than this one, why don't they just move me to this ward straight up, why do I have to remain here if someone is being treated more severely than I am or better than I am, or more prioritised than I am you know?	*as restrained. Restrain? Or is that protection? Language changed from a bit restrained to very restraining – a sense that this is an active feeling.*
	I: Do you feel like you have been treated differently to others on the ward?	*It's degrading – a sense of humiliation being in hospital for mental health or a loss of self-respect or perceived value? Stigma?*
	Karl: yeah	*"Trapped"*
	I: In what way?	*"Irrationally" – suggests that he has awareness that behaviour is not always proportionate to event/circumstance*
Feeling stuck in the system with no clear understanding of why, and not being helped in the same way as others	Karl: Priorities, prioritisation. Like some patients are more prioritised than I am, you know, in the sense of like care and needs you know, some patients just makes certain requests at certain times and they're being helped, they're being responded to and spoken to. Otherwise, me, at some point, I get, verbally like I can't explain it but like I'm treated in a way that like, I'm in a better state, you know, but my point is that, if I'm being treated like I'm better than someone,	*A sense that there's a disparity*

	mentally, because this is a mental health sector, why am I in such a ward? Does that make sense? [Researcher: yeah] like does that mean that I've been overreacted to my situation or something? Cause if I'm here because of one bad reaction that means they've overreacted to my reaction you know? Yeah. I: How have these experiences impacted on your relationship with staff? Karl: Sometimes good, sometimes shit. I: Do you mind telling me a bit more?	*A sense that others are treated better/cared for more than him, but he is told that he is in a better situation/condition than others – so, needs ignored? Minimised? Not unwell enough? To get the same level of care but on the same ward that suggests level of support is needed)*
	Karl: Erm, with staff, fairly speaking, my relationship with staff are very good, so far. Only some of them have been a bit unprofessional, with things like, they get carried away, you know. Or maybe because we're from the same place, they don't take me seriously as a patient. But, generally, my reactions with staff are fairly standard and good. I have good relationships with staffs. I: When you say things like "they get carried away" and "they don't take you seriously because you're	*They don't take me seriously as a patient – perhaps a sense of humiliation or embarrassment that people perceive his need for care as a joke?*

	from the same place" do you mind just telling a bit what you mean about that? Karl: Erm, I mean for instance like, I will say it may be lack of experience in the mental health sector. Some of them are fairly new, maybe like one year, two year, experience in the mental health sector. Like, you could be prone to mistakes, but then they're having the first encounter of experience, you know	*"from the same place" - does it reinforce a narrative that people like him should not need help?*
	I: Have these experiences impacted on your relationships with other service users on the ward? Karl: What do you mean by service user? I: Like patients Karl: No	*"Lack of experience. Prone to mistakes"* - *Is he trying to rationalise, or justify the discrepancy in care*

Appendix 2-B

Example of Personal Experiential Themes with Supportive Quotes

PET	Experiential Statements	Quotes
Feeling trapped, restrained and confined to the ward and the system	Feeling restrained by the procedures	"It wasn't nice, I felt restrained, even til now I still have some restrain. For instance, I cant have a one to one with a female staff without the company of male staff. That is because of my history in previous mental health hospital whereby I have crisis of writing love poetries to female staffs. It's not something that occurs in this hospital, it's something that is being prevented in this hospital already, so, otherwise, I feel a bit restrained (yawns). Not exactly isolated, because its not my first time in hospital, otherwise I would feel isolated but it's very restraining, it's degrading to my mental health because being sectioned makes me feel trapped and it can make me react irrationally, ya know, yeah"
	There is nowhere to go to get away but aggression will get you moved	"If we're in the community, yeah, and, I have a neighbour in my house trying to talk to you, you're ignoring me, then one day you decide you want to start talking to me, I walk away. But in here this is cram zone, this is trap, I'm trapped in here, meaning

		that there’s nowhere I can go here. You are in here to work for 6 to 8 hours to 10 hours to 12 hours, you understand. If the communal area is where I am and you’re there, I have no choice but to react because I’ve nowhere to go to. I’m not gonna lock myself in my room because of you, so I have to react negatively to kick you out of the ward.”
Feeling stuck in the system with no clear understanding of why I’m in hospital when I’m not being helped in the same way as others	Not taken seriously as a patient	“Or maybe because we’re from the same place, they don’t take me seriously as a patient.”
	Too well to be helped, too unwell to be discharged	“In the event maybe I get into a state of crisis, yeah? it’s not going to be taken seriously as someone who is very acute, you know. So it’s a priority, like they

		prioritise needs of some people better than some people, because of how the doctors have portrayed my situation to be, you know.” “If some people are being worse than others, or some people are being treated better than others, they shouldn’t be here, like myself, I feel like I shouldn’t be in hospital, you know?”
Navigating the system and understanding it	It all depends who is on shift	“No, they do what they like. Like for instance was yesterday, you know. I took my depot yesterday. He gave my depot yesterday and he did a fantastic job”
	How they interact with me effects how I interact with them	“Sometimes the way they respond to me, might want to make me react. An example is how I got from [redacted] to [redacted] ward. There was this staff, she comes here once in a while, but we don’t have any problems anymore, I apologised to her. Yeah, there was this staff who just comes to the ward. When I was on [redacted] yeah, you know, you see each other in the morning you say hi, good morning, yeah? She was coming, I was saying hi, good morning, she ignore me, I would try to make conversation, where you from? Where are you from? You know, I’m Nigerian, what

	part of Nigeria, cause I like to make conversation to make sure you know me, you know. Then one very good day I was sitting on my own, yeah? After, or before the doctor, before the doctor… because I take depot injection. I was sitting on my own, she kept trying to talk to me. In my mind how is it that someone that I been ignoring, yeah? Someone that has been ignoring me is trying to talk to me, and the doctor is asking me to take injection, like, I feel like, they kind of trigger me to keep longer in hospital, so I reacted very badly”

Appendix 2-C

Example of Developing Group Experiential Themes with quotes

GET: THE RELATIONSHIP WITH STAFF	
Trials and tribulations of navigating relationships and trust with staff "I just felt I was ignored a lot, and there was a lot of games being played" "well, I don't trust them really"	Esther
Staff work hard and do their best "Mmm, erm, I- i- I think the staff, they, the junior staff, they're really doing well, they're working hard, so there's- they're on their toes and trying to help everybody, trying to make the environment conducive. I think they're doing fantastic job that's what I think."	Gloria
Recognition for the staffs efforts throughout hospital admission "no, no… there's no, there's no difference, there's really no difference, everyone is doing their job perfectly well, exactly, and if you are open minded to talk, we like to talk, the nurses are willing to sit with you to have that conversation with you, and if they see that you're not comfortable with them, they leave, you can get someone who you're confident with so it's really nice… it's nice."	Vivienne
Testing the relationships / Needing to test others to distinguish who to trust "the staff can be annoying" "cause the staff doesn't know you and the staff and the staff wants to get to know and see what they, they're trying to test you" "they're trying to test you"	Jermaine

GET: LOSS OF FREEDOM AND FEELING STUCK	
Feeling stuck in the system with no clear understanding of why I'm in hospital when I'm not being helped in the same way as others "Priorities, prioritisation. Like some patients are more prioritised than I am, you know, in the sense of like care and needs you know, some patients just makes certain requests at certain times and they're being helped, they're being responded to and spoken to. Otherwise, me, at some point, I get, verbally like I can't explain it but like I'm treated in a way that like, I'm in a better state, you know, but my point is that, if I'm being treated like I'm better than someone, mentally, because this is a mental health sector, why am I in such a ward?"	Karl

Navigating the system and how you engage with staff to get the support you need "so my advice to anybody when they first come in here just, just, engage with the staff and be mannerly to them so when, if you be mannerly to them and you say okay there's this guy like this erm, so we will, we try to help him out as best as possible"	Jermaine
Not understanding the reason for hospital admission "I didn't feel bad, I didn't feel bad, I didn't have relapses, I just brought me here to this ward"	Gabriel
Feeling left out of discussions and not knowing how to get better "Then for the, for the other, the part that I didn't really like was because I never get to have erm, have conversations about, maybe because I was having psychosis anyway, never get to have conversations about… what caused it."	Vivienne

GET: SUPPRESSED BY MEDICATION AND LOSING IDENTITY	
Feeling a loss of independence when in hospital "This is "I just find it frustrating to have to depend on them for everything"	Esther
A loss of self "They don't have the same knowledge that I have, you know it's sad for me to see my fellow… brother and sister being, being reduced to medication, yeah that is what is going on in NHS"	Gloria
Lack of clarity and loss of sense of self "They consider me some kind of bipolar (inaudible) they are not sure" "You will become very meek a person",	Gabriel
Limited Treatment outside of medication "but they don't care about it, they just give tablet, it's not enough"	Gabriel

GET: THE EXPERIENCE OF BEING A BLACK INPATIENT	
The impact of having staff of the same race / ethnicity "although I was loud, erm… erm, I was loud and it seems like some was not alright to me, and some of them understood, some of them they didn't especially people from my, from my country, they were reacting bad to me, they were saying negative things like, they saw me behave- I'm deliberating behaving the way I'm behaving, it was not nice from my own people and yes they were staff, yeah"	Gloria
Black staff were more forthcoming and inclusive	Vivienne

"So from the beginning I could see it, but for generally, they've ***all*** been caring, working, doing their job. Just like, I feel like those people have been trying to inquire more, asking ***me*** the person, not the normal."	
The understanding of outside racial influences experience of care in hospital "Yeah cause, erm, everybody like Nigerians so, everybody likes Nigerians cause erm, after the Jamaicans, after the Caribbean, erm, I think I think, it was Nigerians that were most successful in the UK so, but I still feel that, I still feel that, erm, the, the government and everybody around the community work favours the Nigerians more than the Jamaicans, even though it's supposed to be the other way around, cause the Jamaican's is the first, the Caribbean's is the first ones to come as a slavery"	Jermaine
Assumptions and stereotypes based on skin colour "Then I was misjudged, if I tried to talk to people I was accused of being confrontational, aggressive, which I was not."	Esther

Appendix 2-D

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Tables and Figures

Table 2-1

Participant Inclusion-Exclusion Criteria.

Inclusion Criteria	Exclusion Criteria
Any gender identity ages 18 years and over	Individuals who do not speak English or have endured organic brain damage
Participants must be receiving care within an Inpatient setting, this can be informal or formal detention under the MHA, or have experience of receiving care within an NHS inpatient service within the past 10 years.	Individuals detained in CAMHS, LD or forensic wards due to the additional medical and legal factors associated with these populations.
Participants must be of Black British, Black Welsh, African or Caribbean ethnicity demographic	Individuals under the influence of any drugs or alcohol at the time of the interview
Research participants can be of any socio-economic grouping	Individuals experiencing acute levels of psychosis
English speaking to conversational ability, and able to communicate via video/telephone if required	

Table 2-2

Demographics of the Sample

	Age	Gender *M (Male) F (Female)*	Ethnicity	Migration status
Jermaine	26-34	M	Black British	1st Generation
Karl	26-34	M	African	1st Generation
Esther	35-45	F	Black British	2nd Generation
Vivienne	26-34	F	African	1st Generation
Gloria	35-45	F	African	1st Generation
Gabriel	46-59	M	African	1st Generation

Section Three: Critical Appraisal

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Critical Appraisal

This paper presents a critical review of the research process undertaken in order to complete both the systematic literature review and the empirical project. The critical appraisal will begin by summarising the findings from both the systematic literature review and empirical paper, as well as discussing matters that have not yet been addressed. This section will also include reflections on various aspects of the research process such as methodological issues, clinical implications and future research. There will also be some personal reflections about the process of completing this thesis. In addition to presenting reflections on this process from the perspective of the researcher, there will also be consideration of the implications of this research in relation to future clinical practice, policies, and development of services. Alongside this will be reflections of my journey throughout the research project, which will include why the project was chosen, the challenges endured and the emotional responses that were evoked during the process.

It is important to highlight the political context that this thesis was written in, and the change in the UK that has occurred since the initial starting point of the research. The change in Government from Conservative to Labour may be of service to the cause of this research. Labour’s stated commitments to mental health equity and racial justice include an introduction to a Race and Equality Act to root out racial inequalities; and reformation of mental health legislation to ensure patients have rights, autonomy, and dignity. These will not eradicate all the existing issues highlighted from the accounts of participants experiences, but it is hoped that this will contribute to the called for changes to support Black mental health.

Summary of Papers

The overall aim of this thesis project was to explore the factors affecting psychological wellbeing for Black people. The systematic review explored the role of masculinity in the functioning of Black men’s psychological wellbeing and as a barrier to help seeking. The review highlighted that Black men feel a pressure to conform to masculine ‘norms’ and don’t feel that they have permission to engage in emotional expression or conversations about their mental health for fear that it will jeopardise their masculine status in their community. Black men expressed their heightened sense of responsibility and duty for others in their community which at times perpetuated feelings of distress in addition to their own personal stressors. Additionally, existing beliefs about healthcare professionals made it difficult to feel that accessing support would be helpful.

The empirical paper used qualitative research methods to explore the experiences of inpatient care for Black patients, using Interpretative Phenomenological Analysis (IPA). The purpose of this study was to gain insight into people’s experience of inpatient mental health care with an interest in understanding the role of perceived discrimination within the experience. The study included six participants who were interviewed using a semi-structured topic guide. Four themes emerged from the data: 1) Loss of freedom and feeling stuck, 2) The clash of spirituality, religion and mental health – suppressed by medication and losing identity, 3) The relationship with staff, and 4) Being Black changes things. The subthemes within these highlighted that lack of clarity, feeling restricted, religious identity, and race were central to participants’ experience of inpatient mental health care. Some patients expressed that they felt these experiences increased their distress but how it was motivating them to want to obtain positions where they would be able to support others in similar situations in the future. This study contributes to the literature by providing personal perspectives on the experiences of inpatient mental health care for Black patients. The findings highlight that there is a need to continue exploring lived experiences as the richness and nuance of data available is informative for professionals that are supporting individuals of the global majority. Research like this has an important role to play in helping professionals develop a better understanding of the experiences of Black patients, as it puts their accounts of their experiences into the evidence base. A prominent reflection from this research is in relation to the recruitment of participants in services as an external researcher, given the challenges that can present when identifying and assessing eligibility and suitability to participate and the limited timeframes around this. Future research should prioritise the relationships with the population sample from the starting point of designing the research to support recruitment.

Selection of the Topic

This thesis was clinically relevant as the systematic review and empirical research paper looked to gain a better understanding of the nuanced experiences of mental health for Black people. It has been highlighted by previous researchers that academic research in Clinical Psychology exploring mental health in the UK has neglected the perspectives of individuals from the global majority (Wood & Patel, 2017). Additionally, there is a clinical need to develop cultural competency amongst healthcare professionals in order to meet the needs of the diverse populations we serve, and address the inequalities and disparities in access to services. As a result, this project is of clinical value as it provides insight into the nuanced experiences that Black people are facing when trying to manage their mental wellbeing.

My interest in researching the experiences of inpatient mental health care for Black patients was influenced by my previous work experience, where unfortunately an individual chose to end their life whilst being cared for in an inpatient mental health unit. As staff participated in the debrief, they shared reflections on whether they felt the individual's cultural identity was considered enough within their formulation and whether this had impacted their perception of treatment. I had also worked with another Black patient on a different ward where racial abuse was indirectly implicit by peers, this patient shared that this made them feel awkward on the ward but they felt unable to discuss this due to fears that this would cause friction and negatively affect them. In both these cases, the individuals were the only Black patients on their ward and on reflection, I wonder how they internally processed their experience of being overtly different to others. Additionally, I am aware that population groups within the global majority are under-researched; as I identify as a member of the Black community I felt a pull to use my power and position as a trainee Clinical Psychologist and researcher to utilise the opportunity, to provide a space where the voices of people within the Black population can have their stories heard with hopes that this can inform more culturally sensitive care in services in the future.

Methodological Issues

One methodological challenge was the aspect of conducting research recruiting from inpatient services, as an external researcher. Recruitment was supported by NHS trusts however recruitment relied heavily on the staff team on the wards, which meant potential participants had little interaction with the researcher prior to interview. This may have influenced the rate of recruitment or been a deterrent for potential participants where trust with healthcare professionals is already fraught, in particular as relationships and connectedness has been highlighted as important for Black people (Myers, 2006; 2010). All interviews were conducted face-to-face, despite virtual interviews also being offered as an option. This was to support the needs of the service but also the needs of the sample population. With the slow uptake of participants attempts were made to recruit via social media however this was to no avail, reasons for which can only be hypothesised. It could be suggested that the advertisement was not reaching the relevant audience as social media pages typically require the target audience to be following the page in order for the content to be seen. Efforts were made to overcome this by asking existing pages and groups to repost the recruitment poster, however this strategy did not increase uptake. This highlights why it is important for the researcher to be able to embed themselves – where they can, ethically - within the target sample population so that they are able to develop relationships from the start of the research design, adapt and consider strategies to mutually benefit the participant and the researcher in recruitment.

Throughout the recruitment process I had to contend with timeframes for discharge of potential participants. On two occasions, participants had been discharged by the service prior to the interview, and at this time recruitment was not available via social media to offer an alternative recruitment route. This felt frustrating as a researcher but I was also pleased as a trainee clinician, that people were being discharged from services, in particular from having conducted interviews where participants had expressed feeling ‘stuck in the system’ and from my own experience of working in these settings where delayed discharges can sometimes be an issue and cause additional distress for the individual.

Guides for qualitative research suggest an hour for interviews (Patton, 2015). This research did suggest interviews of up to an hour, however, most were shorter than this. This could be a reflection of the topic guide despite attempts to mediate this with consultation on the topic guide during the design, and by offering participants time at the end of the interview to share anything else about their experience that they wanted to share. Some participants were notably time checking throughout the interview, so perhaps the duration is also a reflection of the researcher’s ability to engage the participants in discussion of their experience. Additionally, other factors may have been affecting participants’ concentration levels, such as medication. However, despite the shorter duration of interviews, data provided by participants were still meaningful contributions.

Data Analysis

Prior to completing this research, I had little experience of IPA and therefore was conscious about wanting to ‘get it right’ in order to do the research justice, in particular given the importance of the topic. I was guided throughout; following the steps involved in the methodology as publish by Smith et al. (2022) which supported my confidence with the process of analysing and interpreting the data. I found the guidelines particularly helpful when moving from descriptive to interpretative, where my drive to ‘get it right’ was at the forefront, desperately wanting to make sure that participants’ experiences were accurately, and well represented. It helped me engage with the significance of what was verbalised, and of the ways that participants made sense of their experiences to identify patterns within the data. The guidance encourages the researcher to look for patterns of similarity but also patterns of difference for a quality IPA study that acknowledges individual characteristics.

The iterative nature of IPA was beneficial when it came to the selection of extracts for the narrative write up of the data. It allows the researcher to continuously analyse and refine themes throughout to ensure that it is reflective of the captured data and the stories shared by participants, in order to engage the reader (Nizza et al., 2021). In this instance, having a smaller participant sample enabled me to share the voices of all involved by including at least one perspective of every participant involved within the research. This is in line with guidance by Smith et al. (2022) to ensure that the analysis is representative of the whole sample, which can be trickier to achieve with larger sample sizes. However, there may be themes where one participant’s voice is used more dominantly when articulating the narrative.

Clinical Implications

Overall, the findings from both the systematic review and the empirical paper suggest that there is much work needed by healthcare professionals working in services to support the needs of Black people.

The majority of participants did not comment on treatment beyond medication which suggests that it was either not available or that it was not a significant part of their experience. This has clinical implications as guidelines recommend medication in conjunction with psychological treatment (NICE, 2014). These reflections may be indicative of the need for greater psychological input for individuals to support a person-centred and holistic approach within their experience of care. Additionally, this could also be representative of wider systemic issues that have been highlighted in previous research, identifying that Black people are more likely to be offered medication than access to psychological interventions (Das-Munshi et al., 2018).

This research highlights the need for community collaborations in clinical settings to support and improve access to services for individuals from diverse communities so that available services are able to meet their needs. For example, services could consider adopting approaches that are operationalised within social justice frameworks, such as community-based participatory research (CBPR), where members of communities are involved in research processes, promoting co-learning and trust, and could aid the NHS agenda for community transformations in mental health care that aim to advance qualities for minority ethic communities. Professionals could map themes raised e.g. spirituality or identity, and whether these themes are reflected in the available support, and consider how that might influence the needs that are catered for.

Strengths and Limitations

Academic research exploring mental health in the UK and obtaining the perspectives of Black people has been highlighted as lacking within the field of Clinical Psychology (Wood & Patel, 2017). This study provides the lens of lived experience and contributes to the existing literature, giving contextual information to quantitative research and builds on the sought after knowledge and understanding of mental health care for Black people. IPA was felt appropriate for this research study as its methods allow a deeper understanding of people's experiences and the meanings attached to them to be gained. Therefore this is also considered a strength of this project as it allowed for a rich and in-depth qualitative exploration into the experience of black inpatients in mental health services which is particularly beneficial as this is an under-researched population.

One of the limitations of the research study was that although the study aimed to recruit 6-10 participants, it only managed to recruit to the lower end of the target. There are many hypothesised reasons for this, one being that the demographic of this population is one that has longstanding relationship and trust issues with health professionals. Therefore there may have been some trepidation about participating in the research and anticipation of negative consequences, or concern that the research was 'tokenistic' and not borne out of genuine interest and desire to improve quality of care for this population. In order to overcome this barrier, building a rapport with potential participants could have supported recruitment uptake, however the researcher was not situated within any of the recruitment sites to build trust and encourage participation. Rather than continue to recruit to reach 10 participants I decided to stop recruitment in order to allow an adequate amount of time to analyse the data. There is no definitive sample size for IPA, although six to ten is the recommended range from for doctoral IPA studies (Smith et al., 2022; Smith & Eatough, 2015) however some researchers advocate for continued recruitment until data saturation (the point where no new themes are emerging from the data) (Constantinou et al., 2017; Vasileiou et al., 2018).

Unfortunately, due to time constraints, lack of funding to offer compensation, and unsuccessful outreach, no experts by experience were involved in the design, data collection or analysis of the research study. This highlights the systemic factors that contribute to the problem of limited research with this population, with no clear pathway for patient and public involvement input in these topics. However, consultation on the topic guide was sought from a stakeholder during the design stage of the research. The stakeholder was an individual who identified as a member of the global majority and has experience of working with the targeted recruitment sample.

The study was also limited geographically, in that participants were recruited from one NHS trust, therefore may not represent the experiences of patients across the UK where diversity in demographic populations varies to a greater or lesser extent, and cannot be generalised to wider populations. Initially, the study set out to recruit participants from one service, however as participant yield was slow, a decision was made to contact other services within the same NHS trust but this was at a later stage of the project. This had the potential to have influenced recruitment and subsequently findings of the study as it limited opportunities for eligible participants to have been made aware of the project and respond. In addition, it is possible that different geographical locations differing in population diversity, may also provide additional nuances within the findings. However, despite a smaller sample than hoped of participants, of those that did participate, individuals did form a relatively homogeneous group of participants which is recommended for IPA studies (Smith et al., 2022) and is therefore a strength of the research project. Another strength of the research study was that all participants provided rich and detailed information regarding their experience of inpatient mental health services which led to the aim of the research being achieved.

Personal Reflections

During the process of completing this thesis, I have had numerous reflections about my identity as a Black female. The collection of data from both the systematic literature review and the empirical study have spoken to experiences that have personal resonance. At times it has been upsetting to continually hear these stories, and I noticed great feelings of responsibility when thinking about how this research can make a difference, and can truly address some of these huge systemic and political issues that impact Black people. In the latter period of this thesis, there had been a significant event within the North West of England that incited racial riots across the UK. I was compelled with feelings of irony of exploring the aspects of racial discrimination within experiences of inpatient care, whilst feeling confined to my own home due the violent attacks that were displayed in the public. During this time the ability to immerse myself in the thesis felt particularly difficult, fighting with the drive to persevere to complete within the training period whilst also recognising that my threat system around this topic was particularly heightened at the time, feeling frustrated with systems that were not responding quickly enough to keep people safe. Managing these emotions and reflecting on how they influenced my engagement with my thesis was essential.

Process Issues and Reflexivity

IPA acknowledges the ‘double hermeneutic’ process which indicates that the researcher’s subjectivity and personal views and experiences play an integral role in shaping the data collection and analysis processes (Smith et al., 2022). Therefore it was imperative that I remained mindful of the fact that my past work experiences and personal relations or connections will have had an influence on my interpretations of the data as a researcher.

Additionally, some of these interpretations will have also been influenced by the relevant related research that I have become familiar with during this process, in addition to my values, role and training as a Clinical Psychologist and researcher.

Throughout the process I have aimed to be mindful of my own reflexivity by keeping a journal as a way of accounting any biases and acknowledging their potential to impact on the analysis of the data (Smith et al., 2022). This process felt particularly useful to engage in following interviews and during the transcription. Additionally, I received external supervision from a Black Clinical Psychologist separate to the research team to explore any bias within the process. This helped to maintain the credibility and integrity of the findings of the study (Noble & Smith., 2015).

My reflections in the diary acknowledge how the process of conducting the research – predominantly conducting the interviews, interpreting and analysis have been influenced by my existing, personal knowledge and past experience of working with Black patients. Furthermore, I reflected on my own personal experience of identifying as a member of the global majority and being able to relate to their experiences somewhat, despite the different contexts. In particular where participants expressed feeling ‘different’ to societal expectations and the on-going fight against the stigma against Black people. The hermeneutic nature of IPA supports researcher reflexivity to allow for interpretations to be made for both the researcher’s experience and the researched phenomenon (Shaw, 2010). As researchers are not immune to their own experiences, biases or assumptions, being able to reflect on and evaluate the role of oneself and emotions in qualitative research has been encouraged to minimise risks of misinterpretation of the data (Johnson, 2009).

My clinical skills as a Trainee Clinical Psychologist supported me during the research process. For example, when conducting the interviews I was able to utilise person-centred skills such as summarising, paraphrasing and asking open questions. These skills have been highlighted by researchers as beneficial to support the facilitation of authentic and mutually respectful engagement with participants (Sandvik & McCormack, 2018), which I felt supported the participants to feel at ease and comfortable with sharing their experiences with me. Additionally, having had experience of conducting clinical interviews in the past, I had considered how to appropriately guide the interview back to the question asked, in the event that the conversation drifted away from the topic.

I also became more aware of the overlap between my roles and skills as a Trainee Clinical Psychologist and a researcher whilst conducting this study. For example, the importance of reflective practice during my clinical practice is highly important as it provides a space to reflect on the influences from personal biases, experiences and motivations (British Psychological Society [BPS], 2017).

I have learnt a great deal from the research process; it has allowed me to develop and refine skills that will continue to be of value as I progress in my career as a Clinical Psychologist. From this process I have developed skills in being able to devise a clinically relevant research question, develop a protocol, complete an application and meet with a committee for ethical approval and execute a research study using qualitatively research methods to analyse data. The enjoyable part of this process was providing participants with an opportunity to have their voices heard and share their story, although I also found it challenging when facing barriers in particular around recruitment and managing the time pressures that come with conducting research as part of a training programme.

Conclusion

This project has provided insight into the experiences of managing mental health for Black people of the global majority. This was achieved by a meta-ethnography of the role of masculinity as a barrier to help-seeking for Black men, and through using IPA to explore experiences of inpatient mental health care for Black patients. Both papers add to the small pool of literature available on these topics and for a group that remains clinically relevant yet under researched. The process of this project has been challenging at times, however my motivation to serve the Black community by using my position to amplify their voices sustained my perseverance. I will remain grateful to the participants that spared their time to meet with me and share their stories. I plan to share the findings with the NHS services that supported the recruitment of participants for the study, as staff that I networked with expressed an interest in the topic of the study and keen to receive the findings. The two papers will also be prepared for submission to relevant journals to be accessible to a wider audience.

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Section Four: Ethics Section

Ethics application for research paper: Experiences of mental health inpatient care for Black patients

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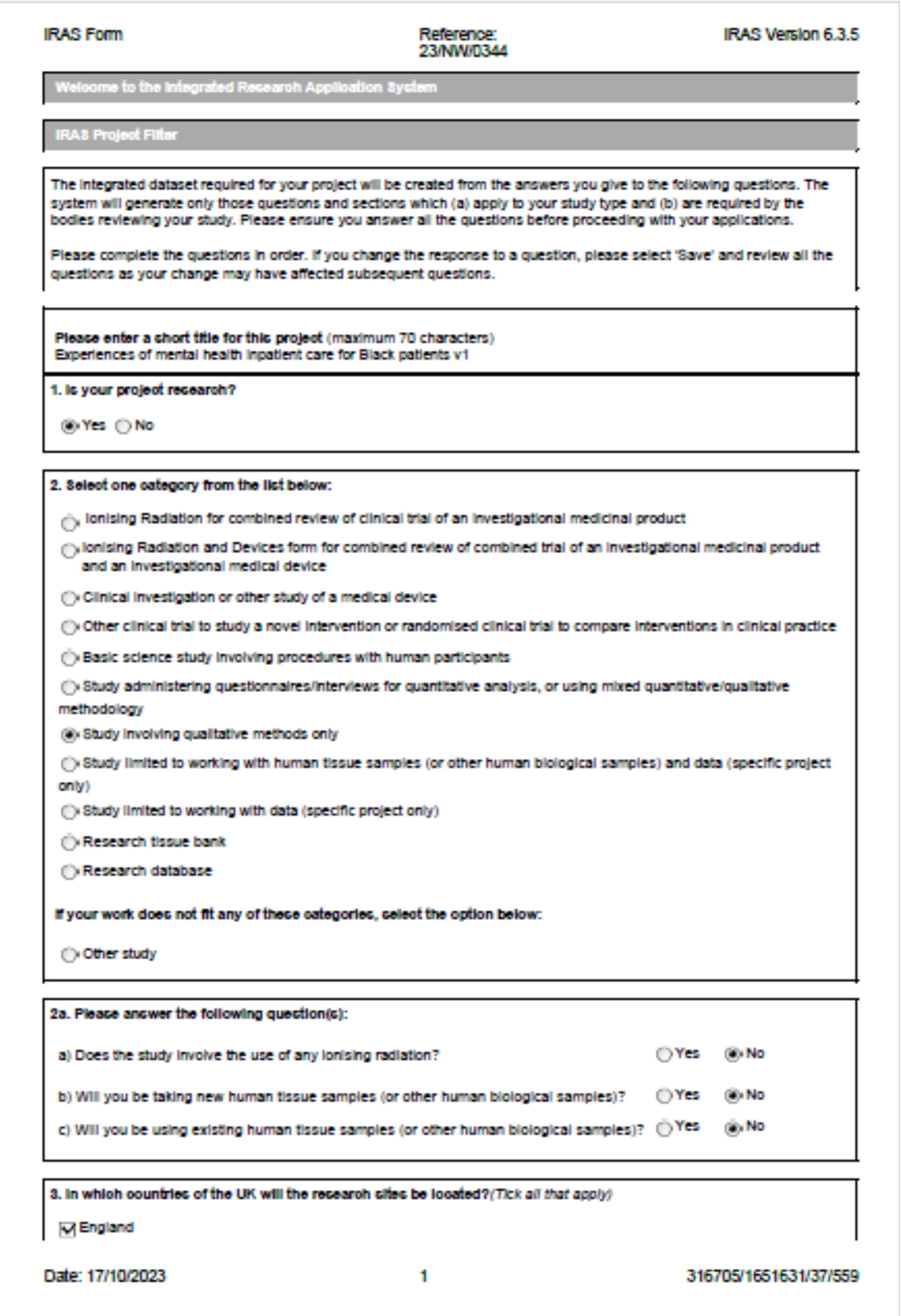
1. **Approved Ethics Application**



IRAS Form | Reference: 23/NW/0344 | IRAS Version 6.3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Experiences of mental health inpatient care for Black patients v1

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Ionising Radiation for combined review of clinical trial of an investigational medicinal product

○ Ionising Radiation and Devices form for combined review of combined trial of an investigational medicinal product and an investigational medical device

○ Clinical investigation or other study of a medical device

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○ Basic science study involving procedures with human participants

○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

● Study involving qualitative methods only

○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

○ Study limited to working with data (specific project only)

○ Research tissue bank

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If your work does not fit any of these categories, select the option below:

○ Other study

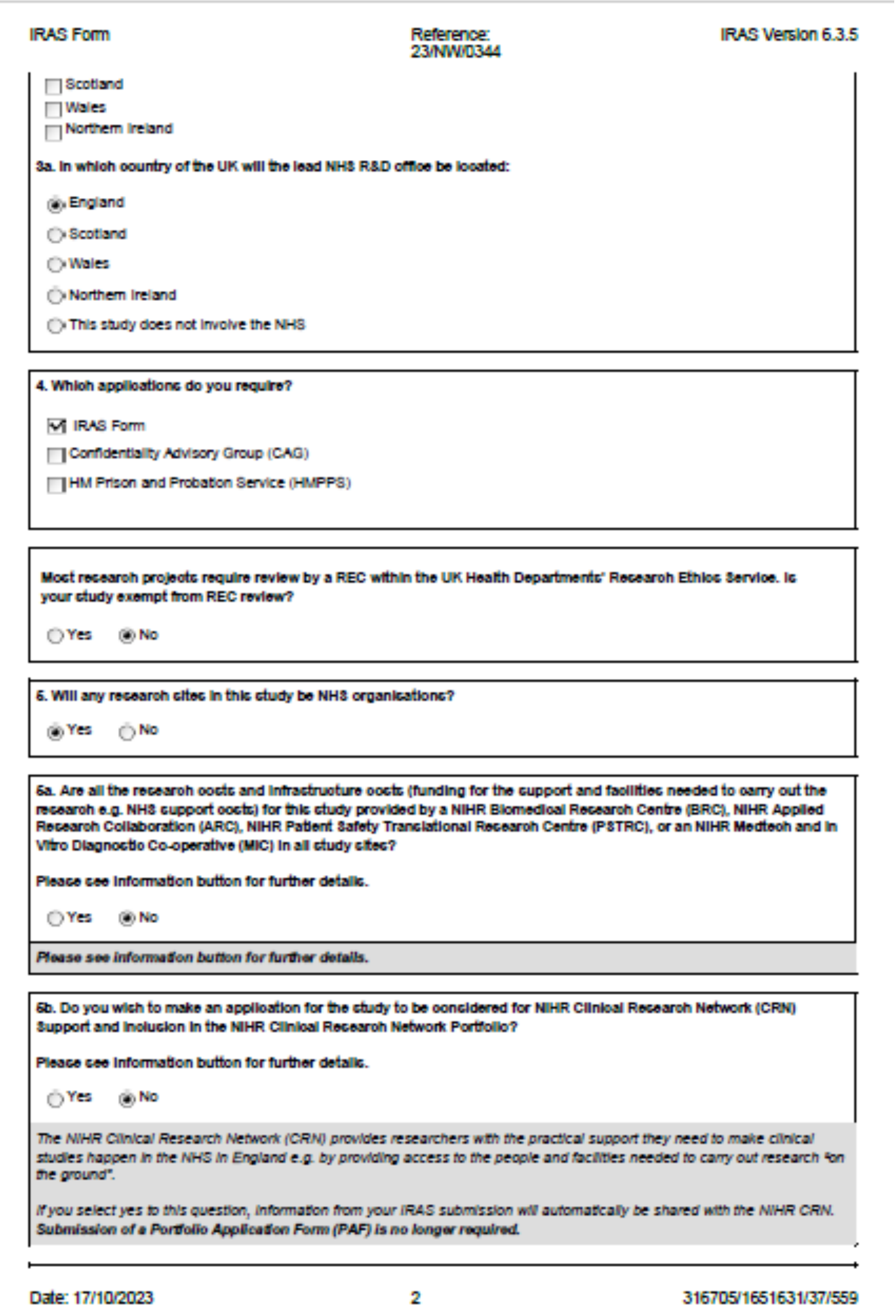
2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England

Date: 17/10/2023 | 1 | 316705/1651631/37/559



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☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ HM Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

○ Yes ● No

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ● No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ● No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

Date: 17/10/2023 | 2 | 316705/1651631/37/559

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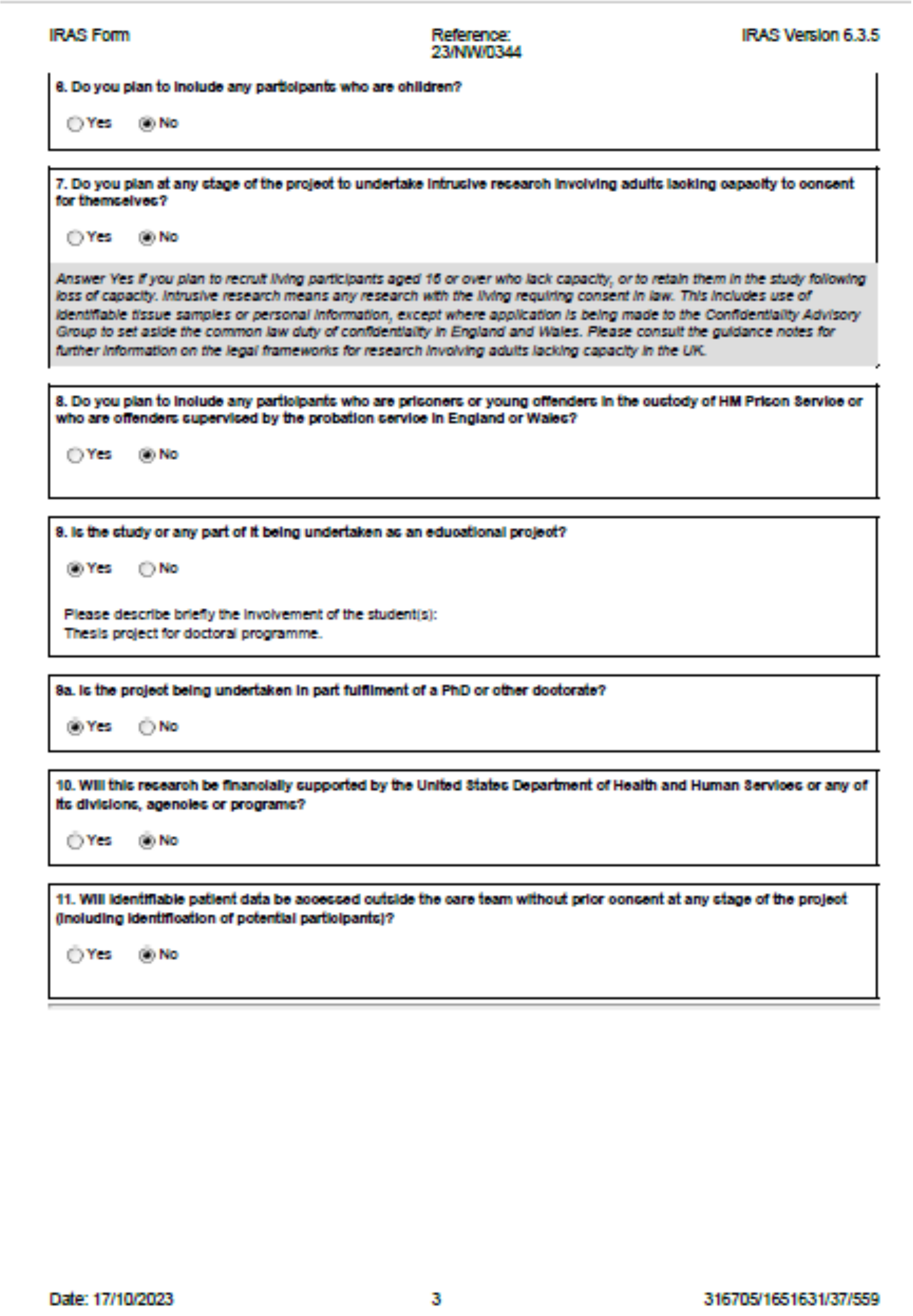

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6. Do you plan to include any participants who are children?

○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
Thesis project for doctoral programme.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

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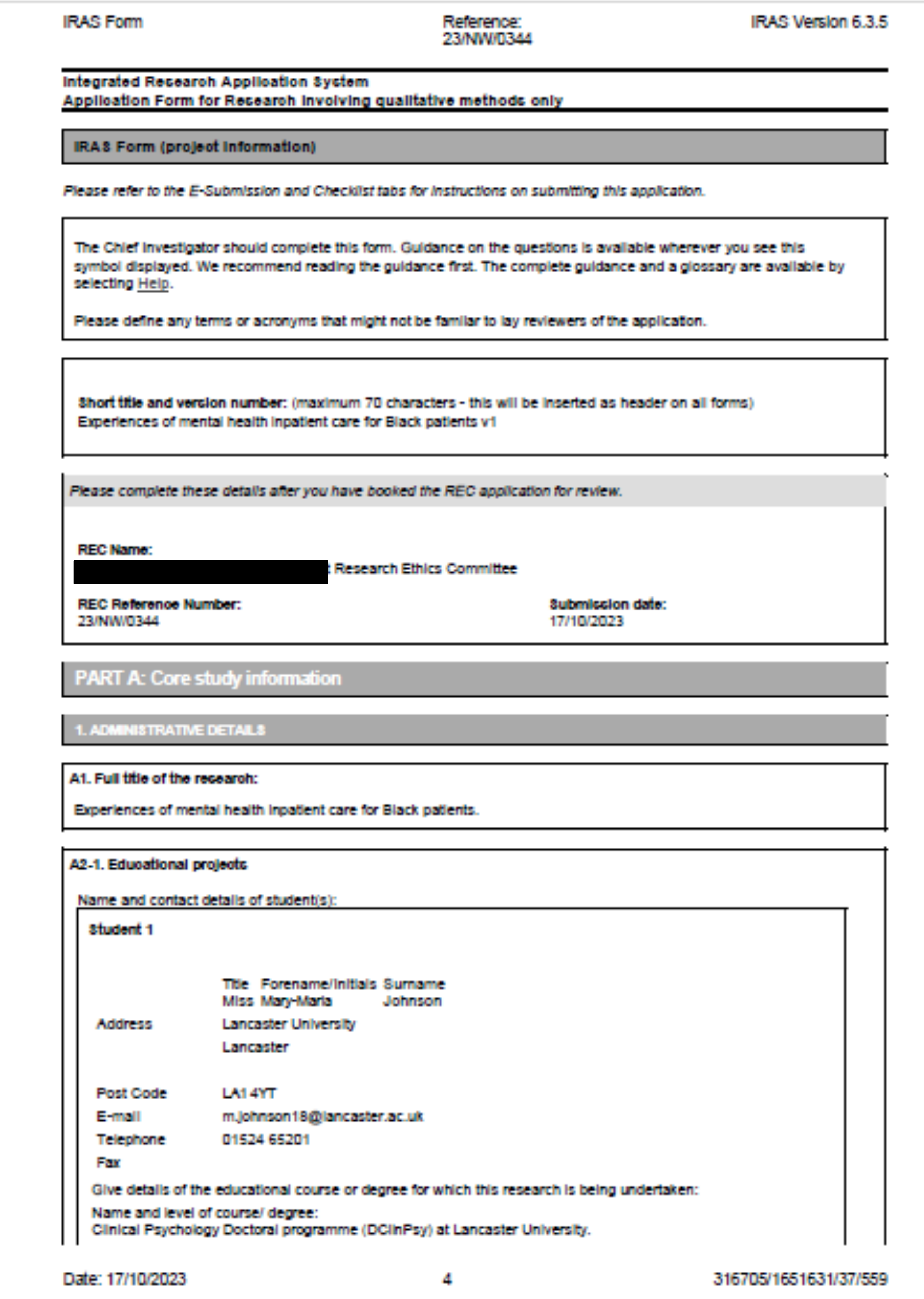


Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Experiences of mental health inpatient care for Black patients v1

Please complete these details after you have booked the REC application for review.

REC Name:
[redacted] Research Ethics Committee

REC Reference Number:
23/NW/0344

Submission date:
17/10/2023

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Experiences of mental health inpatient care for Black patients.

A2-1. Educational projects

Name and contact details of student(s):

Student 1

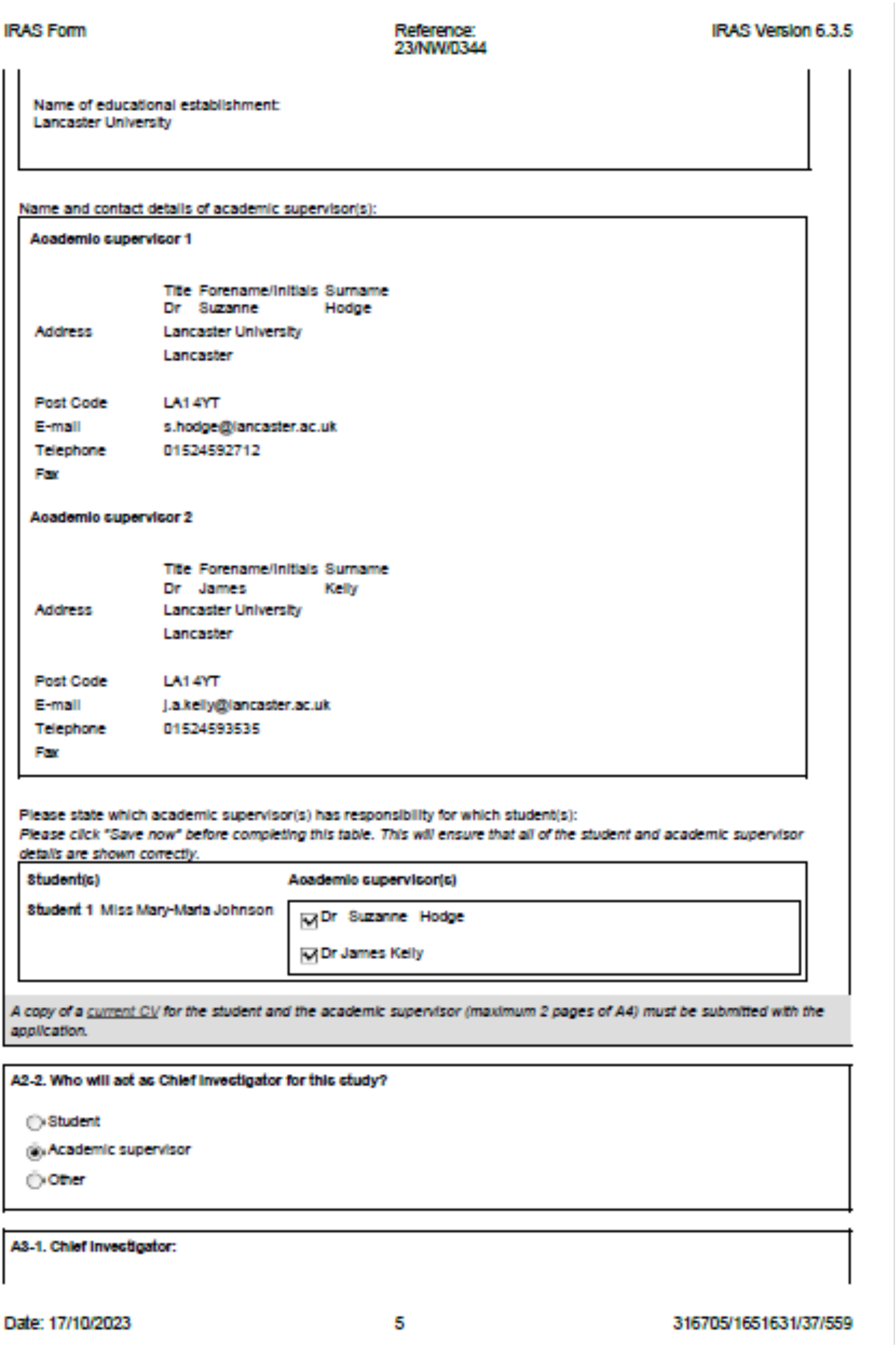
Title	Forename/Initials	Surname
Miss	Mary-Maria	Johnson

Address Lancaster University
Lancaster

Post Code LA1 4YT
E-mail m.johnson18@lancaster.ac.uk
Telephone 01524 65201
Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Clinical Psychology Doctoral programme (DClinPsy) at Lancaster University.



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Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge
Address	Lancaster University Lancaster		
Post Code	LA1 4YT		
E-mail	s.hodge@lancaster.ac.uk		
Telephone	01524592712		
Fax			

Academic supervisor 2

	Title	Forename/Initials	Surname
	Dr	James	Kelly
Address	Lancaster University Lancaster		
Post Code	LA1 4YT		
E-mail	j.a.kelly@lancaster.ac.uk		
Telephone	01524593535		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	**Academic supervisor(s)**
Student 1 Miss Mary-Maria Johnson	☑ Dr Suzanne Hodge ☑ Dr James Kelly

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

○ Student
● Academic supervisor
○ Other

A3-1. Chief Investigator:

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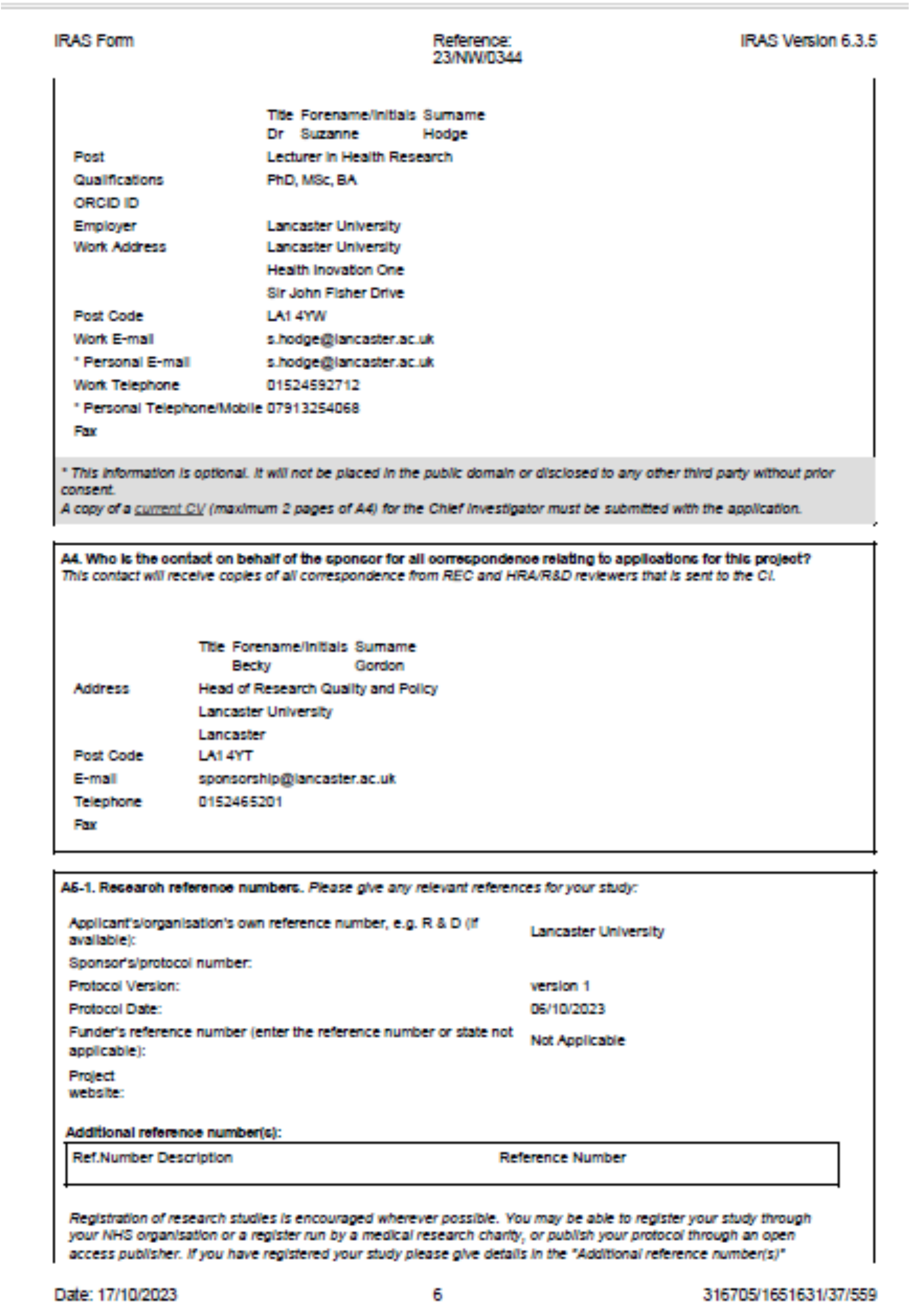


	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge

Post	Lecturer in Health Research
Qualifications	PhD, MSc, BA
ORCID ID	
Employer	Lancaster University
Work Address	Lancaster University Health Inovation One Sir John Fisher Drive
Post Code	LA1 4YW
Work E-mail	s.hodge@lancaster.ac.uk
* Personal E-mail	s.hodge@lancaster.ac.uk
Work Telephone	01524592712
* Personal Telephone/Mobile	07913254068
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
		Becky	Gordon

Address	Head of Research Quality and Policy Lancaster University Lancaster
Post Code	LA1 4YT
E-mail	sponsorship@lancaster.ac.uk
Telephone	0152465201
Fax	

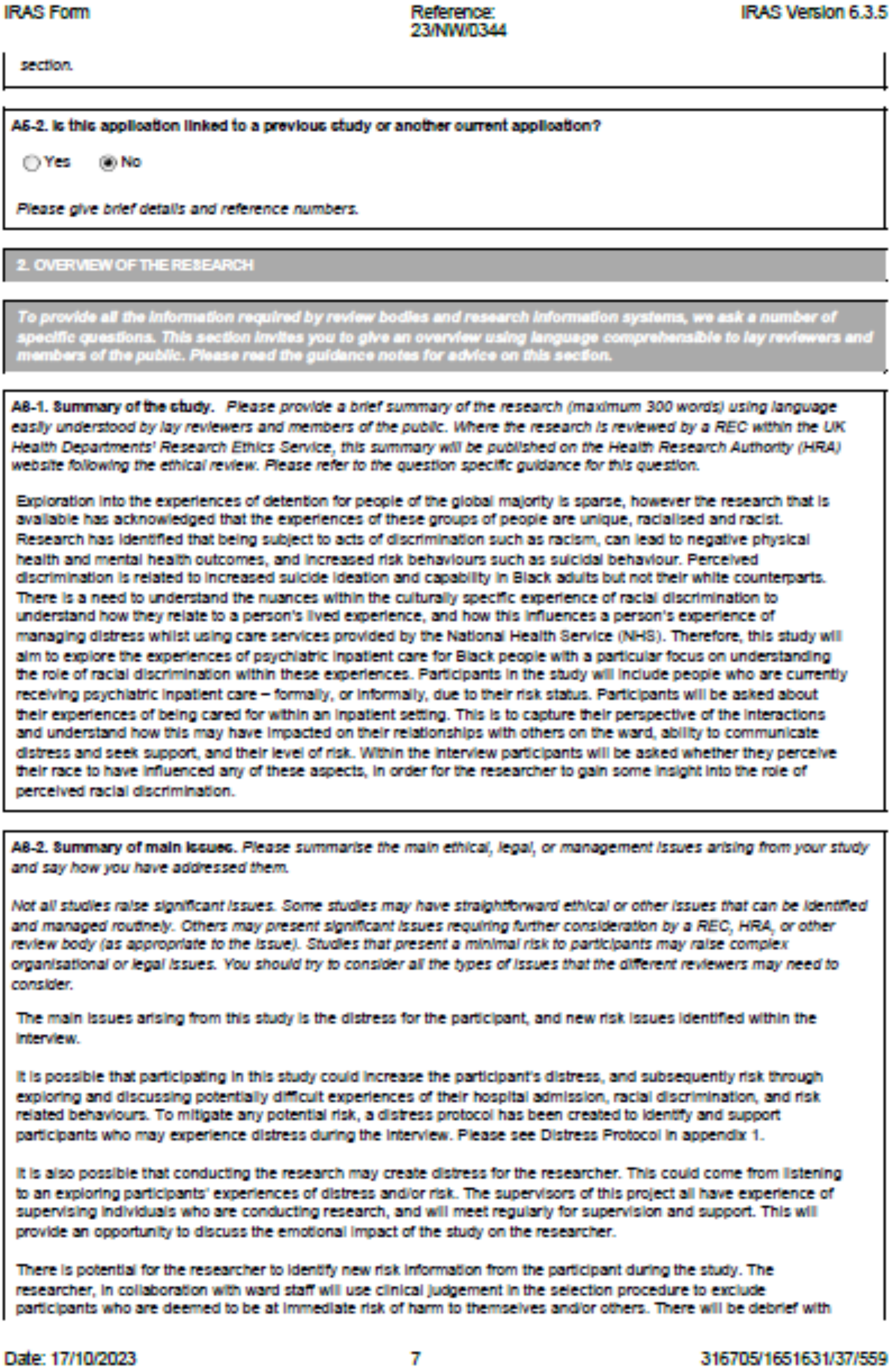
A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	Lancaster University
Sponsor's/protocol number:	
Protocol Version:	version 1
Protocol Date:	06/10/2023
Funder's reference number (enter the reference number or state not applicable):	Not Applicable
Project website:	

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)"



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section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

Exploration into the experiences of detention for people of the global majority is sparse, however the research that is available has acknowledged that the experiences of these groups of people are unique, racialised and racist. Research has identified that being subject to acts of discrimination such as racism, can lead to negative physical health and mental health outcomes, and increased risk behaviours such as suicidal behaviour. Perceived discrimination is related to increased suicide ideation and capability in Black adults but not their white counterparts. There is a need to understand the nuances within the culturally specific experience of racial discrimination to understand how they relate to a person's lived experience, and how this influences a person's experience of managing distress whilst using care services provided by the National Health Service (NHS). Therefore, this study will aim to explore the experiences of psychiatric inpatient care for Black people with a particular focus on understanding the role of racial discrimination within these experiences. Participants in the study will include people who are currently receiving psychiatric inpatient care – formally, or informally, due to their risk status. Participants will be asked about their experiences of being cared for within an inpatient setting. This is to capture their perspective of the interactions and understand how this may have impacted on their relationships with others on the ward, ability to communicate distress and seek support, and their level of risk. Within the interview participants will be asked whether they perceive their race to have influenced any of these aspects, in order for the researcher to gain some insight into the role of perceived racial discrimination.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

The main issues arising from this study is the distress for the participant, and new risk issues identified within the interview.

It is possible that participating in this study could increase the participant's distress, and subsequently risk through exploring and discussing potentially difficult experiences of their hospital admission, racial discrimination, and risk related behaviours. To mitigate any potential risk, a distress protocol has been created to identify and support participants who may experience distress during the interview. Please see Distress Protocol in appendix 1.

It is also possible that conducting the research may create distress for the researcher. This could come from listening to an exploring participants' experiences of distress and/or risk. The supervisors of this project all have experience of supervising individuals who are conducting research, and will meet regularly for supervision and support. This will provide an opportunity to discuss the emotional impact of the study on the researcher.

There is potential for the researcher to identify new risk information from the participant during the study. The researcher, in collaboration with ward staff will use clinical judgement in the selection procedure to exclude participants who are deemed to be at immediate risk of harm to themselves and/or others. There will be debrief with

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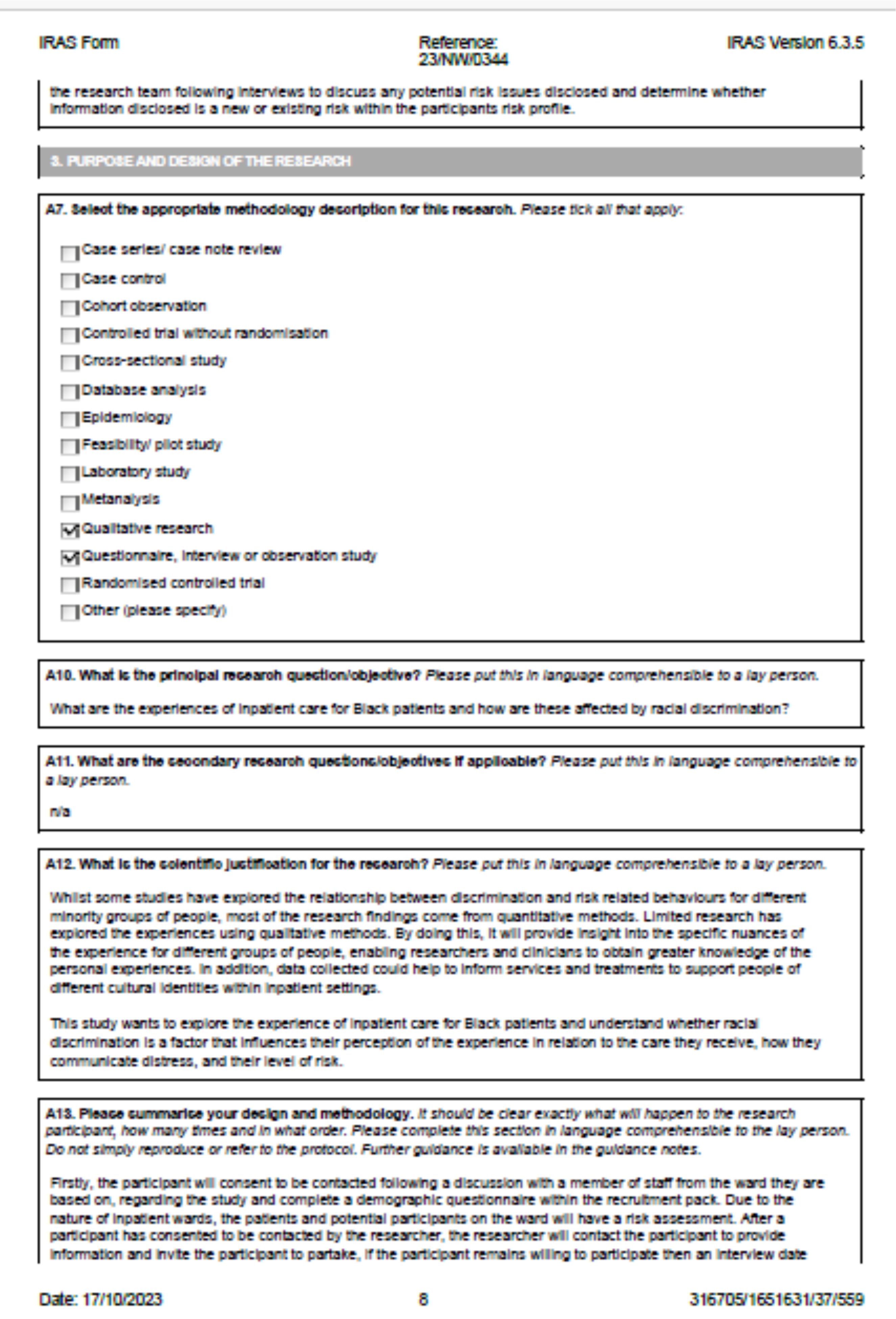


the research team following interviews to discuss any potential risk issues disclosed and determine whether information disclosed is a new or existing risk within the participants risk profile.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

What are the experiences of inpatient care for Black patients and how are these affected by racial discrimination?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

n/a

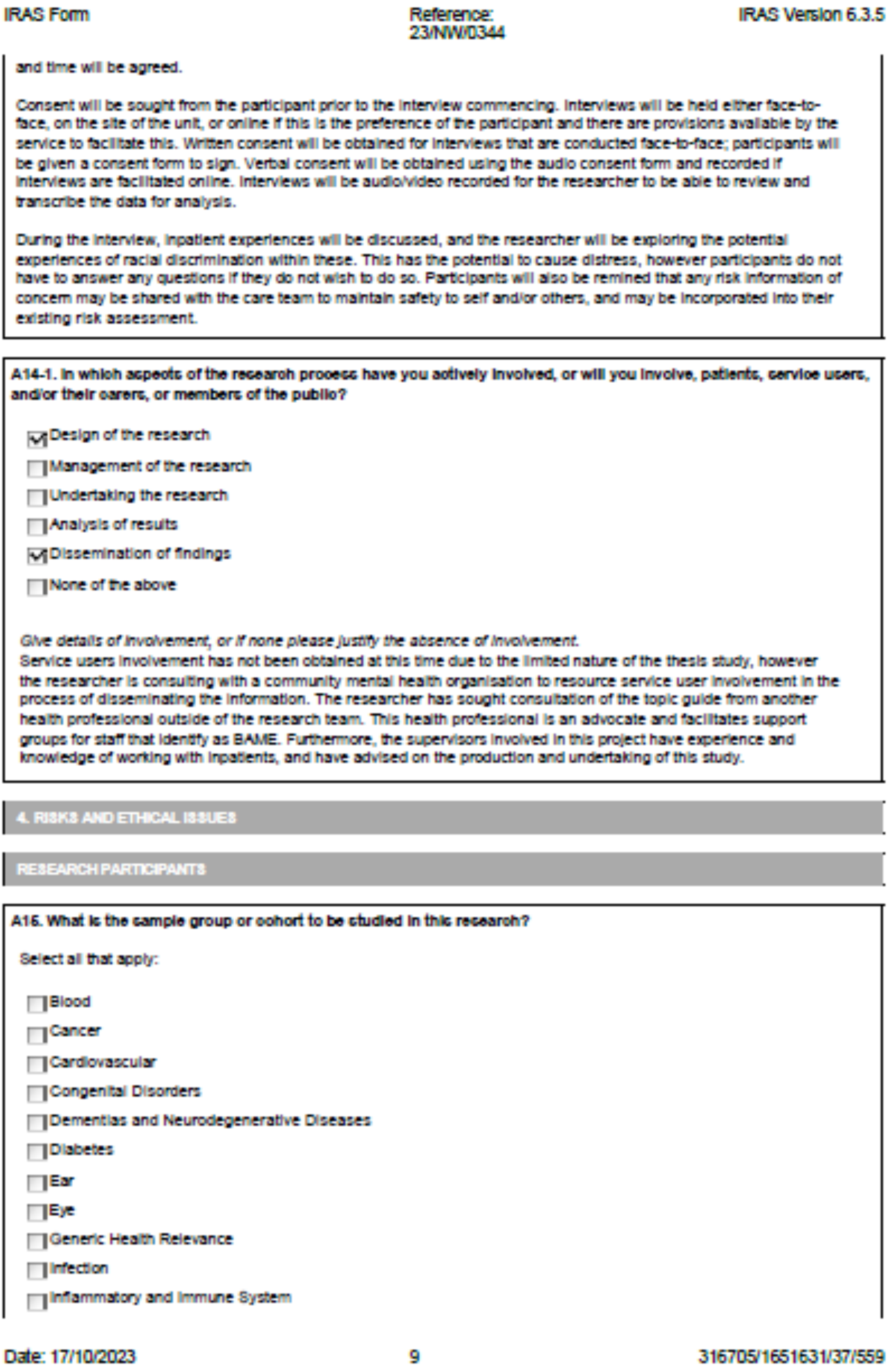
A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Whilst some studies have explored the relationship between discrimination and risk related behaviours for different minority groups of people, most of the research findings come from quantitative methods. Limited research has explored the experiences using qualitative methods. By doing this, it will provide insight into the specific nuances of the experience for different groups of people, enabling researchers and clinicians to obtain greater knowledge of the personal experiences. In addition, data collected could help to inform services and treatments to support people of different cultural identities within inpatient settings.

This study wants to explore the experience of inpatient care for Black patients and understand whether racial discrimination is a factor that influences their perception of the experience in relation to the care they receive, how they communicate distress, and their level of risk.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Firstly, the participant will consent to be contacted following a discussion with a member of staff from the ward they are based on, regarding the study and complete a demographic questionnaire within the recruitment pack. Due to the nature of inpatient wards, the patients and potential participants on the ward will have a risk assessment. After a participant has consented to be contacted by the researcher, the researcher will contact the participant to provide information and invite the participant to partake, if the participant remains willing to participate then an interview date



and time will be agreed.

Consent will be sought from the participant prior to the interview commencing. Interviews will be held either face-to-face, on the site of the unit, or online if this is the preference of the participant and there are provisions available by the service to facilitate this. Written consent will be obtained for interviews that are conducted face-to-face; participants will be given a consent form to sign. Verbal consent will be obtained using the audio consent form and recorded if interviews are facilitated online. Interviews will be audio/video recorded for the researcher to be able to review and transcribe the data for analysis.

During the interview, inpatient experiences will be discussed, and the researcher will be exploring the potential experiences of racial discrimination within these. This has the potential to cause distress, however participants do not have to answer any questions if they do not wish to do so. Participants will also be remined that any risk information of concern may be shared with the care team to maintain safety to self and/or others, and may be incorporated into their existing risk assessment.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☑ Dissemination of findings
☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
Service users involvement has not been obtained at this time due to the limited nature of the thesis study, however the researcher is consulting with a community mental health organisation to resource service user involvement in the process of disseminating the information. The researcher has sought consultation of the topic guide from another health professional outside of the research team. This health professional is an advocate and facilitates support groups for staff that identify as BAME. Furthermore, the supervisors involved in this project have experience and knowledge of working with inpatients, and have advised on the production and undertaking of this study.

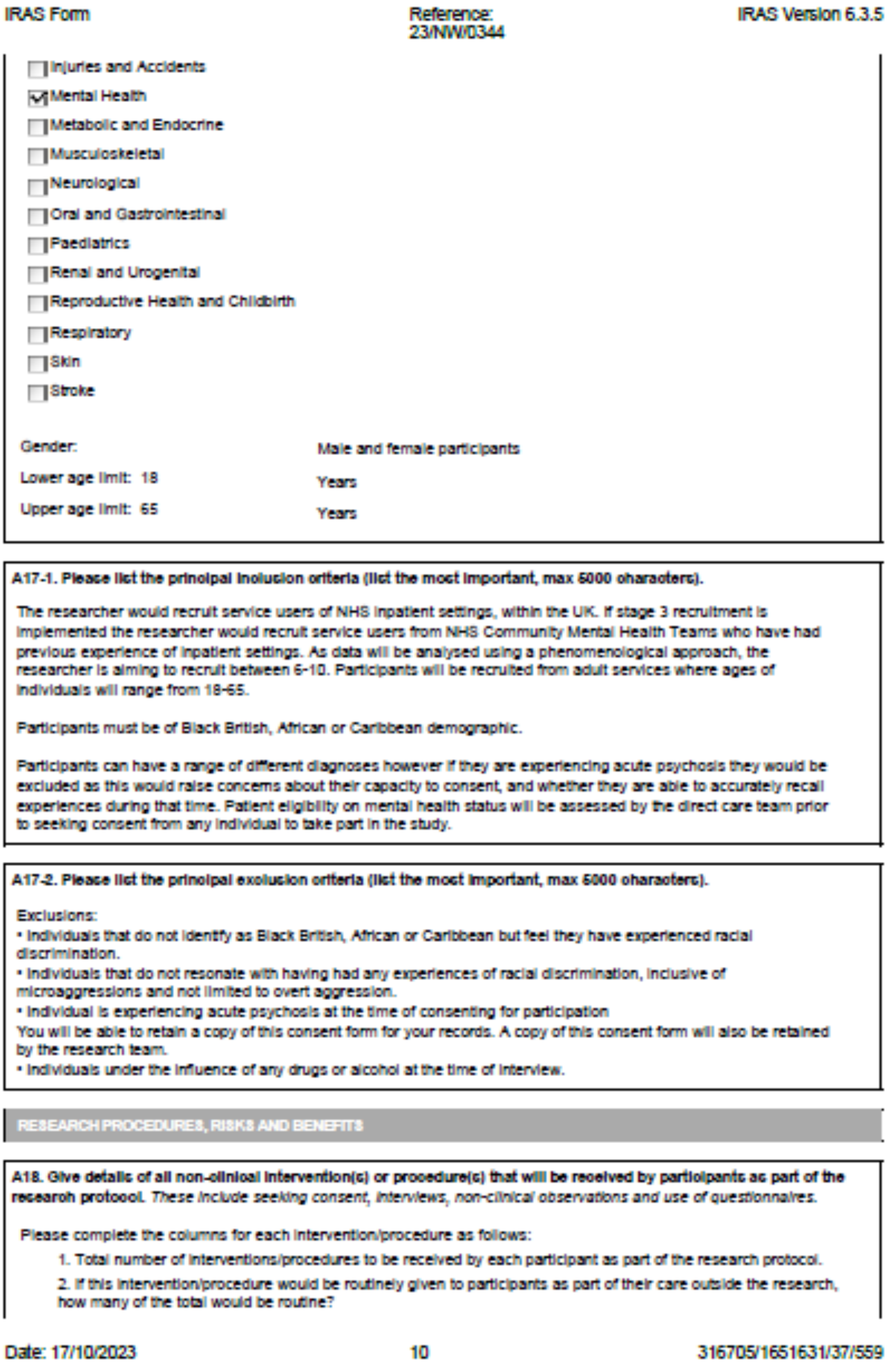
4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

☐ Blood
☐ Cancer
☐ Cardiovascular
☐ Congenital Disorders
☐ Dementias and Neurodegenerative Diseases
☐ Diabetes
☐ Ear
☐ Eye
☐ Generic Health Relevance
☐ Infection
☐ Inflammatory and Immune System



☐ Injuries and Accidents
☑ Mental Health
☐ Metabolic and Endocrine
☐ Musculoskeletal
☐ Neurological
☐ Oral and Gastrointestinal
☐ Paediatrics
☐ Renal and Urogenital
☐ Reproductive Health and Childbirth
☐ Respiratory
☐ Skin
☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 65	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

The researcher would recruit service users of NHS inpatient settings, within the UK. If stage 3 recruitment is implemented the researcher would recruit service users from NHS Community Mental Health Teams who have had previous experience of inpatient settings. As data will be analysed using a phenomenological approach, the researcher is aiming to recruit between 6-10. Participants will be recruited from adult services where ages of individuals will range from 18-65.

Participants must be of Black British, African or Caribbean demographic.

Participants can have a range of different diagnoses however if they are experiencing acute psychosis they would be excluded as this would raise concerns about their capacity to consent, and whether they are able to accurately recall experiences during that time. Patient eligibility on mental health status will be assessed by the direct care team prior to seeking consent from any individual to take part in the study.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Exclusions:
• Individuals that do not identify as Black British, African or Caribbean but feel they have experienced racial discrimination.
• Individuals that do not resonate with having had any experiences of racial discrimination, inclusive of microaggressions and not limited to overt aggression.
• Individual is experiencing acute psychosis at the time of consenting for participation
You will be able to retain a copy of this consent form for your records. A copy of this consent form will also be retained by the research team.
• Individuals under the influence of any drugs or alcohol at the time of interview.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?

3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Providing recruitment pack to potential participant which contains participant information sheet, consent to contact, and demographic questionnaire.	1	0	10 minutes	Member of staff working with the participant.
Initial phone call/video call and arrangement of interview	1	0	15 minutes	Researcher, who will be at home.
Obtaining informed consent	1	0	5 minutes	Researcher, conducted on the site/ward of the participant, or the researcher may be at home.
Interview	1	0	60 minutes	Researcher, conducted on the site/ward of the participant, or the researcher may be at home.
Debrief	1	0	5 minutes	Researcher, conducted on the site/ward of the participant, or the researcher may be at home.

A21. How long do you expect each participant to be in the study in total?

The participant will be in the study for a total of around 2 weeks.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

It is possible that taking part in the study and discussing potentially traumatic experiences may cause distress for the participant. To manage this, this study will use a distress protocol that has been created to assess and manage distress during the study. This will discuss ways to support the participant during the study and to help consider whether the participant is able to continue with the study.

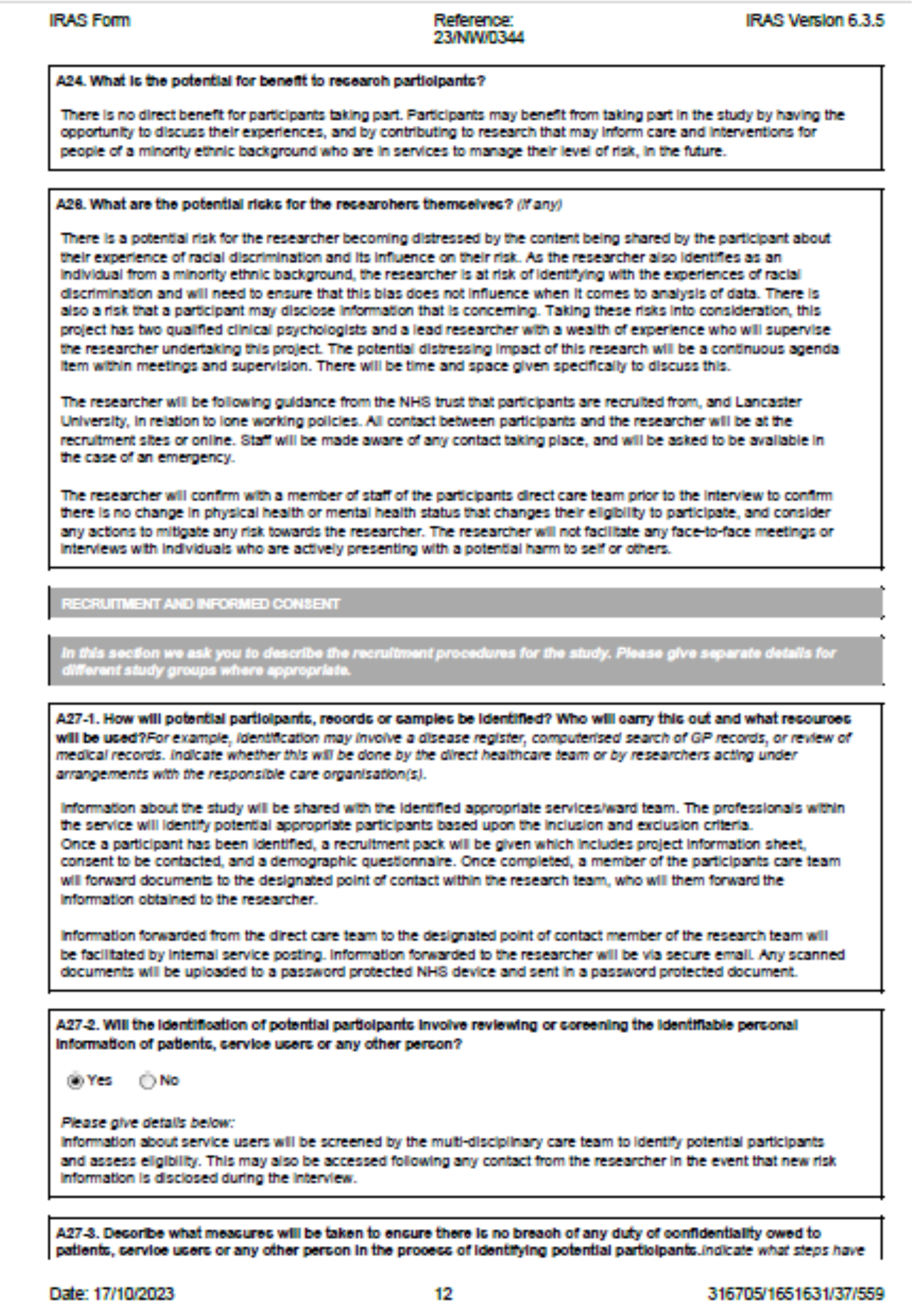
It is also possible that the researcher may become aware of new risk information during the process of interview that may not be known to the existing clinical team working with the individual. Prior to the participant taking part in the study, the researcher will consult with ward staff and will use clinical judgement in the selection of each participant, to ensure they are not at immediate risk of harm to themselves and/or others. If risk information is shared within a contact between the researcher and the participant, this will be shared by the researcher with the clinical team and explained to the participant that confidentiality needs to be broken to ensure safety of themselves and/or others. Information will be shared in a debrief session that will occur following every contact. The risk information will be checked against their pre-existing risk assessment. The process of sharing information will be discussed with the participant prior to the interview taking place.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

The interviews may result in participants reflecting on experiences that could be sensitive or upsetting, however, the participant will have the freedom to decide whether they wish to answer a question. In addition, a distress protocol has been created detailing plans for if participants become distressed within the process of interviewing. This includes options such as pausing the meeting, discussing with the participant if they would like to continue, informing ward staff that the participant has become distressed so that they can implement any risk management protocols as necessary. The distress protocol will be discussed with the participant prior to the interview, and ways to manage risk will be identified collaboratively.



A24. What is the potential for benefit to research participants?

There is no direct benefit for participants taking part. Participants may benefit from taking part in the study by having the opportunity to discuss their experiences, and by contributing to research that may inform care and interventions for people of a minority ethnic background who are in services to manage their level of risk, in the future.

A26. What are the potential risks for the researchers themselves? *(if any)*

There is a potential risk for the researcher becoming distressed by the content being shared by the participant about their experience of racial discrimination and its influence on their risk. As the researcher also identifies as an individual from a minority ethnic background, the researcher is at risk of identifying with the experiences of racial discrimination and will need to ensure that this bias does not influence when it comes to analysis of data. There is also a risk that a participant may disclose information that is concerning. Taking these risks into consideration, this project has two qualified clinical psychologists and a lead researcher with a wealth of experience who will supervise the researcher undertaking this project. The potential distressing impact of this research will be a continuous agenda item within meetings and supervision. There will be time and space given specifically to discuss this.

The researcher will be following guidance from the NHS trust that participants are recruited from, and Lancaster University, in relation to lone working policies. All contact between participants and the researcher will be at the recruitment sites or online. Staff will be made aware of any contact taking place, and will be asked to be available in the case of an emergency.

The researcher will confirm with a member of staff of the participants direct care team prior to the interview to confirm there is no change in physical health or mental health status that changes their eligibility to participate, and consider any actions to mitigate any risk towards the researcher. The researcher will not facilitate any face-to-face meetings or interviews with individuals who are actively presenting with a potential harm to self or others.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Information about the study will be shared with the identified appropriate services/ward team. The professionals within the service will identify potential appropriate participants based upon the inclusion and exclusion criteria.
Once a participant has been identified, a recruitment pack will be given which includes project information sheet, consent to be contacted, and a demographic questionnaire. Once completed, a member of the participants care team will forward documents to the designated point of contact within the research team, who will them forward the information obtained to the researcher.

Information forwarded from the direct care team to the designated point of contact member of the research team will be facilitated by internal service posting. Information forwarded to the researcher will be via secure email. Any scanned documents will be uploaded to a password protected NHS device and sent in a password protected document.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

● Yes ○ No

Please give details below:
Information about service users will be screened by the multi-disciplinary care team to identify potential participants and assess eligibility. This may also be accessed following any contact from the researcher in the event that new risk information is disclosed during the interview.

A27-3. Describe what measures will be taken to ensure there is no breach of any duty of confidentiality owed to patients, service users or any other person in the process of identifying potential participants.*Indicate what steps have* *been or will be taken to inform patients and service users of the potential use of their records for this purpose. Describe the arrangements to ensure that the wishes of patients and service users regarding access to their records are respected. Please consult the guidance notes on this topic.*

Only professionals working with the service user directly will have access to any identifiable information of the participants. For the project, service users will be given an identifying number and personal information will not be stored within the internal system of the treatment team for the individual. Consent forms will be stored and kept separate from the research data.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

○ Yes ● No

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes ● No

A29. How and by whom will potential participants first be approached?

Participants will initially be approached by a member of staff within the identified service/ward(s). This member of staff will be an individual that already works with the potential participant. Factors such as mental state of the individual; current level of risk; capacity to provide consent and understanding will be assessed prior to introducing the study with the individual.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Following identification by the care team, consent to contact will be obtained via the consent to contact document within the recruitment pack. The completed form will be returned to a member of the direct care team to be forwarded to a member of the research team, for the researcher to then contact the participant or visit the site to discuss the study further. When the potential participant has been given all the relevant information and had time to process, consider and decide, the participant will be invited to arrange the interview and consent will be obtained prior to the commencement. Consent will be obtained from the consent form, if interviews are to be online then verbal consent will be obtained using the audio consent form and recorded prior to the interview commencing.

As per the Mental Capacity Act, capacity will be assumed unless there is a reason to suspect otherwise.

If you are not obtaining consent, please explain why not.

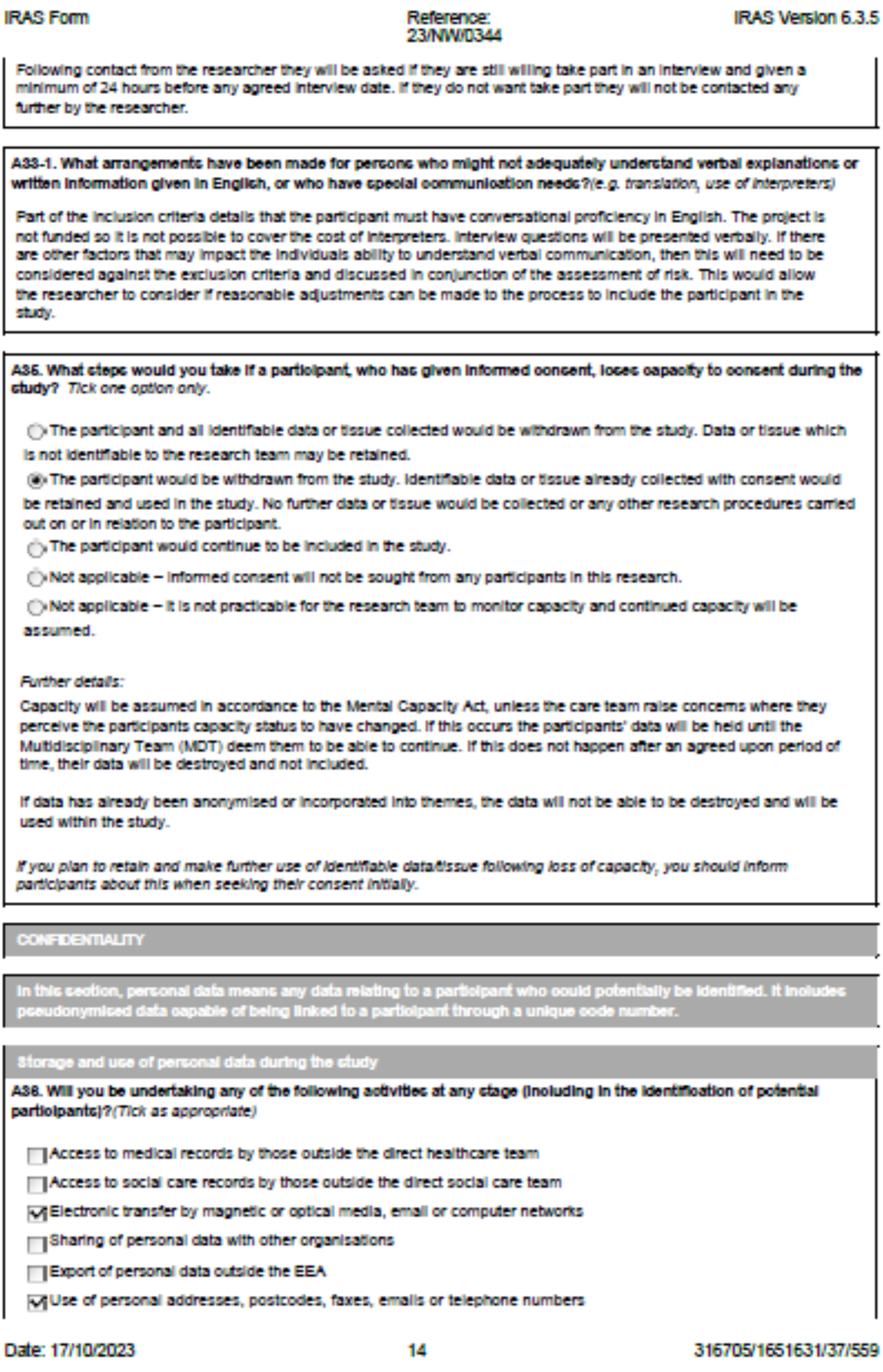
Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will be given a minimum of 24 hours from when they consented to be contacted by the researcher.



Following contact from the researcher they will be asked if they are still willing take part in an interview and given a minimum of 24 hours before any agreed interview date. If they do not want take part they will not be contacted any further by the researcher.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Part of the inclusion criteria details that the participant must have conversational proficiency in English. The project is not funded so it is not possible to cover the cost of interpreters. Interview questions will be presented verbally. If there are other factors that may impact the individuals ability to understand verbal communication, then this will need to be considered against the exclusion criteria and discussed in conjunction of the assessment of risk. This would allow the researcher to consider if reasonable adjustments can be made to the process to include the participant in the study.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

● The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Capacity will be assumed in accordance to the Mental Capacity Act, unless the care team raise concerns where they perceive the participants capacity status to have changed. If this occurs the participants' data will be held until the Multidisciplinary Team (MDT) deem them to be able to continue. If this does not happen after an agreed upon period of time, their data will be destroyed and not included.

If data has already been anonymised or incorporated into themes, the data will not be able to be destroyed and will be used within the study.

If you plan to retain and make further use of identifiable data/tissue following loss of capacity, you should inform participants about this when seeking their consent initially.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team

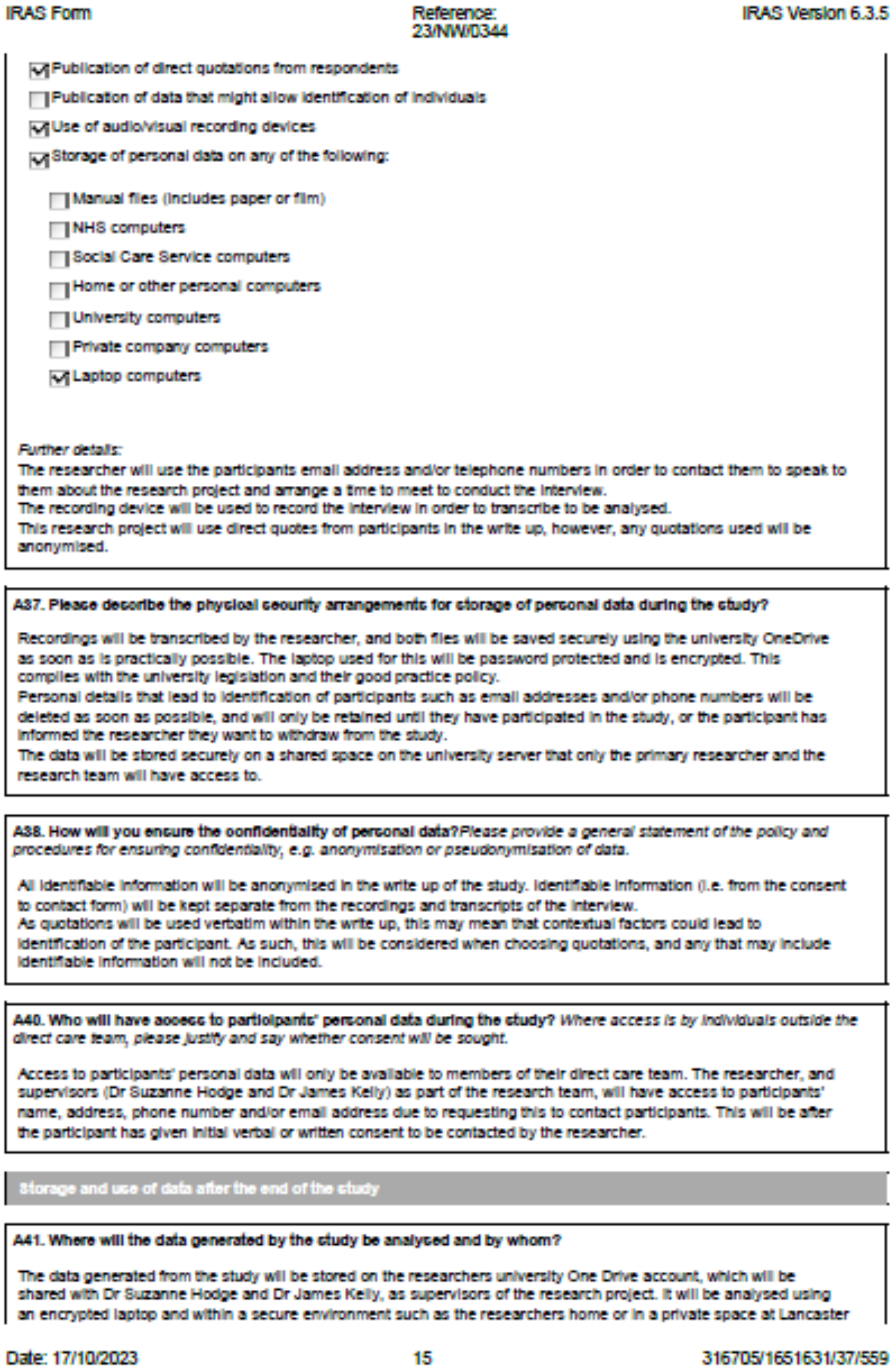
☐ Access to social care records by those outside the direct social care team

☑ Electronic transfer by magnetic or optical media, email or computer networks

☐ Sharing of personal data with other organisations

☐ Export of personal data outside the EEA

☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers



☑ Publication of direct quotations from respondents
☐ Publication of data that might allow identification of individuals
☑ Use of audio/visual recording devices
☑ Storage of personal data on any of the following:

  ☐ Manual files (includes paper or film)
  ☐ NHS computers
  ☐ Social Care Service computers
  ☐ Home or other personal computers
  ☐ University computers
  ☐ Private company computers
  ☑ Laptop computers

Further details:
The researcher will use the participants email address and/or telephone numbers in order to contact them to speak to them about the research project and arrange a time to meet to conduct the interview.
The recording device will be used to record the interview in order to transcribe to be analysed.
This research project will use direct quotes from participants in the write up, however, any quotations used will be anonymised.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Recordings will be transcribed by the researcher, and both files will be saved securely using the university OneDrive as soon as is practically possible. The laptop used for this will be password protected and is encrypted. This complies with the university legislation and their good practice policy.
Personal details that lead to identification of participants such as email addresses and/or phone numbers will be deleted as soon as possible, and will only be retained until they have participated in the study, or the participant has informed the researcher they want to withdraw from the study.
The data will be stored securely on a shared space on the university server that only the primary researcher and the research team will have access to.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

All identifiable information will be anonymised in the write up of the study. Identifiable information (i.e. from the consent to contact form) will be kept separate from the recordings and transcripts of the interview.
As quotations will be used verbatim within the write up, this may mean that contextual factors could lead to identification of the participant. As such, this will be considered when choosing quotations, and any that may include identifiable information will not be included.

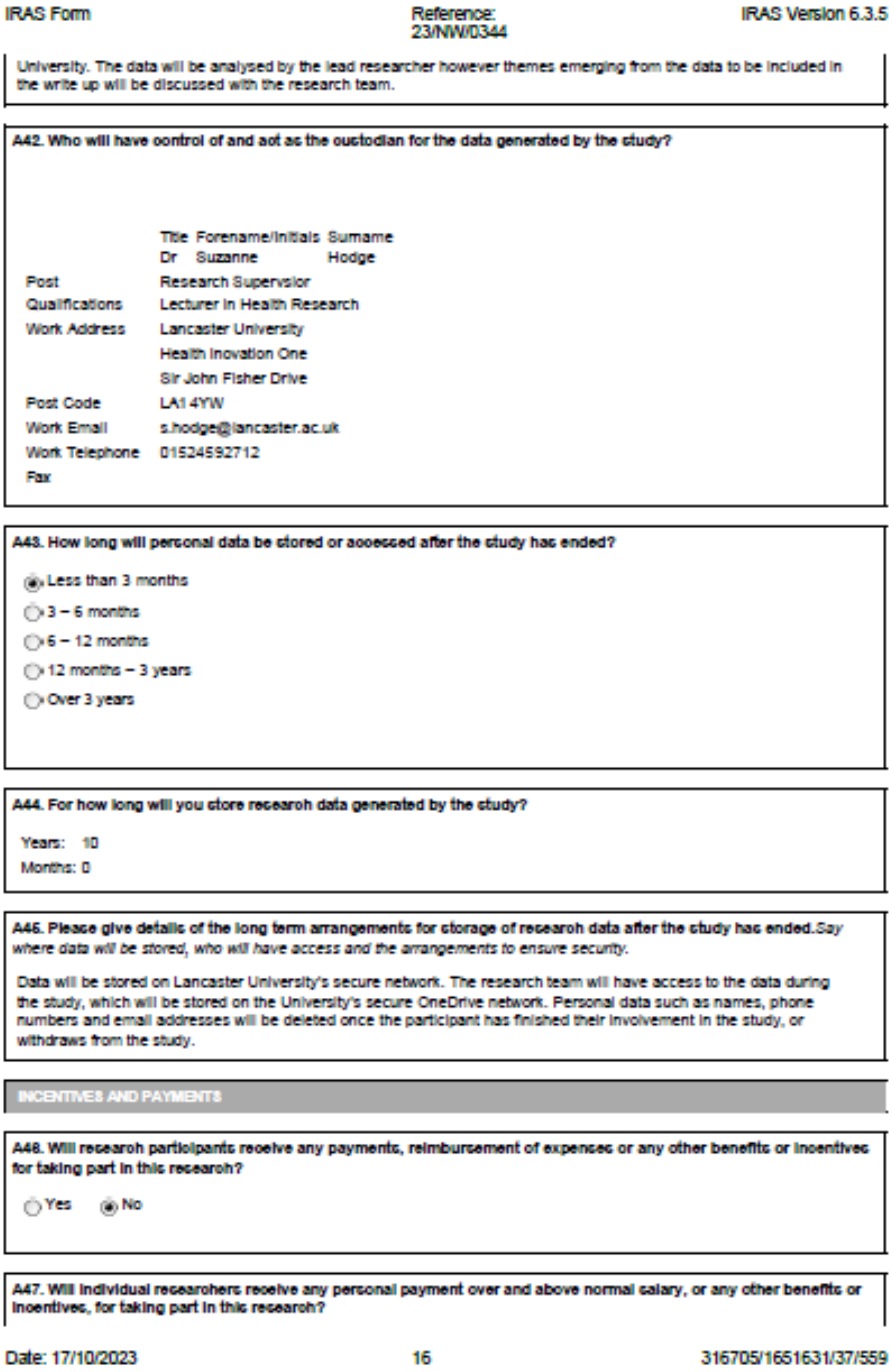
A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Access to participants' personal data will only be available to members of their direct care team. The researcher, and supervisors (Dr Suzanne Hodge and Dr James Kelly) as part of the research team, will have access to participants' name, address, phone number and/or email address due to requesting this to contact participants. This will be after the participant has given initial verbal or written consent to be contacted by the researcher.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

The data generated from the study will be stored on the researchers university One Drive account, which will be shared with Dr Suzanne Hodge and Dr James Kelly, as supervisors of the research project. It will be analysed using an encrypted laptop and within a secure environment such as the researchers home or in a private space at Lancaster



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University. The data will be analysed by the lead researcher however themes emerging from the data to be included in the write up will be discussed with the research team.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Suzanne	Hodge

Post	Research Supervsior
Qualifications	Lecturer in Health Research
Work Address	Lancaster University Health Inovation One Sir John Fisher Drive
Post Code	LA1 4YW
Work Email	s.hodge@lancaster.ac.uk
Work Telephone	01524592712
Fax	

A43. How long will personal data be stored or accessed after the study has ended?

● Less than 3 months

○ 3 – 6 months

○ 6 – 12 months

○ 12 months – 3 years

○ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10

Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

Data will be stored on Lancaster University's secure network. The research team will have access to the data during the study, which will be stored on the University's secure OneDrive network. Personal data such as names, phone numbers and email addresses will be deleted once the participant has finished their involvement in the study, or withdraws from the study.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ● No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

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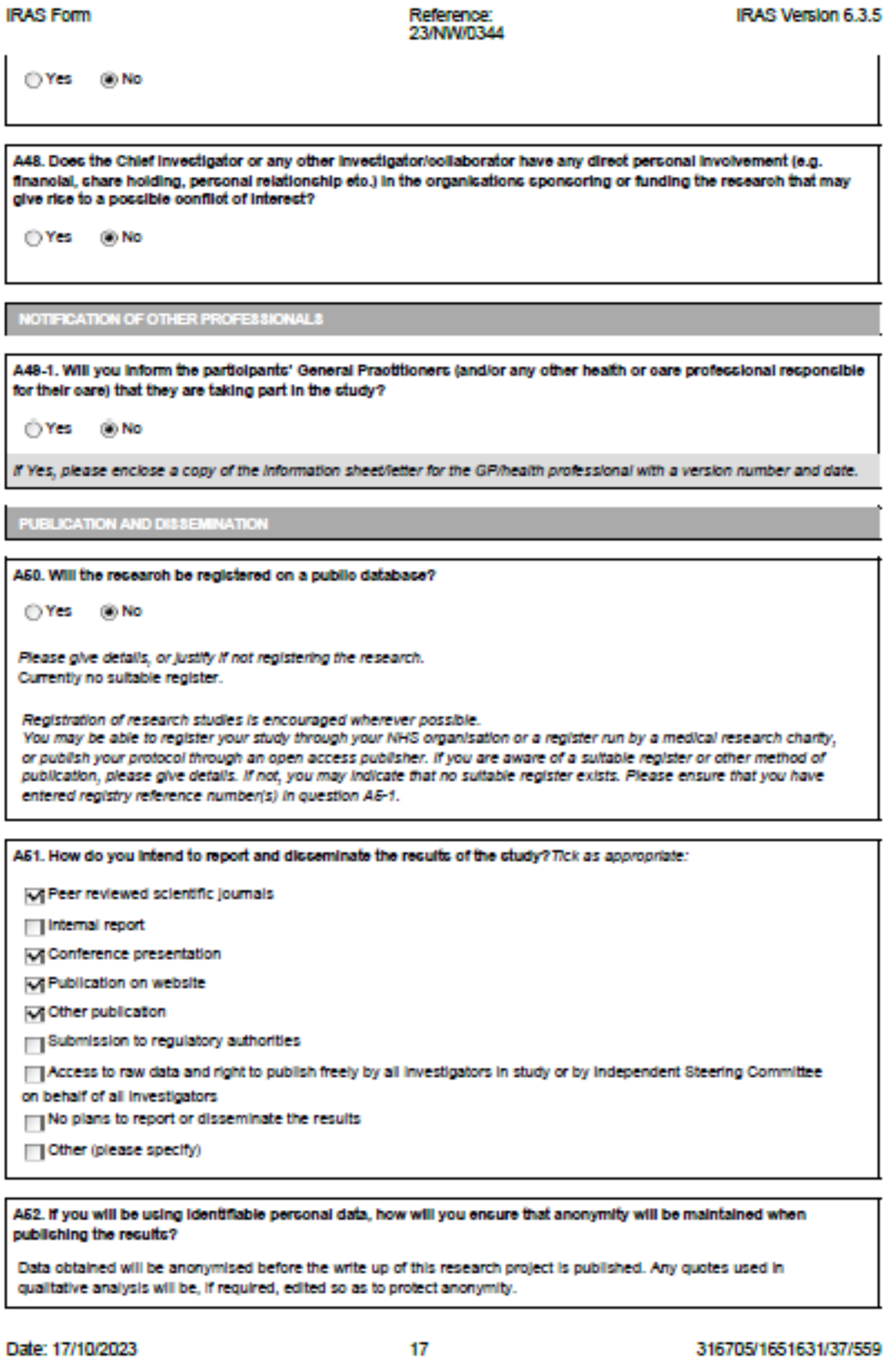


○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ● No

Please give details, or justify if not registering the research.

Currently no suitable register.

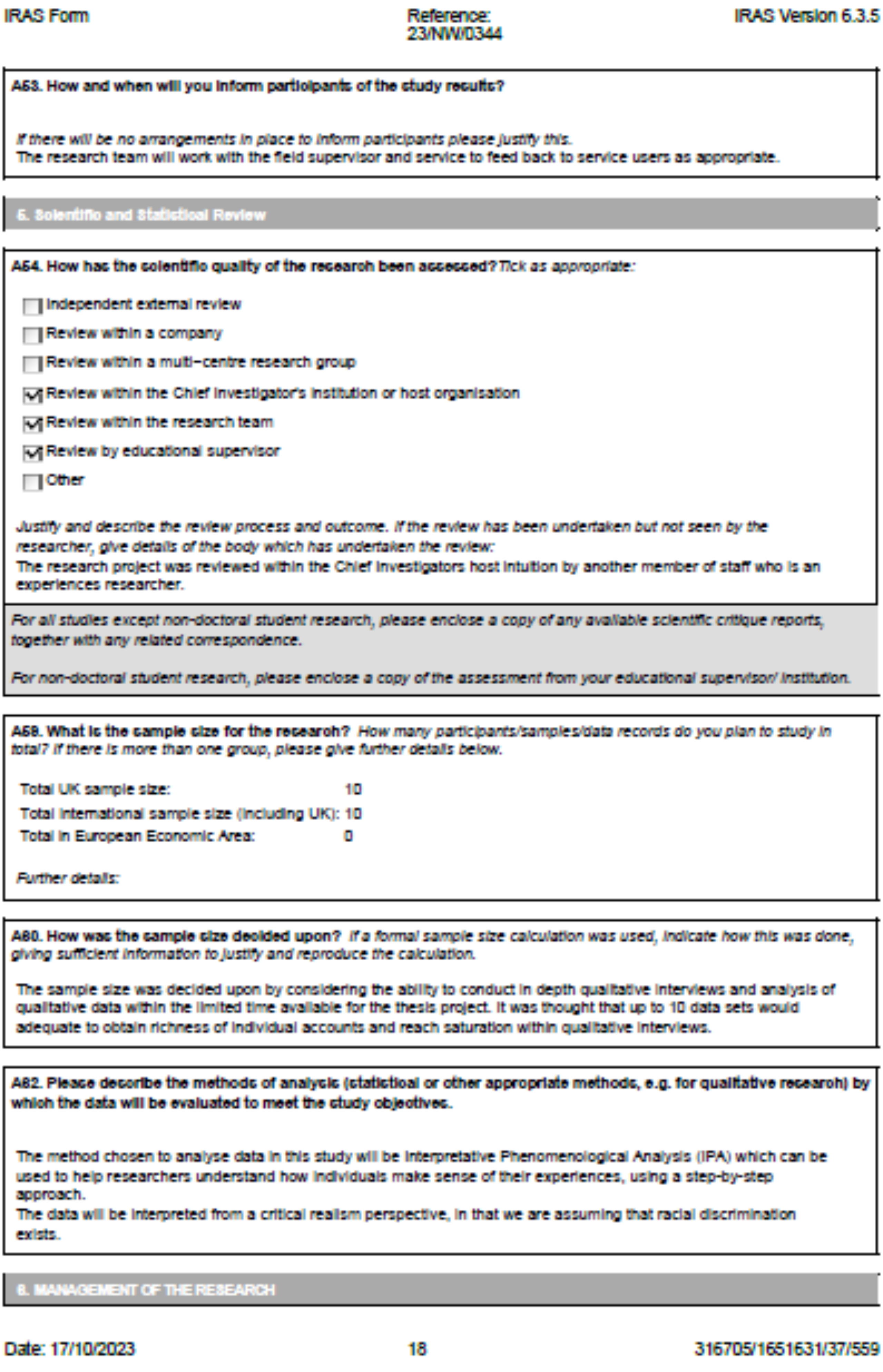
Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☐ Internal report
☑ Conference presentation
☑ Publication on website
☑ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Data obtained will be anonymised before the write up of this research project is published. Any quotes used in qualitative analysis will be, if required, edited so as to protect anonymity.



A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
The research team will work with the field supervisor and service to feed back to service users as appropriate.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review
☐ Review within a company
☐ Review within a multi−centre research group
☑ Review within the Chief Investigator's institution or host organisation
☑ Review within the research team
☑ Review by educational supervisor
☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The research project was reviewed within the Chief Investigators host intuition by another member of staff who is an experiences researcher.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	10
Total international sample size (including UK):	10
Total in European Economic Area:	0

Further details:

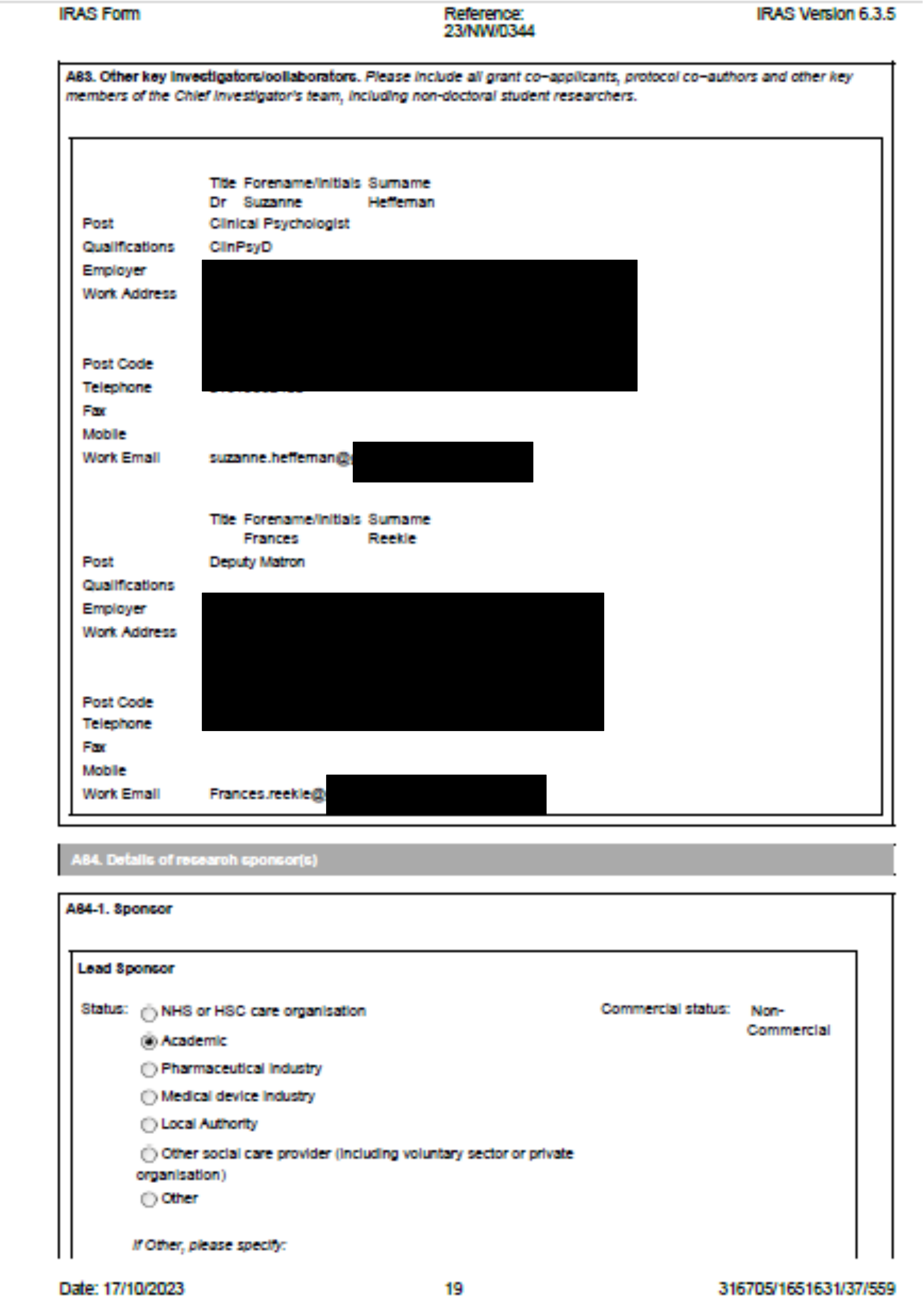
A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The sample size was decided upon by considering the ability to conduct in depth qualitative interviews and analysis of qualitative data within the limited time available for the thesis project. It was thought that up to 10 data sets would adequate to obtain richness of individual accounts and reach saturation within qualitative interviews.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The method chosen to analyse data in this study will be Interpretative Phenomenological Analysis (IPA) which can be used to help researchers understand how individuals make sense of their experiences, using a step-by-step approach.
The data will be interpreted from a critical realism perspective, in that we are assuming that racial discrimination exists.

6. MANAGEMENT OF THE RESEARCH



A68. Other key investigators/collaborators. *Please include all grant co–applicants, protocol co–authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Suzanne	Heffernan

Post Clinical Psychologist
Qualifications ClinPsyD
Employer [redacted]
Work Address
Post Code
Telephone
Fax
Mobile
Work Email suzanne.heffernan@[redacted]

	Title	Forename/Initials	Surname
		Frances	Reekie

Post Deputy Matron
Qualifications
Employer [redacted]
Work Address
Post Code
Telephone
Fax
Mobile
Work Email Frances.reekie@[redacted]

A64. Details of research sponsor(s)

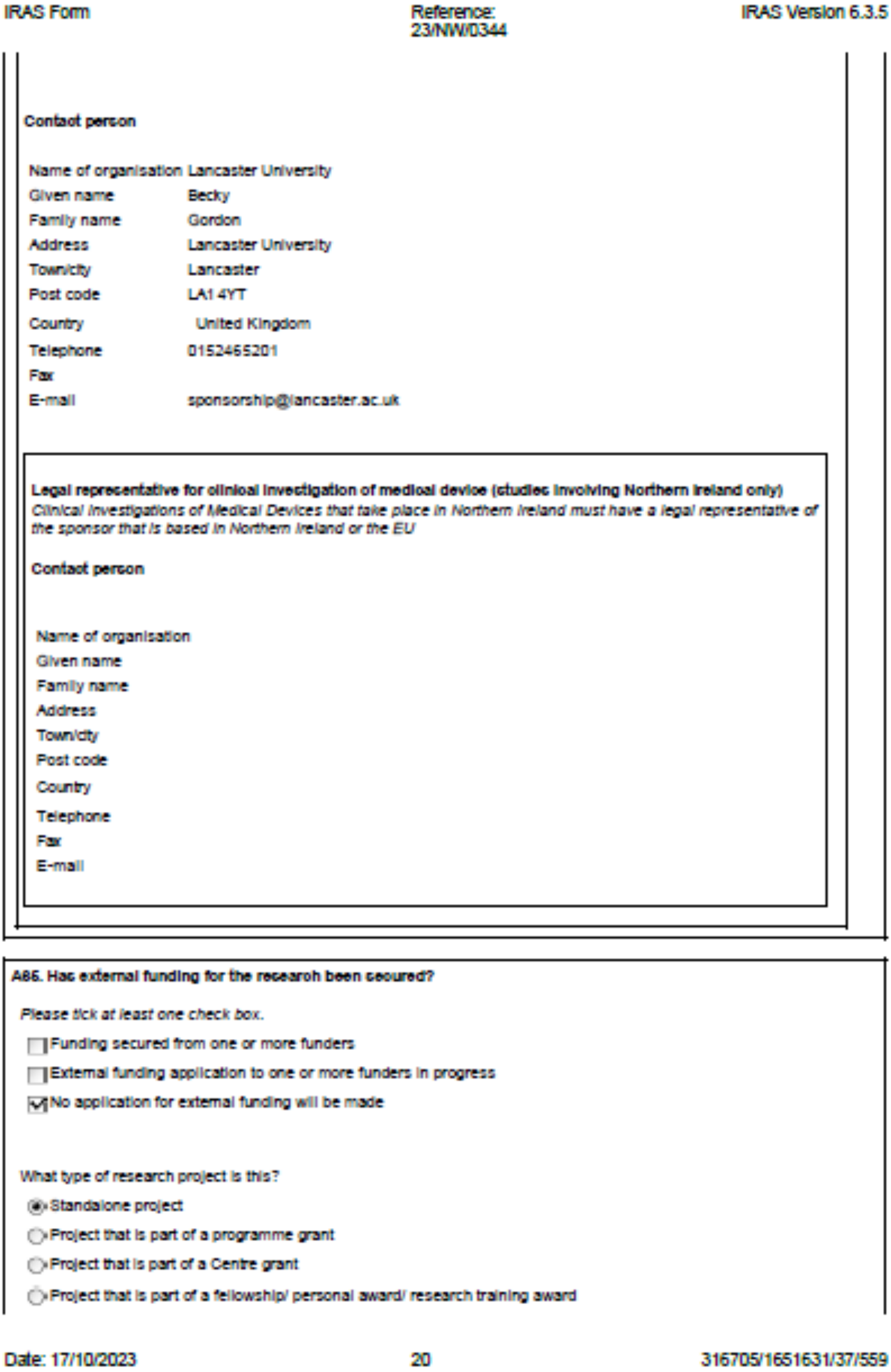
A64-1. Sponsor

Lead Sponsor

Status:
○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

Commercial status: Non-Commercial

If Other, please specify:



Contact person

Name of organisation	Lancaster University
Given name	Becky
Family name	Gordon
Address	Lancaster University
Town/city	Lancaster
Post code	LA1 4YT
Country	United Kingdom
Telephone	0152465201
Fax	
E-mail	sponsorship@lancaster.ac.uk

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)

Clinical investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU

Contact person

Name of organisation	
Given name	
Family name	
Address	
Town/city	
Post code	
Country	
Telephone	
Fax	
E-mail	

A65. Has external funding for the research been secured?

Please tick at least one check box.

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress

☑ No application for external funding will be made

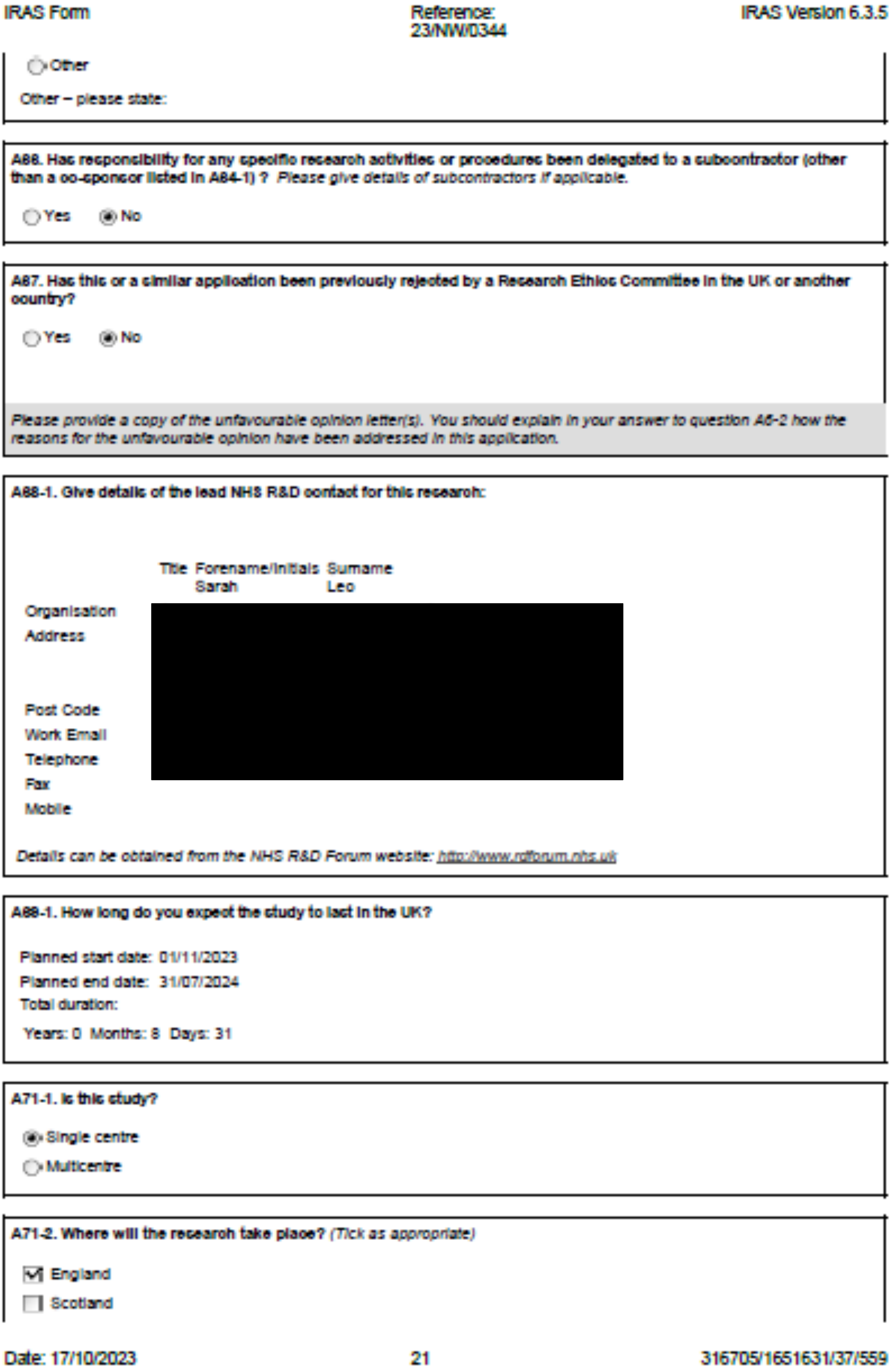
What type of research project is this?

● Standalone project

○ Project that is part of a programme grant

○ Project that is part of a Centre grant

○ Project that is part of a fellowship/ personal award/ research training award



○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ● No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title	Forename/Initials	Surname
	Sarah	Leo

Organisation
Address
Post Code
Work Email
Telephone
Fax
Mobile

[redacted]

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/11/2023
Planned end date: 31/07/2024
Total duration:
Years: 0 Months: 8 Days: 31

A71-1. Is this study?

● Single centre
○ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland

☐ Wales

☐ Northern Ireland

☐ Other countries in European Economic Area

Total UK sites in study 1

Does this trial involve countries outside the EU?

○ Yes ● No

A72. Which organisations in the UK will host the research?*Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	1
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Joint health and social care agencies (eg community mental health teams)	
☐ Local authorities	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent (private or voluntary sector) organisations	
☑ Educational establishments	1
☐ Independent research units	
☐ Other (give details)	
Total UK sites in study:	2

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

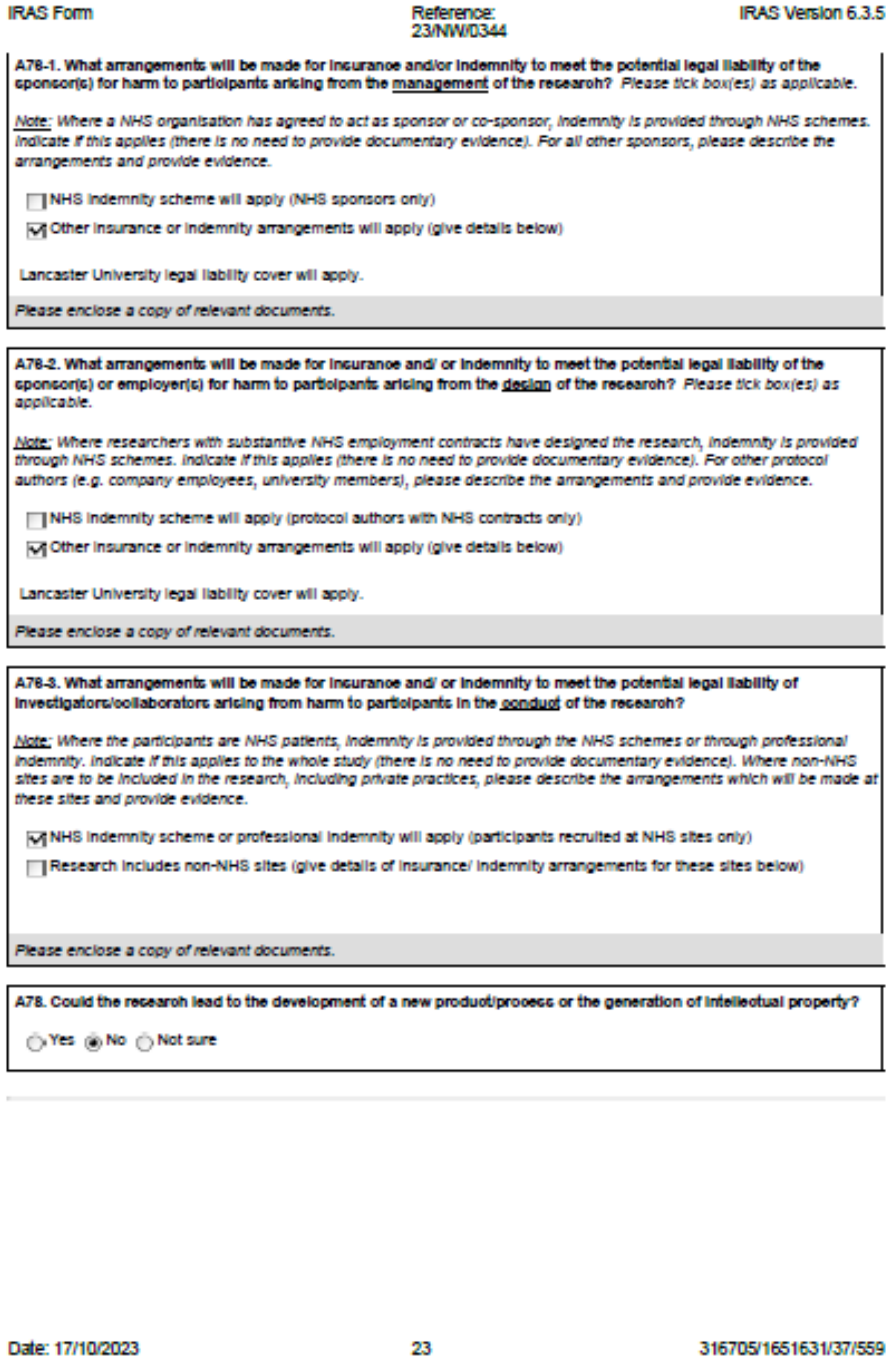
○ Yes ● No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

Supervisors will monitor and audit the conduct of the research.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:** In this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*



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A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ● No ○ Not sure

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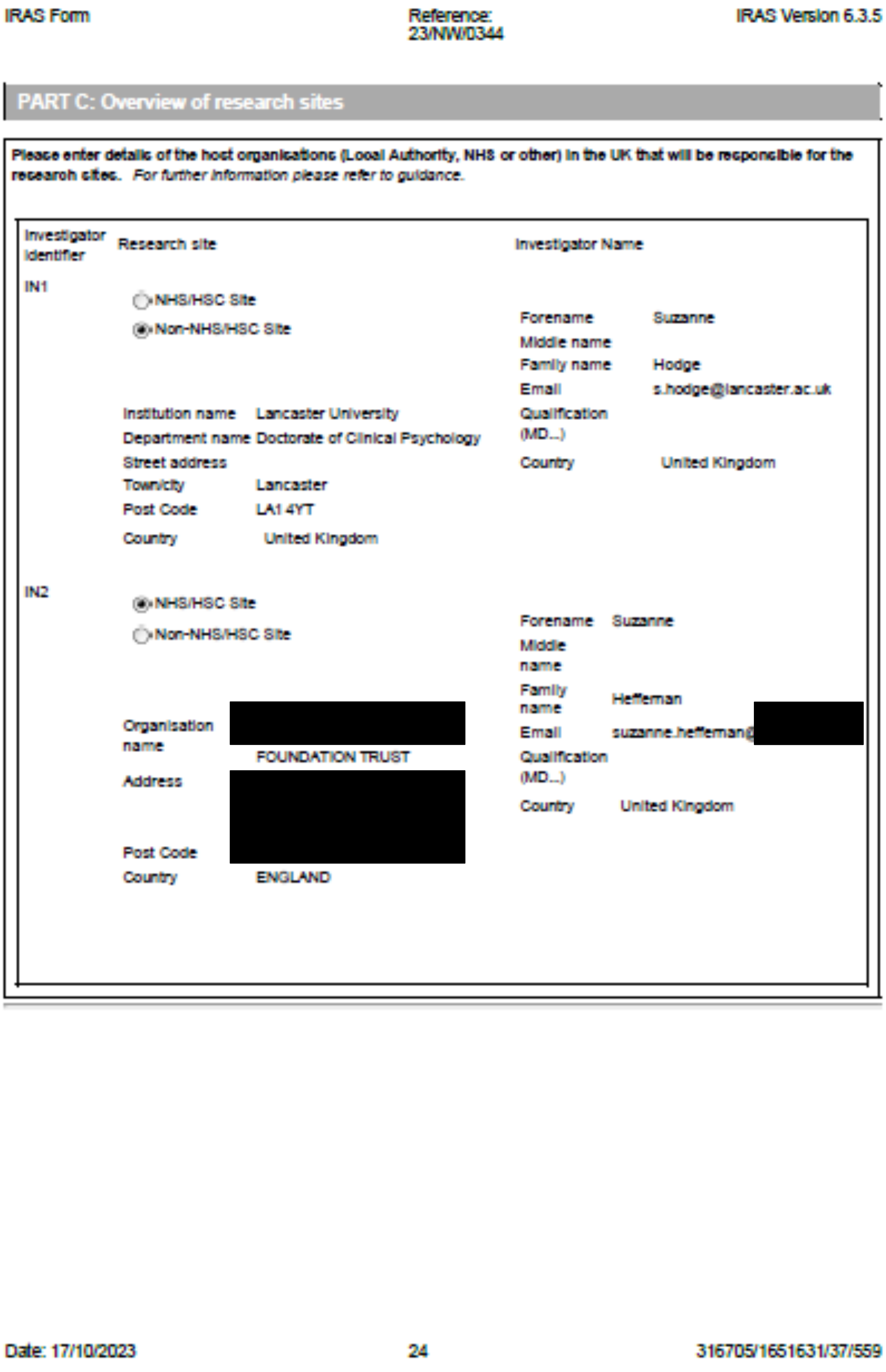

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PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	○ NHS/HSC Site ● Non-NHS/HSC Site Institution name: Lancaster University Department name: Doctorate of Clinical Psychology Street address: Town/city: Lancaster Post Code: LA1 4YT Country: United Kingdom	Forename: Suzanne Middle name: Family name: Hodge Email: s.hodge@lancaster.ac.uk Qualification (MD...): Country: United Kingdom
IN2	● NHS/HSC Site ○ Non-NHS/HSC Site Organisation name: [redacted] FOUNDATION TRUST Address: [redacted] Post Code: Country: ENGLAND	Forename: Suzanne Middle name: Family name: Heffernan Email: suzanne.heffernan@ [redacted] Qualification (MD...): Country: United Kingdom

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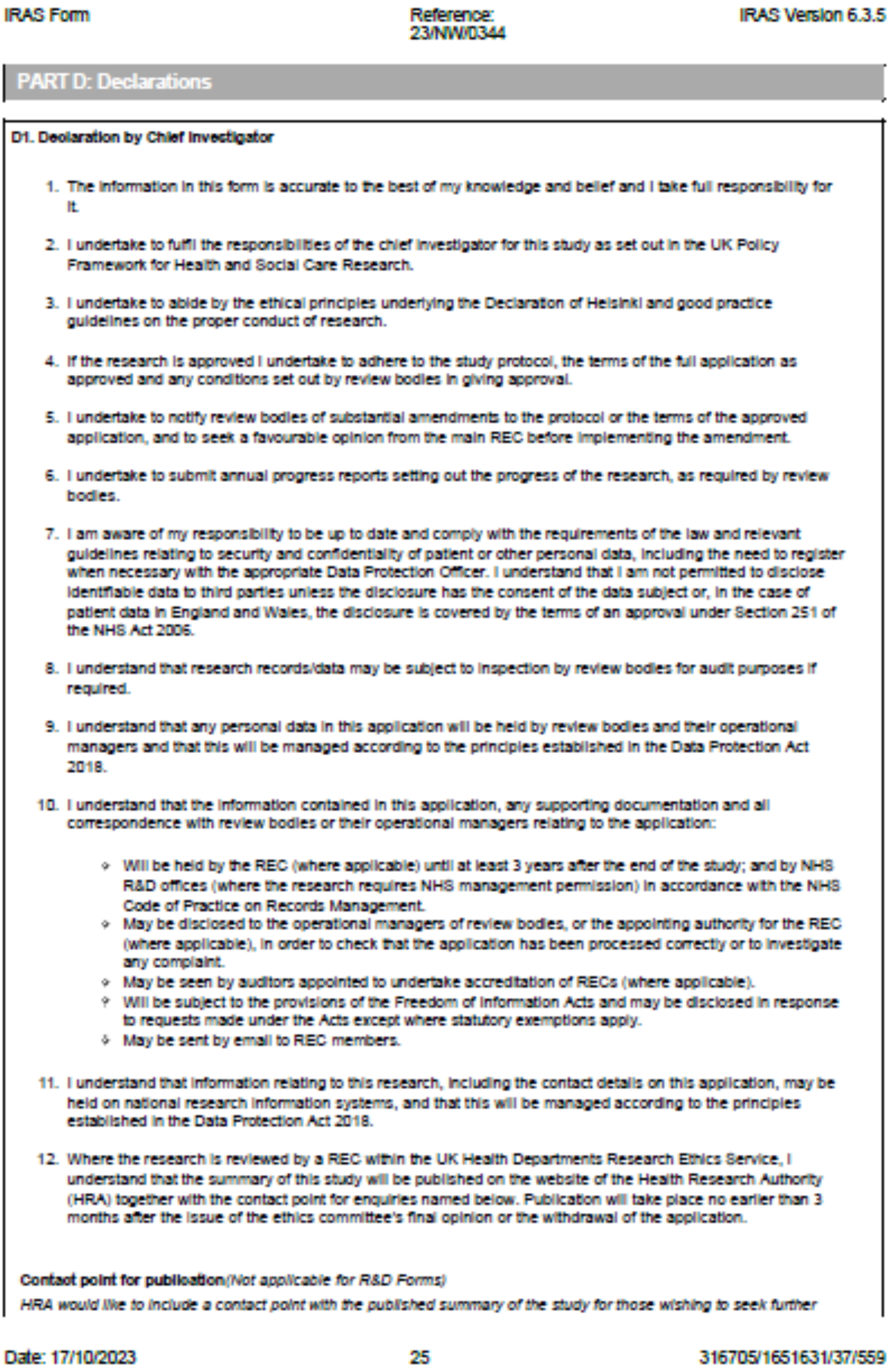

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PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further

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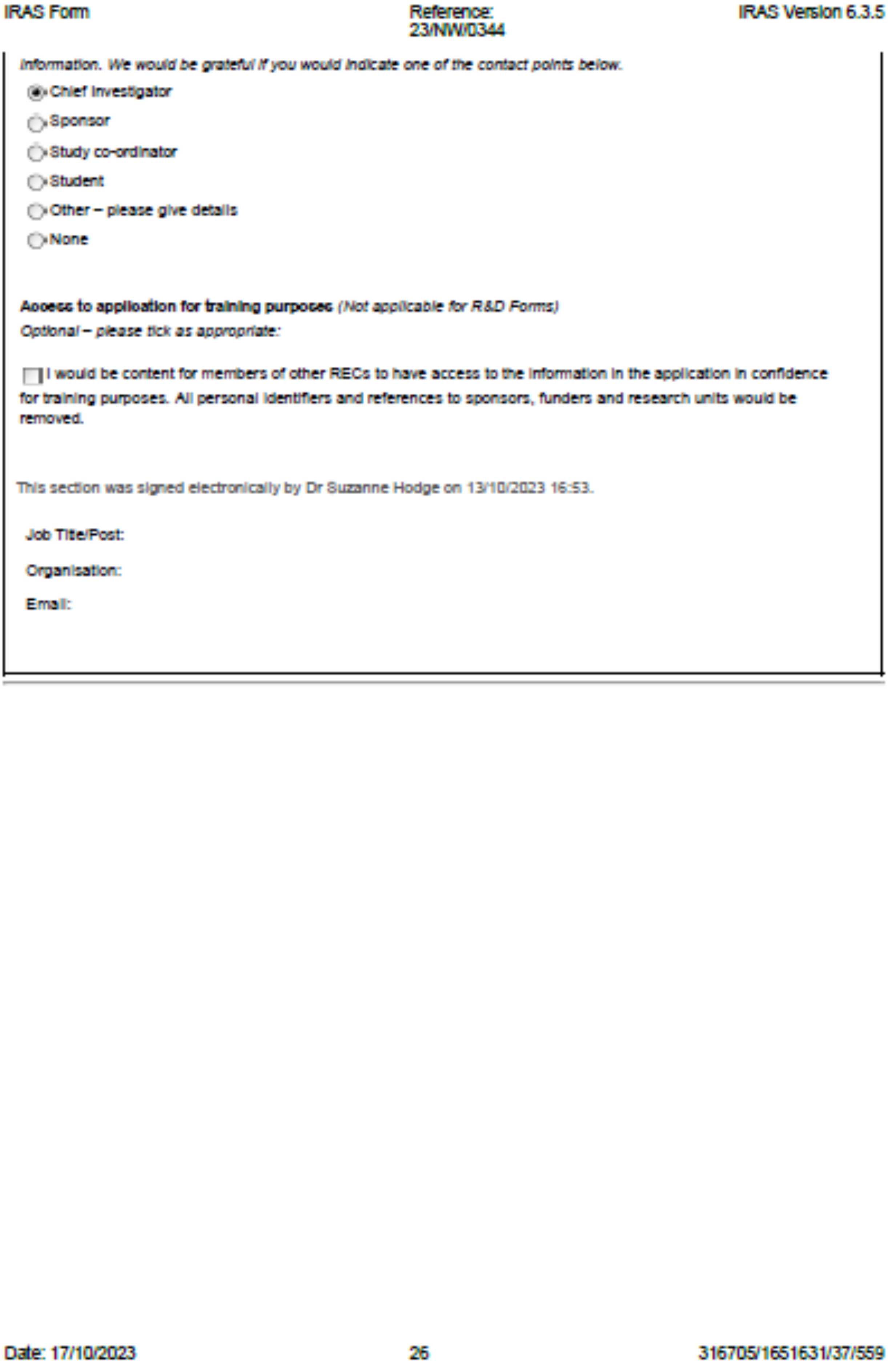

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information. We would be grateful if you would indicate one of the contact points below.

● Chief Investigator

○ Sponsor

○ Study co-ordinator

○ Student

○ Other – please give details

○ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

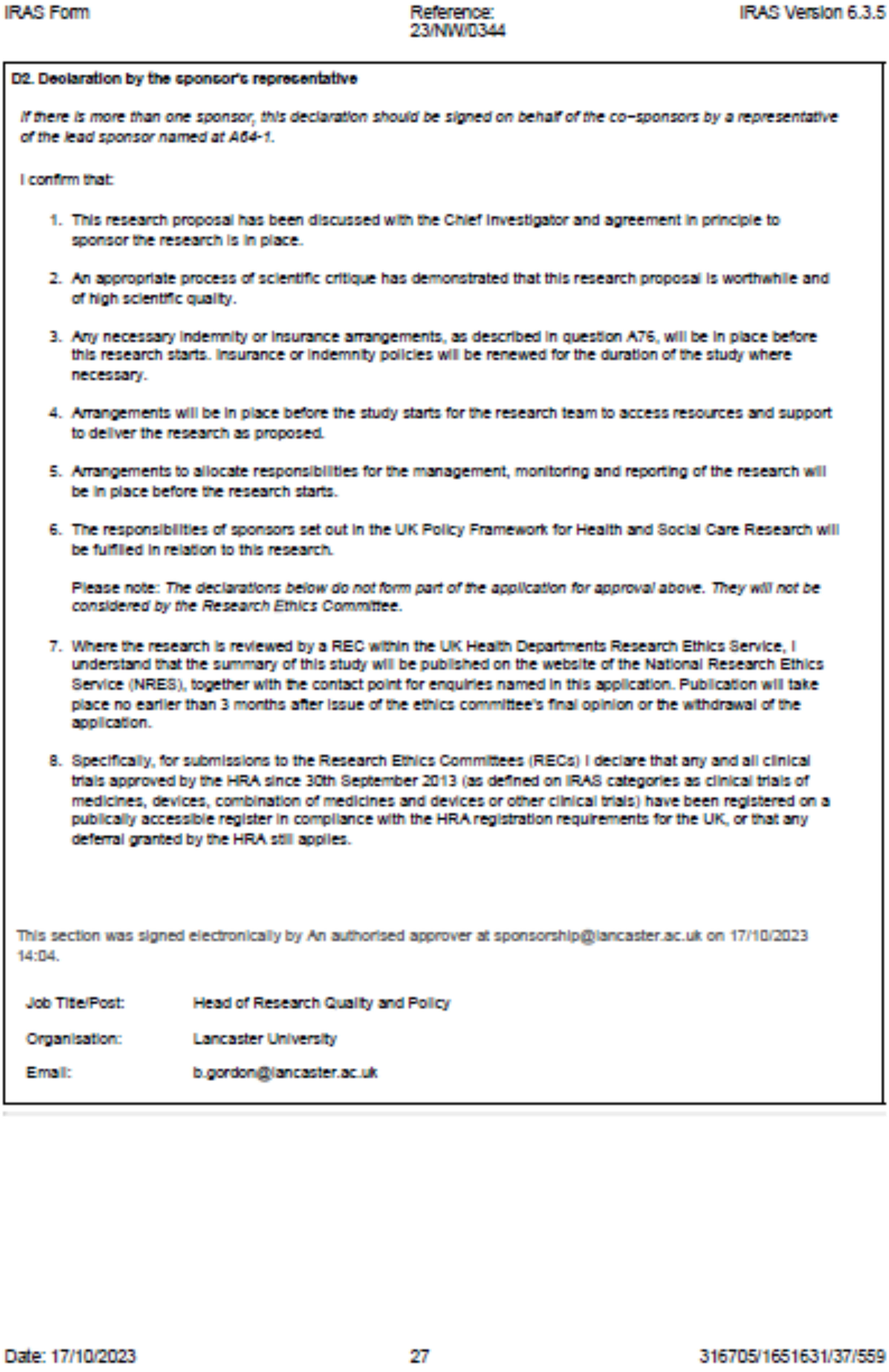
This section was signed electronically by Dr Suzanne Hodge on 13/10/2023 16:53.

Job Title/Post:

Organisation:

Email:

Date: 17/10/2023 26 316705/1651631/37/559



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D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 17/10/2023 14:04.

Job Title/Post:	Head of Research Quality and Policy
Organisation:	Lancaster University
Email:	b.gordon@lancaster.ac.uk

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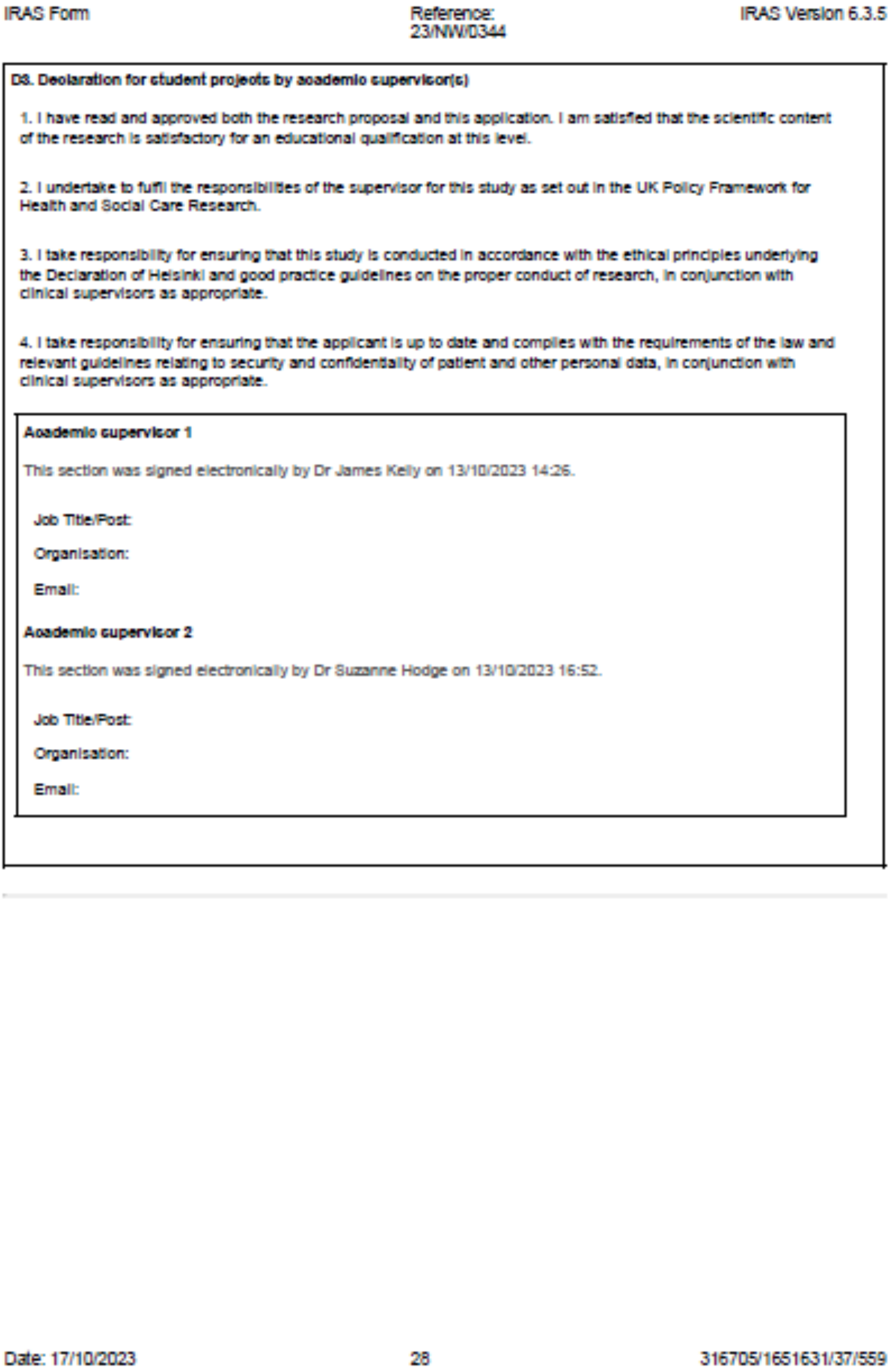

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D8. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr James Kelly on 13/10/2023 14:26.

Job Title/Post:

Organisation:

Email:

Academic supervisor 2

This section was signed electronically by Dr Suzanne Hodge on 13/10/2023 16:52.

Job Title/Post:

Organisation:

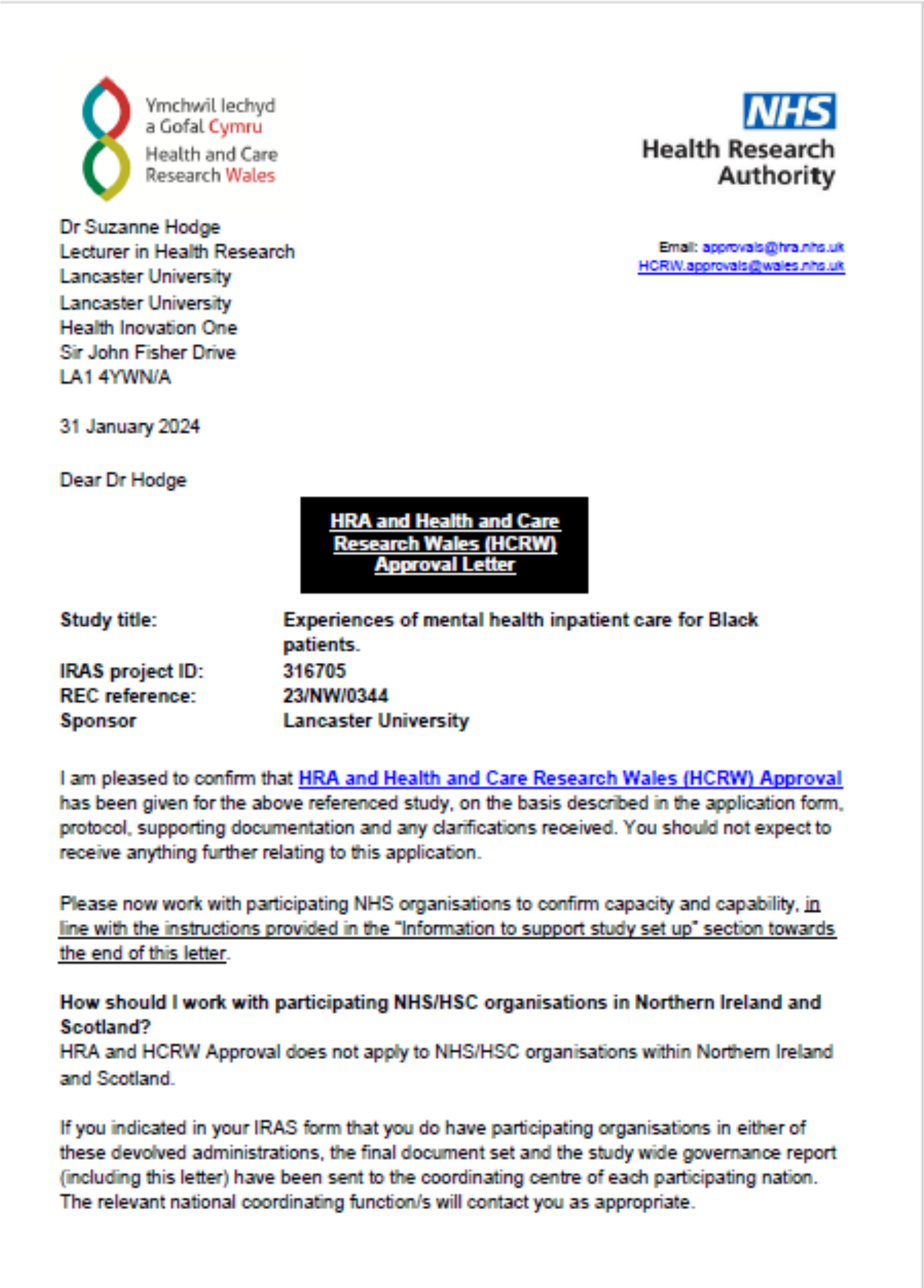
Email:

Date: 17/10/2023 | 28 | 316705/1651631/37/559

Appendices

Appendix 4-A

HRA Approval Letter



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

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

Dr Suzanne Hodge
Lecturer in Health Research
Lancaster University
Lancaster University
Health Inovation One
Sir John Fisher Drive
LA1 4YWN/A

31 January 2024

Dear Dr Hodge

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

Study title:	**Experiences of mental health inpatient care for Black patients.**
IRAS project ID:	**316705**
REC reference:	**23/NW/0344**
Sponsor	**Lancaster University**

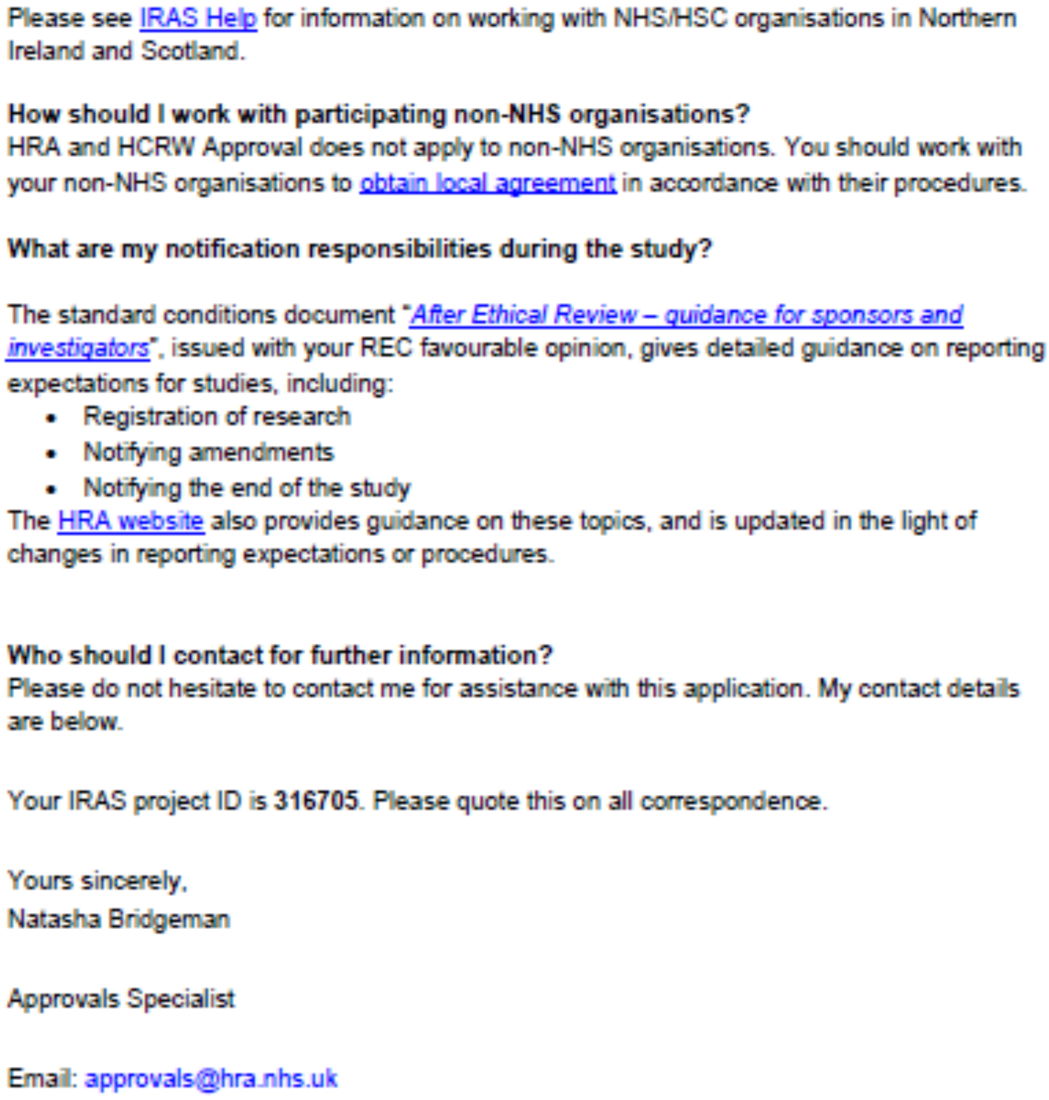
I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating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

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

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

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

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



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

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

What are my notification responsibilities during the study?

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

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

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

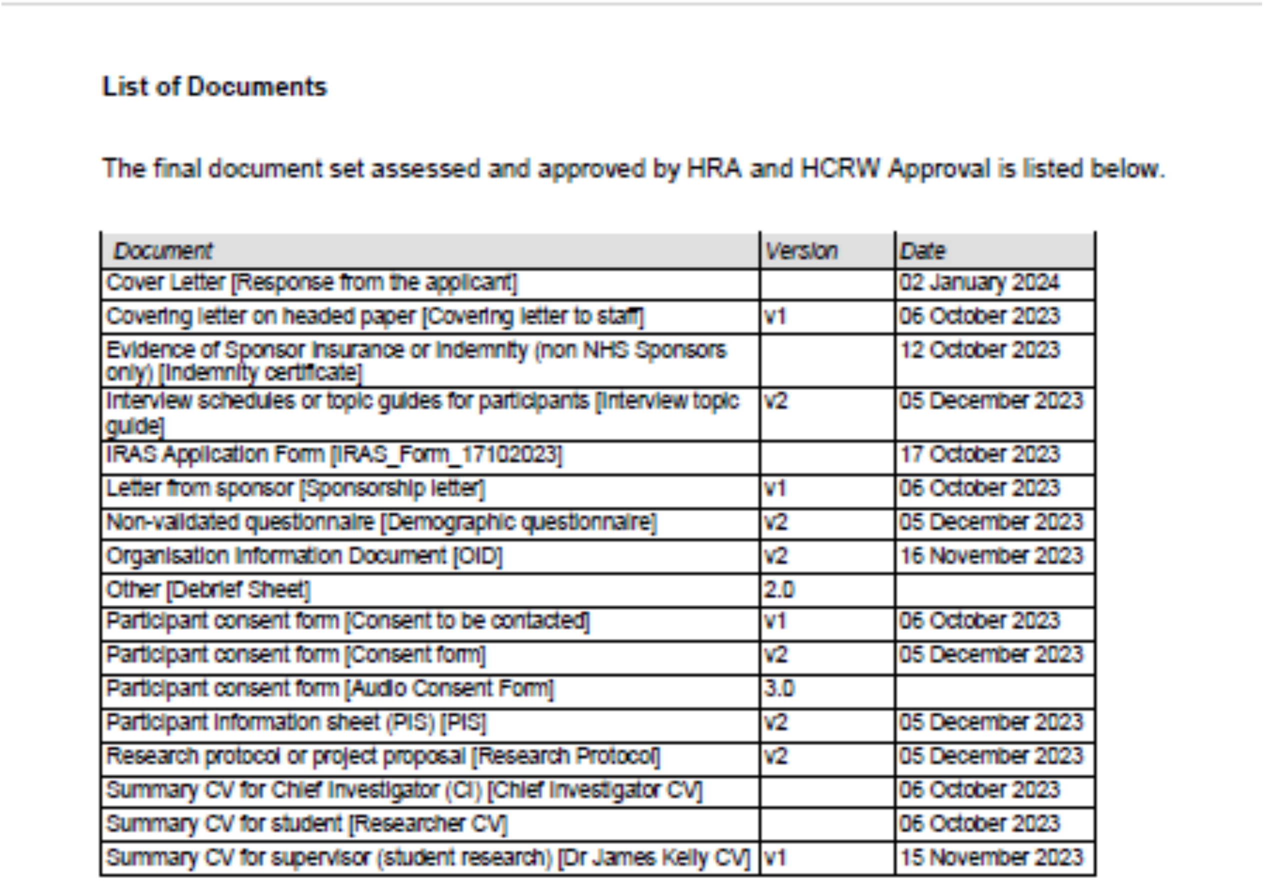
Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **316705**. Please quote this on all correspondence.

Yours sincerely,
Natasha Bridgeman

Approvals Specialist

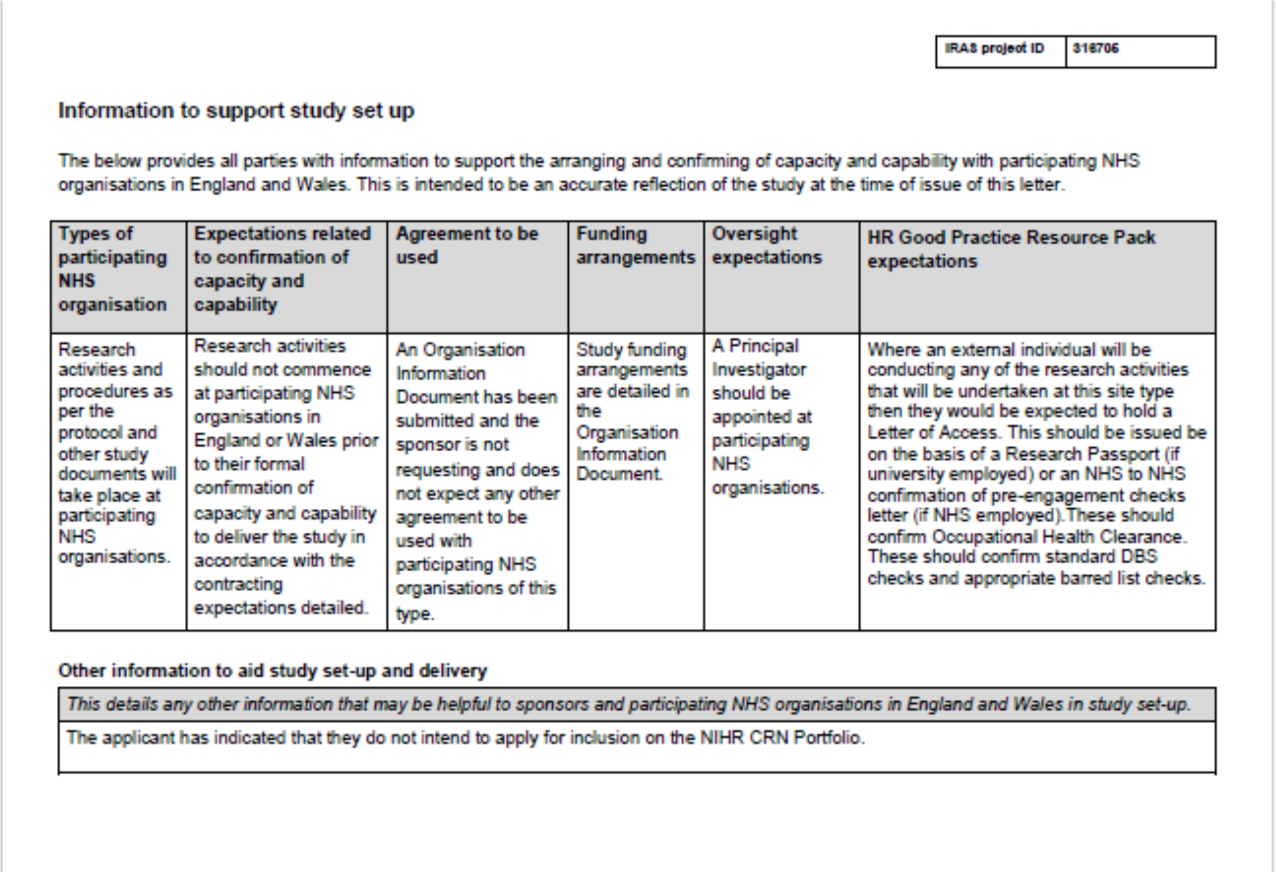
Email: approvals@hra.nhs.uk



List of Documents

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

Document	*Version*	*Date*
Cover Letter [Response from the applicant]		02 January 2024
Covering letter on headed paper [Covering letter to staff]	v1	06 October 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity certificate]		12 October 2023
Interview schedules or topic guides for participants [Interview topic guide]	v2	05 December 2023
IRAS Application Form [IRAS_Form_17102023]		17 October 2023
Letter from sponsor [Sponsorship letter]	v1	06 October 2023
Non-validated questionnaire [Demographic questionnaire]	v2	05 December 2023
Organisation Information Document [OID]	v2	16 November 2023
Other [Debrief Sheet]	2.0	
Participant consent form [Consent to be contacted]	v1	06 October 2023
Participant consent form [Consent form]	v2	05 December 2023
Participant consent form [Audio Consent Form]	3.0	
Participant information sheet (PIS) [PIS]	v2	05 December 2023
Research protocol or project proposal [Research Protocol]	v2	05 December 2023
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		06 October 2023
Summary CV for student [Researcher CV]		06 October 2023
Summary CV for supervisor (student research) [Dr James Kelly CV]	v1	15 November 2023



IRAS project ID	316706

Information to support study set up

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

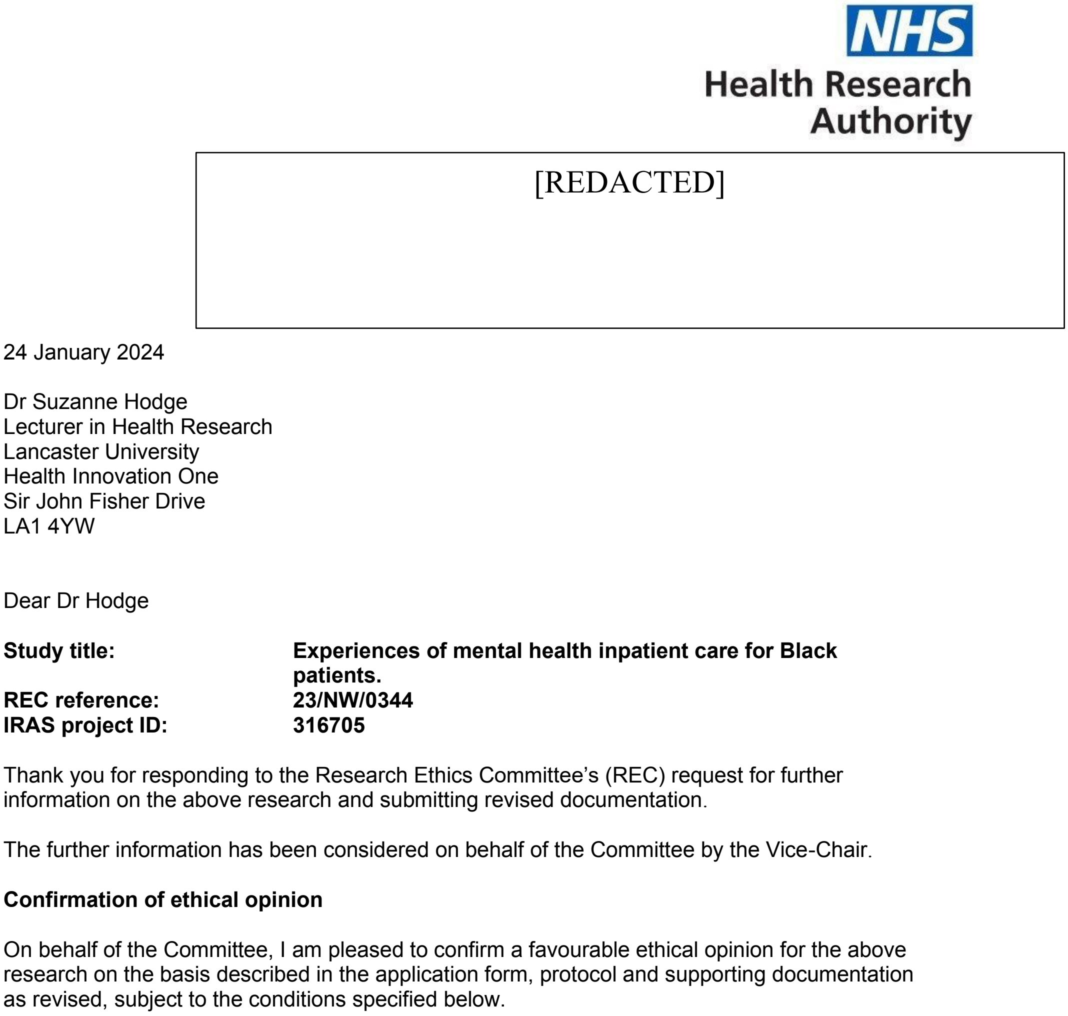
Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	Study funding arrangements are detailed in the Organisation Information Document.	A Principal Investigator should be appointed at participating NHS organisations.	Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed).These should confirm Occupational Health Clearance. These should confirm standard DBS checks and appropriate barred list checks.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 4-B

REC Favourable Opinion Letter



Health Research Authority

[REDACTED]

24 January 2024

Dr Suzanne Hodge
Lecturer in Health Research
Lancaster University
Health Innovation One
Sir John Fisher Drive
LA1 4YW

Dear Dr Hodge

Study title:	**Experiences of mental health inpatient care for Black patients.**
REC reference:	**23/NW/0344**
IRAS project ID:	**316705**

Thank you for responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Good practice principles and responsibilities

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

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

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

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

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

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

Registration of Clinical Trials

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

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, ‘clinical trials’ are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

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

Publication of Your Research Summary

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

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

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

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

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

After ethical review: Reporting requirements

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

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

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

Ethical review of research sites

NHS/HSC sites

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

Non-NHS/HSC sites

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

Approved documents

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

Document	*Version*	*Date*
Cover Letter [Response from the applicant]		02 January 2024
Covering letter on headed paper [Covering letter to staff]	v1	06 October 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity certificate]		12 October 2023
Interview schedules or topic guides for participants [Interview topic guide]	v2	05 December 2023
IRAS Application Form [IRAS_Form_17102023]		17 October 2023
Letter from sponsor [Sponsorship letter]	v1	06 October 2023
Non-validated questionnaire [Demographic questionnaire]	v2	05 December 2023
Other [Debrief Sheet]	v1	05 December 2023
Other [Debrief Sheet]	2.0	
Participant consent form [Consent to be contacted]	v1	06 October 2023
Participant consent form [Audio consent form]	v2	05 December 2023
Participant consent form [Consent form]	v2	05 December 2023
Participant consent form [Audio Consent Form]	3.0	
Participant information sheet (PIS) [PIS]	v2	05 December 2023
Research protocol or project proposal [Research Protocol]	v2	05 December 2023
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		06 October 2023
Summary CV for student [Researcher CV]		06 October 2023
Summary CV for supervisor (student research) [Dr James Kelly CV]	v1	15 November 2023

Statement of compliance

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

User Feedback

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

HRA Learning

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

IRAS project ID: 316705 Please quote this number on all correspondence

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

Yours sincerely

pp.
Dr Gary Whittle
Vice-Chair

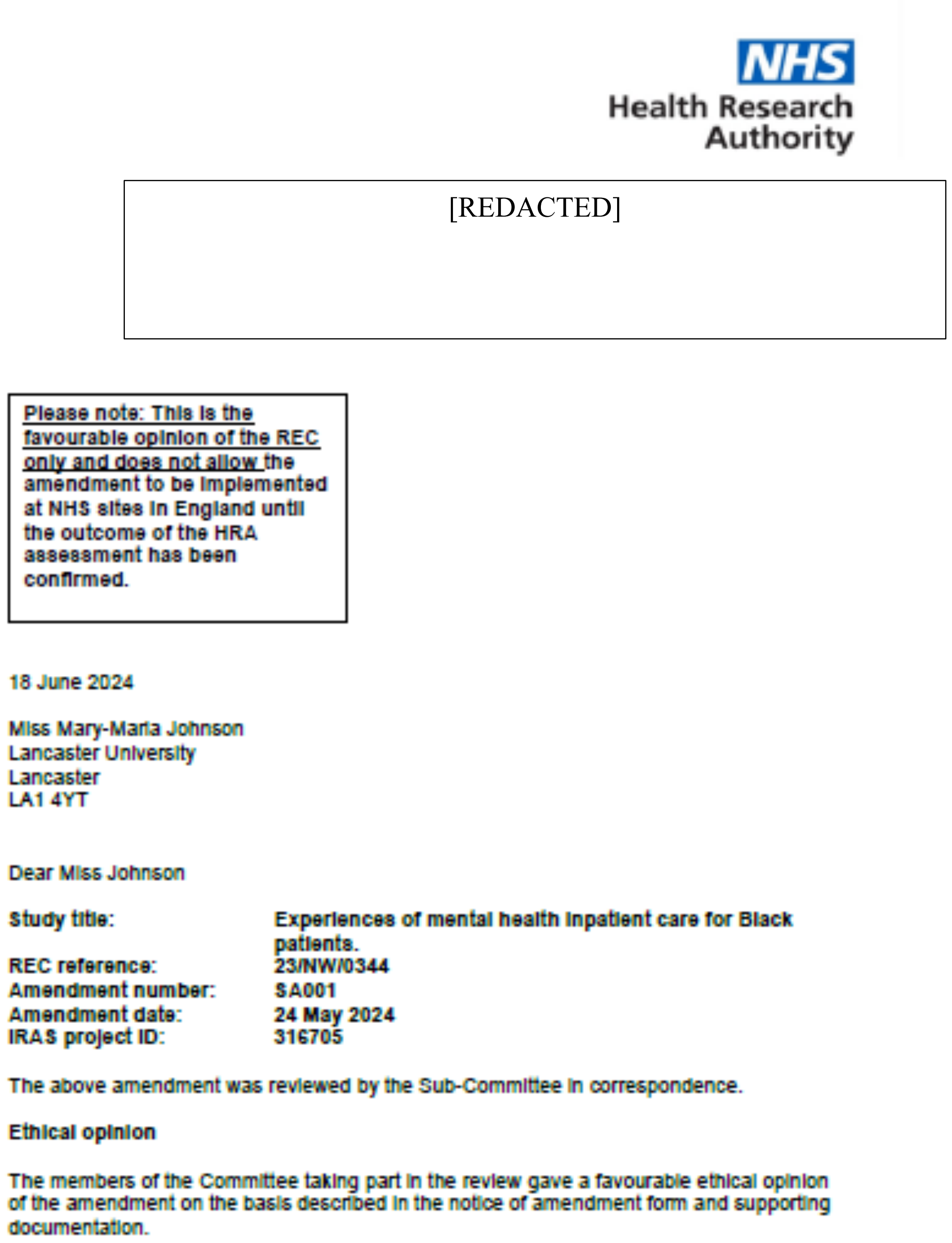
Email:[redacted]@hra.nhs.uk

Enclosures: “After ethical review – guidance for researchers” *[SL-AR2]*

Copy to:

Appendix 4-C

REC Favourable Opinion for Substantial Amendment Letter



NHS
Health Research
Authority

[REDACTED]

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

18 June 2024

Miss Mary-Maria Johnson
Lancaster University
Lancaster
LA1 4YT

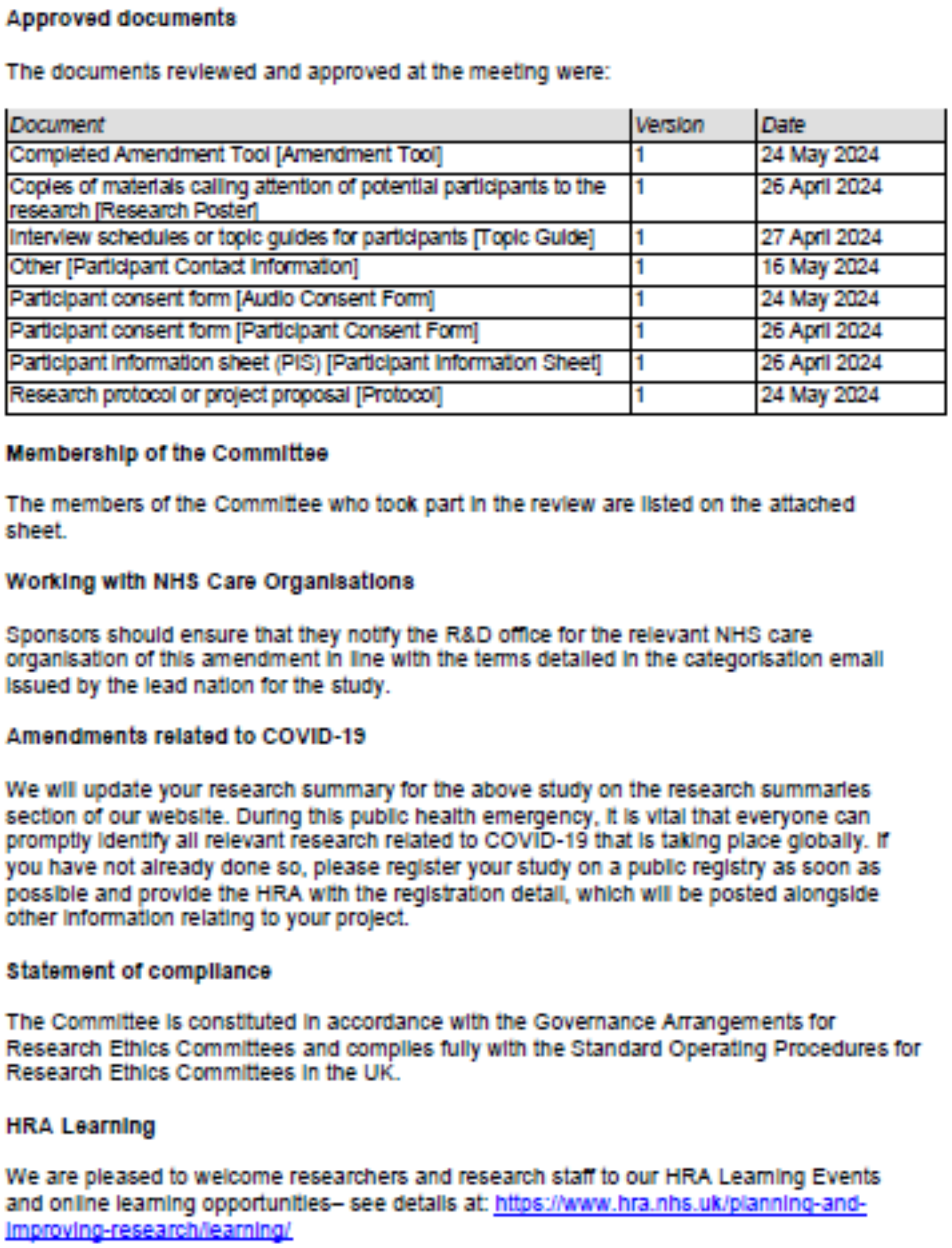
Dear Miss Johnson

Study title: **Experiences of mental health inpatient care for Black patients.**
REC reference: **23/NW/0344**
Amendment number: **SA001**
Amendment date: **24 May 2024**
IRAS project ID: **316705**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.



Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Completed Amendment Tool [Amendment Tool]	1	24 May 2024
Copies of materials calling attention of potential participants to the research [Research Poster]	1	26 April 2024
Interview schedules or topic guides for participants [Topic Guide]	1	27 April 2024
Other [Participant Contact Information]	1	16 May 2024
Participant consent form [Audio Consent Form]	1	24 May 2024
Participant consent form [Participant Consent Form]	1	26 April 2024
Participant information sheet (PIS) [Participant Information Sheet]	1	26 April 2024
Research protocol or project proposal [Protocol]	1	24 May 2024

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

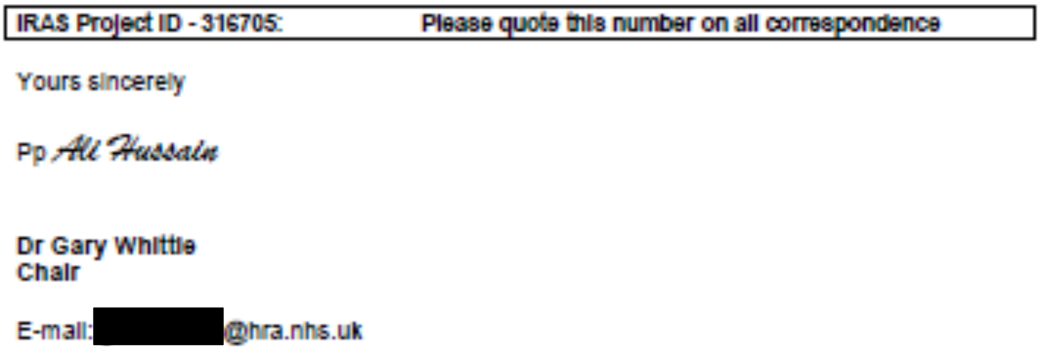
We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

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

HRA Learning

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



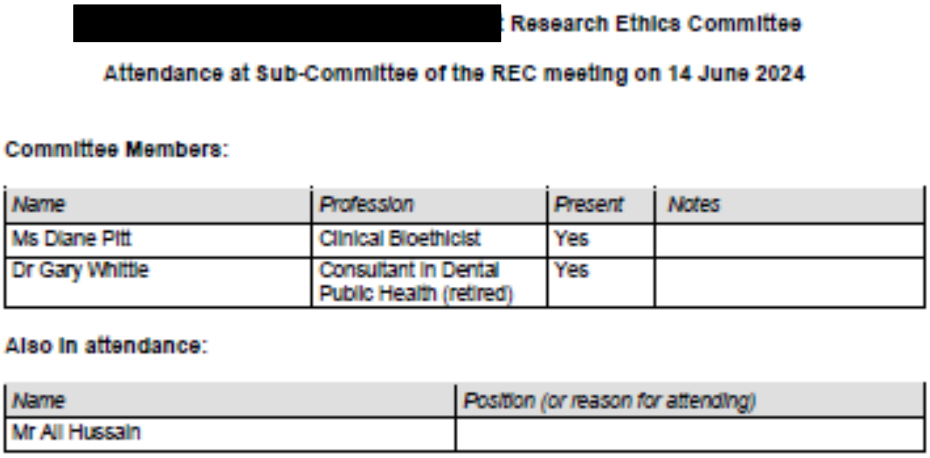
IRAS Project ID - 316705:	Please quote this number on all correspondence

Yours sincerely

Pp Ali Hussain

Dr Gary Whittle
Chair

E-mail: [redacted]@hra.nhs.uk



[redacted] Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 14 June 2024

Committee Members:

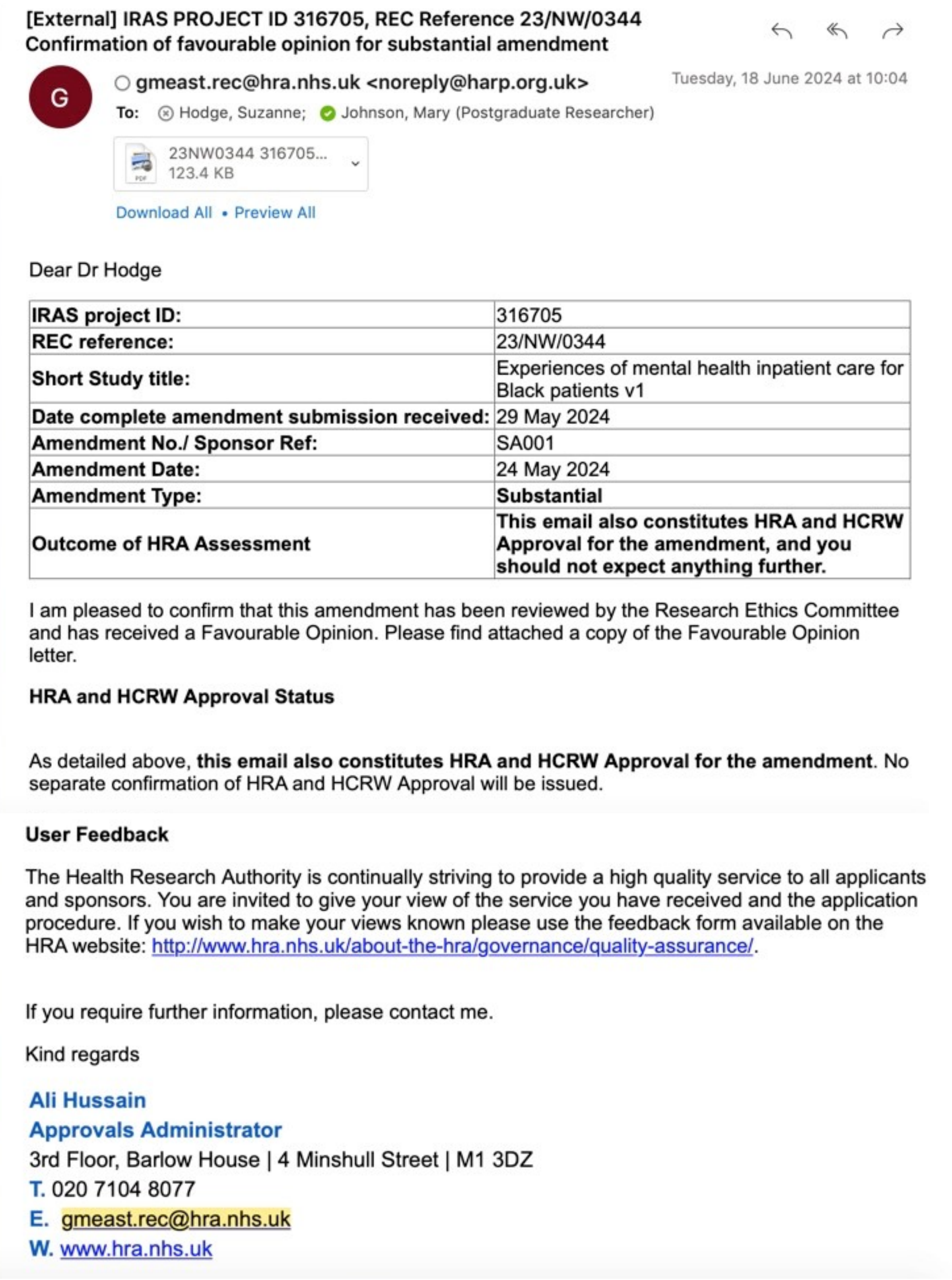
Name	*Profession*	*Present*	*Notes*
Ms Diane Pitt	Clinical Bioethicist	Yes	
Dr Gary Whittle	Consultant in Dental Public Health (retired)	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Mr Ali Hussain	

Appendix 4-D

HRA Substantial Amendment Approval Email



[External] IRAS PROJECT ID 316705, REC Reference 23/NW/0344 Confirmation of favourable opinion for substantial amendment

○ **gmeast.rec@hra.nhs.uk <noreply@harp.org.uk>**

Tuesday, 18 June 2024 at 10:04

To: Hodge, Suzanne; Johnson, Mary (Postgraduate Researcher)

Dear Dr Hodge

IRAS project ID:	316705
REC reference:	23/NW/0344
Short Study title:	Experiences of mental health inpatient care for Black patients v1
Date complete amendment submission received:	29 May 2024
Amendment No./ Sponsor Ref:	SA001
Amendment Date:	24 May 2024
Amendment Type:	**Substantial**
Outcome of HRA Assessment	**This email also constitutes HRA and HCRW Approval for the amendment, and you should not expect anything further.**

I am pleased to confirm that this amendment has been reviewed by the Research Ethics Committee and has received a Favourable Opinion. Please find attached a copy of the Favourable Opinion letter.

HRA and HCRW Approval Status

As detailed above, **this email also constitutes HRA and HCRW Approval for the amendment**. No separate confirmation of HRA and HCRW Approval will be issued.

User Feedback

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

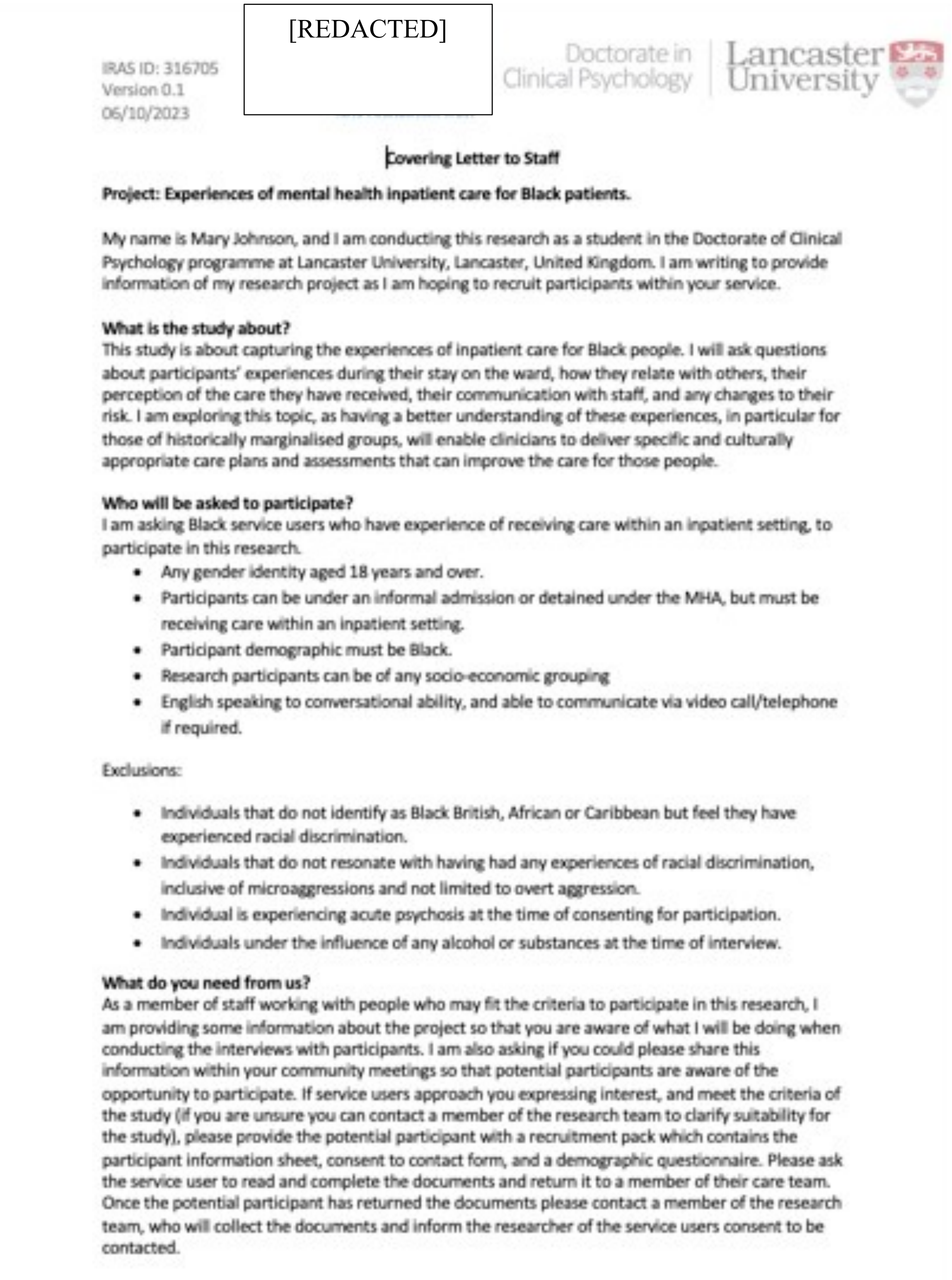
If you require further information, please contact me.

Kind regards

Ali Hussain
Approvals Administrator
3rd Floor, Barlow House | 4 Minshull Street | M1 3DZ
T. 020 7104 8077
E. gmeast.rec@hra.nhs.uk
W. www.hra.nhs.uk

Appendix 4-E

Cover Letter to Staff



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IRAS ID: 316705
Version 0.1
06/10/2023

Doctorate in Clinical Psychology | Lancaster University

Covering Letter to Staff

Project: Experiences of mental health inpatient care for Black patients.

My name is Mary Johnson, and I am conducting this research as a student in the Doctorate of Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom. I am writing to provide information of my research project as I am hoping to recruit participants within your service.

What is the study about?

This study is about capturing the experiences of inpatient care for Black people. I will ask questions about participants' experiences during their stay on the ward, how they relate with others, their perception of the care they have received, their communication with staff, and any changes to their risk. I am exploring this topic, as having a better understanding of these experiences, in particular for those of historically marginalised groups, will enable clinicians to deliver specific and culturally appropriate care plans and assessments that can improve the care for those people.

Who will be asked to participate?

I am asking Black service users who have experience of receiving care within an inpatient setting, to participate in this research.

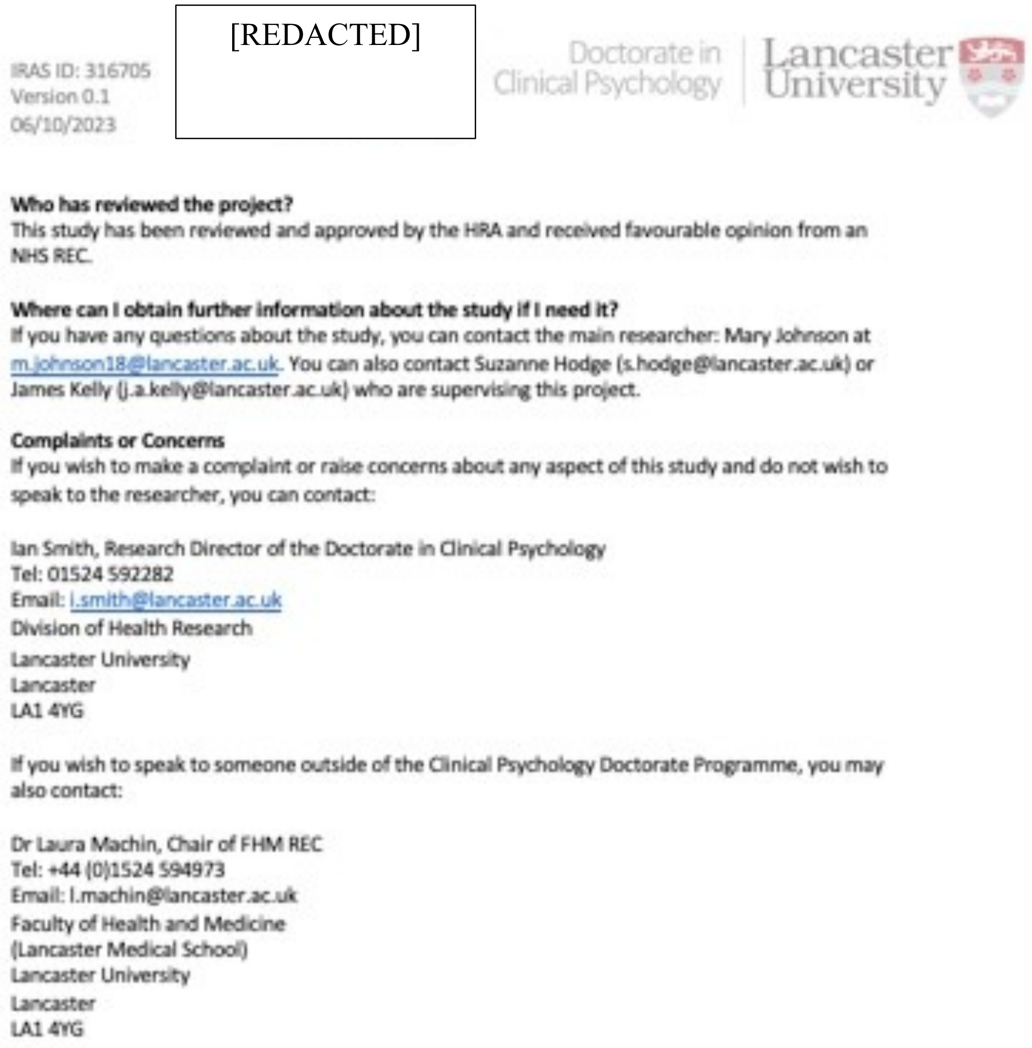
- Any gender identity aged 18 years and over.
- Participants can be under an informal admission or detained under the MHA, but must be receiving care within an inpatient setting.
- Participant demographic must be Black.
- Research participants can be of any socio-economic grouping
- English speaking to conversational ability, and able to communicate via video call/telephone if required.

Exclusions:

- Individuals that do not identify as Black British, African or Caribbean but feel they have experienced racial discrimination.
- Individuals that do not resonate with having had any experiences of racial discrimination, inclusive of microaggressions and not limited to overt aggression.
- Individual is experiencing acute psychosis at the time of consenting for participation.
- Individuals under the influence of any alcohol or substances at the time of interview.

What do you need from us?

As a member of staff working with people who may fit the criteria to participate in this research, I am providing some information about the project so that you are aware of what I will be doing when conducting the interviews with participants. I am also asking if you could please share this information within your community meetings so that potential participants are aware of the opportunity to participate. If service users approach you expressing interest, and meet the criteria of the study (if you are unsure you can contact a member of the research team to clarify suitability for the study), please provide the potential participant with a recruitment pack which contains the participant information sheet, consent to contact form, and a demographic questionnaire. Please ask the service user to read and complete the documents and return it to a member of their care team. Once the potential participant has returned the documents please contact a member of the research team, who will collect the documents and inform the researcher of the service users consent to be contacted.



IRAS ID: 316705
Version 0.1
06/10/2023

[REDACTED]

Doctorate in Clinical Psychology | Lancaster University

Who has reviewed the project?
This study has been reviewed and approved by the HRA and received favourable opinion from an NHS REC.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, you can contact the main researcher: Mary Johnson at m.johnson18@lancaster.ac.uk. You can also contact Suzanne Hodge (s.hodge@lancaster.ac.uk) or James Kelly (j.a.kelly@lancaster.ac.uk) who are supervising this project.

Complaints or Concerns
If you wish to make a complaint or raise concerns about any aspect of this study and do not wish to speak to the researcher, you can contact:

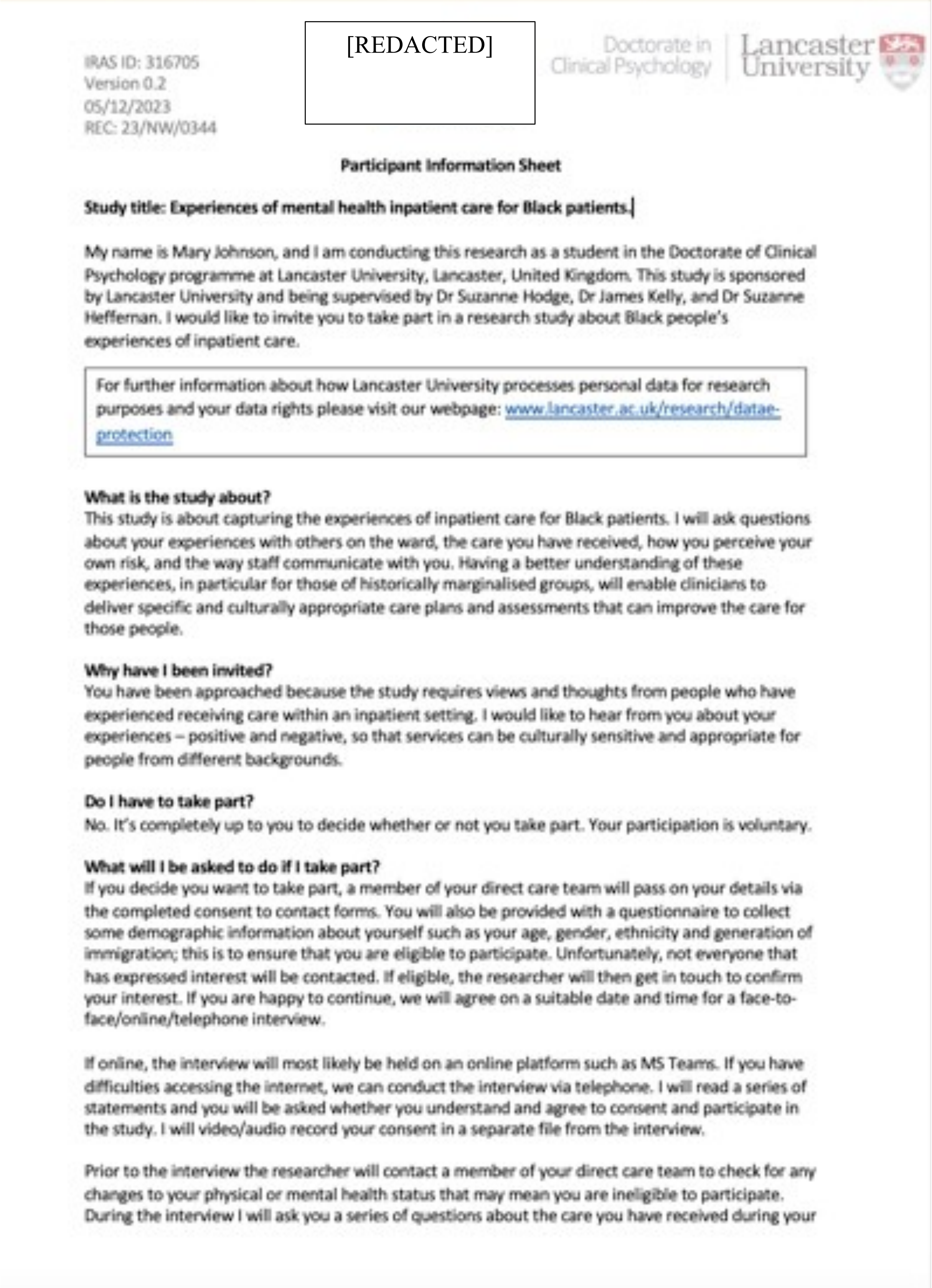
Ian Smith, Research Director of the Doctorate in Clinical Psychology
Tel: 01524 592282
Email: i.smith@lancaster.ac.uk
Division of Health Research
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin, Chair of FHM REC
Tel: +44 (0)1524 594973
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Appendix 4-F

Participant Information Sheet



IRAS ID: 316705
Version 0.2
05/12/2023
REC: 23/NW/0344

[REDACTED]

Doctorate in Clinical Psychology | Lancaster University

Participant Information Sheet

Study title: Experiences of mental health inpatient care for Black patients.

My name is Mary Johnson, and I am conducting this research as a student in the Doctorate of Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom. This study is sponsored by Lancaster University and being supervised by Dr Suzanne Hodge, Dr James Kelly, and Dr Suzanne Heffernan. I would like to invite you to take part in a research study about Black people's experiences of inpatient care.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/datae-protection

What is the study about?
This study is about capturing the experiences of inpatient care for Black patients. I will ask questions about your experiences with others on the ward, the care you have received, how you perceive your own risk, and the way staff communicate with you. Having a better understanding of these experiences, in particular for those of historically marginalised groups, will enable clinicians to deliver specific and culturally appropriate care plans and assessments that can improve the care for those people.

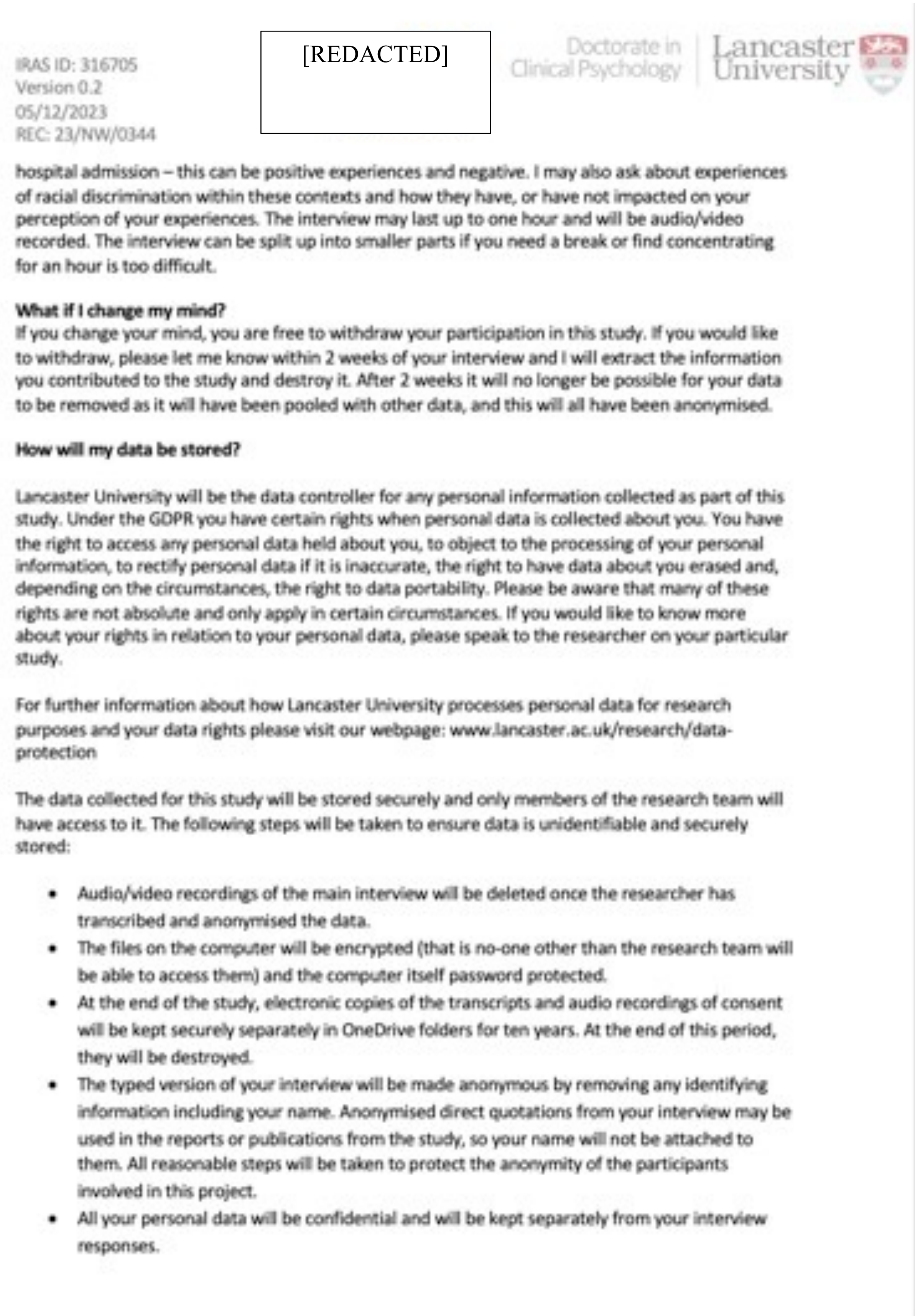
Why have I been invited?
You have been approached because the study requires views and thoughts from people who have experienced receiving care within an inpatient setting. I would like to hear from you about your experiences – positive and negative, so that services can be culturally sensitive and appropriate for people from different backgrounds.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part. Your participation is voluntary.

What will I be asked to do if I take part?
If you decide you want to take part, a member of your direct care team will pass on your details via the completed consent to contact forms. You will also be provided with a questionnaire to collect some demographic information about yourself such as your age, gender, ethnicity and generation of immigration; this is to ensure that you are eligible to participate. Unfortunately, not everyone that has expressed interest will be contacted. If eligible, the researcher will then get in touch to confirm your interest. If you are happy to continue, we will agree on a suitable date and time for a face-to-face/online/telephone interview.

If online, the interview will most likely be held on an online platform such as MS Teams. If you have difficulties accessing the internet, we can conduct the interview via telephone. I will read a series of statements and you will be asked whether you understand and agree to consent and participate in the study. I will video/audio record your consent in a separate file from the interview.

Prior to the interview the researcher will contact a member of your direct care team to check for any changes to your physical or mental health status that may mean you are ineligible to participate. During the interview I will ask you a series of questions about the care you have received during your



IRAS ID: 316705
Version 0.2
05/12/2023
REC: 23/NW/0344

[REDACTED]

hospital admission – this can be positive experiences and negative. I may also ask about experiences of racial discrimination within these contexts and how they have, or have not impacted on your perception of your experiences. The interview may last up to one hour and will be audio/video recorded. The interview can be split up into smaller parts if you need a break or find concentrating for an hour is too difficult.

What if I change my mind?
If you change your mind, you are free to withdraw your participation in this study. If you would like to withdraw, please let me know within 2 weeks of your interview and I will extract the information you contributed to the study and destroy it. After 2 weeks it will no longer be possible for your data to be removed as it will have been pooled with other data, and this will all have been anonymised.

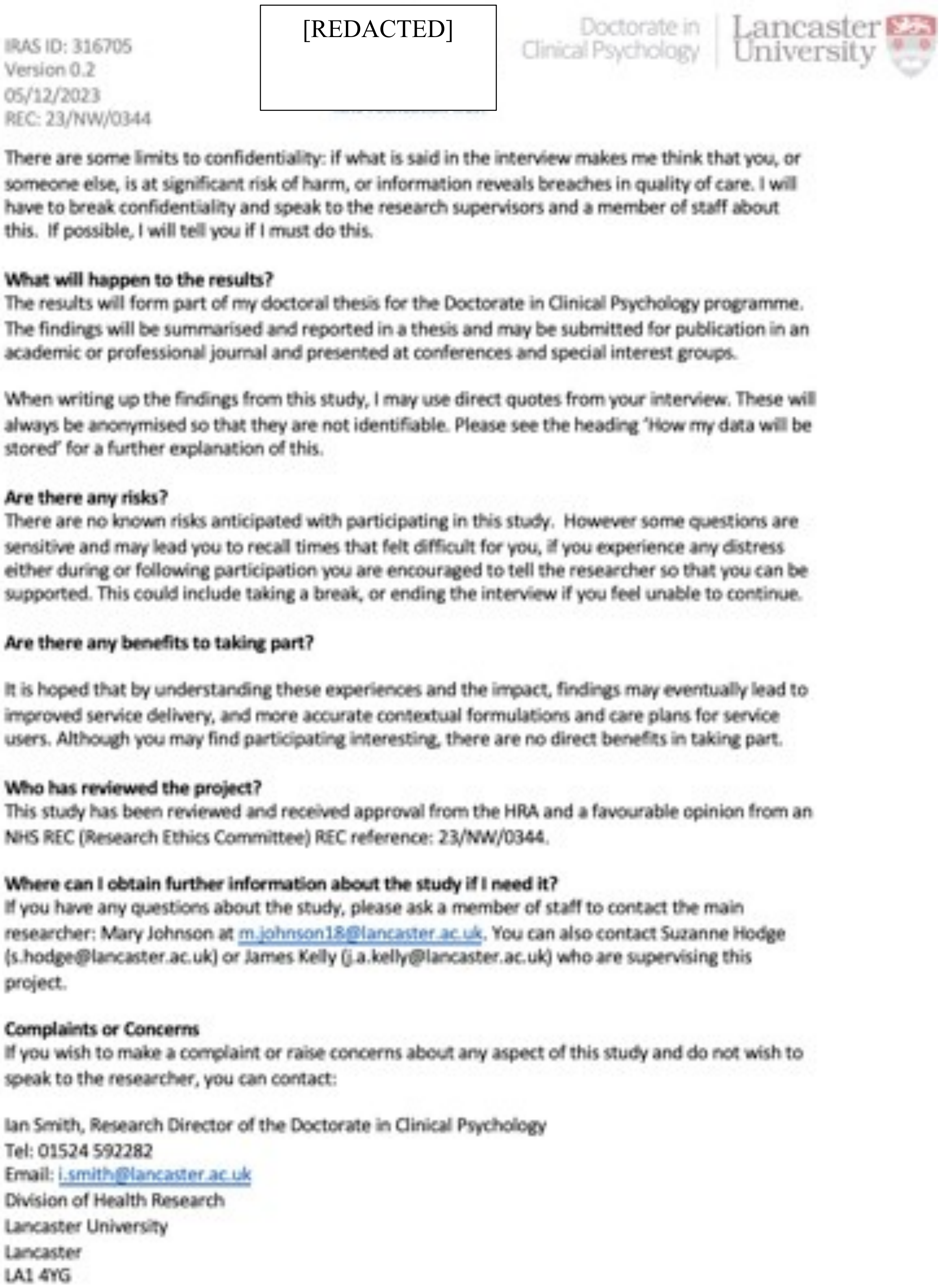
How will my data be stored?

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

The data collected for this study will be stored securely and only members of the research team will have access to it. The following steps will be taken to ensure data is unidentifiable and securely stored:

- Audio/video recordings of the main interview will be deleted once the researcher has transcribed and anonymised the data.
- The files on the computer will be encrypted (that is no-one other than the research team will be able to access them) and the computer itself password protected.
- At the end of the study, electronic copies of the transcripts and audio recordings of consent will be kept securely separately in OneDrive folders for ten years. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.



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05/12/2023
REC: 23/NW/0344

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There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, or information reveals breaches in quality of care. I will have to break confidentiality and speak to the research supervisors and a member of staff about this. If possible, I will tell you if I must do this.

What will happen to the results?
The results will form part of my doctoral thesis for the Doctorate in Clinical Psychology programme. The findings will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal and presented at conferences and special interest groups.

When writing up the findings from this study, I may use direct quotes from your interview. These will always be anonymised so that they are not identifiable. Please see the heading 'How my data will be stored' for a further explanation of this.

Are there any risks?
There are no known risks anticipated with participating in this study. However some questions are sensitive and may lead you to recall times that felt difficult for you, if you experience any distress either during or following participation you are encouraged to tell the researcher so that you can be supported. This could include taking a break, or ending the interview if you feel unable to continue.

Are there any benefits to taking part?

It is hoped that by understanding these experiences and the impact, findings may eventually lead to improved service delivery, and more accurate contextual formulations and care plans for service users. Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?
This study has been reviewed and received approval from the HRA and a favourable opinion from an NHS REC (Research Ethics Committee) REC reference: 23/NW/0344.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please ask a member of staff to contact the main researcher: Mary Johnson at m.johnson18@lancaster.ac.uk. You can also contact Suzanne Hodge (s.hodge@lancaster.ac.uk) or James Kelly (j.a.kelly@lancaster.ac.uk) who are supervising this project.

Complaints or Concerns
If you wish to make a complaint or raise concerns about any aspect of this study and do not wish to speak to the researcher, you can contact:

Ian Smith, Research Director of the Doctorate in Clinical Psychology
Tel: 01524 592282
Email: i.smith@lancaster.ac.uk
Division of Health Research
Lancaster University
Lancaster
LA1 4YG

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REC: 23/NW/0344

[REDACTED]

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Clinical Psychology
Lancaster
University

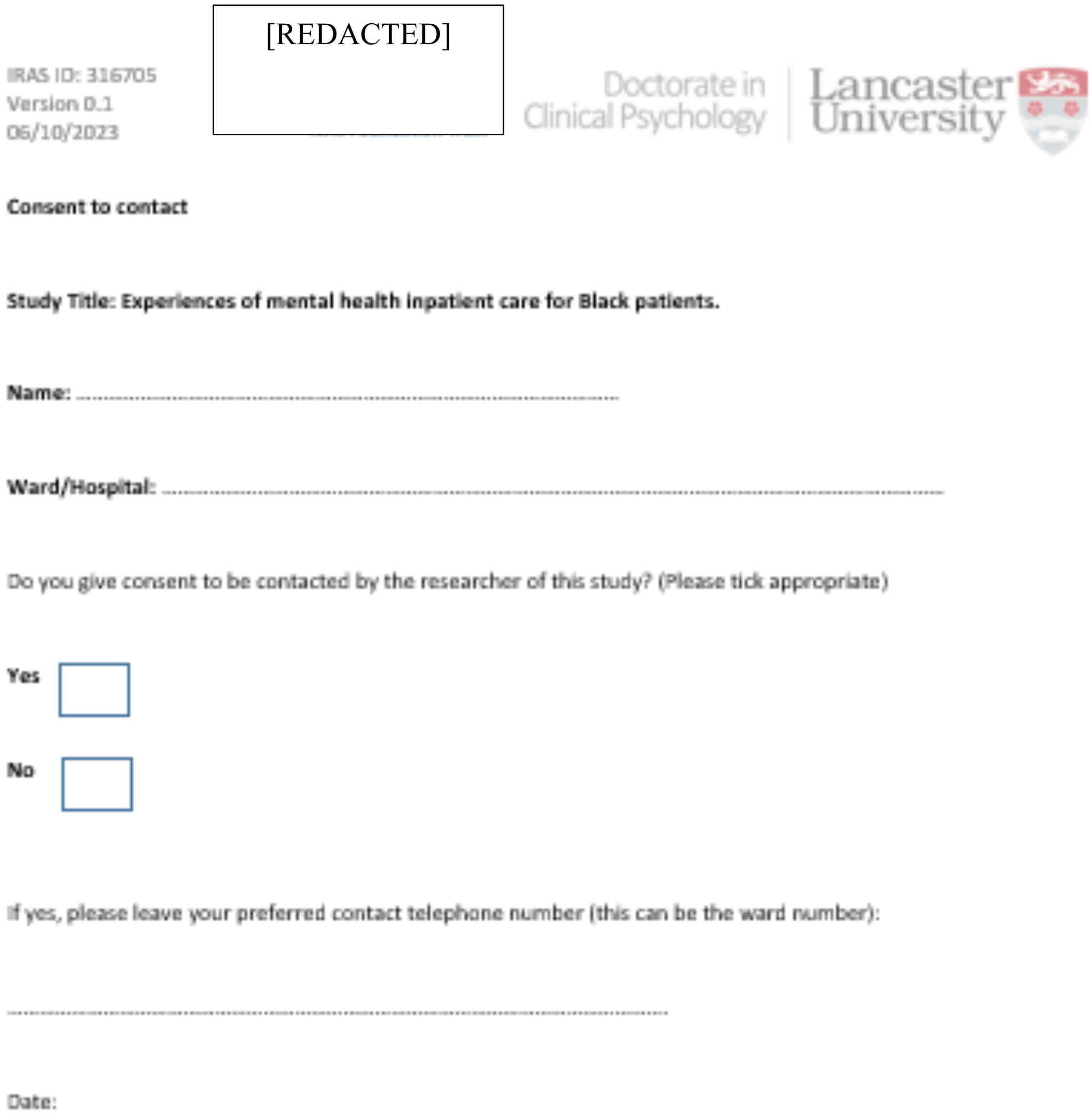
If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Dr Laura Machin, Chair of FHM REC
Tel: +44 (0)1524 594973
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for your consideration to participate in this project.

Appendix 4-G

Consent to Contact Form



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Version 0.1
06/10/2023

Doctorate in Clinical Psychology | Lancaster University

Consent to contact

Study Title: Experiences of mental health inpatient care for Black patients.

Name: ……………………………………………………………………………………

Ward/Hospital: ………

Do you give consent to be contacted by the researcher of this study? (Please tick appropriate)

Yes ☐

No ☐

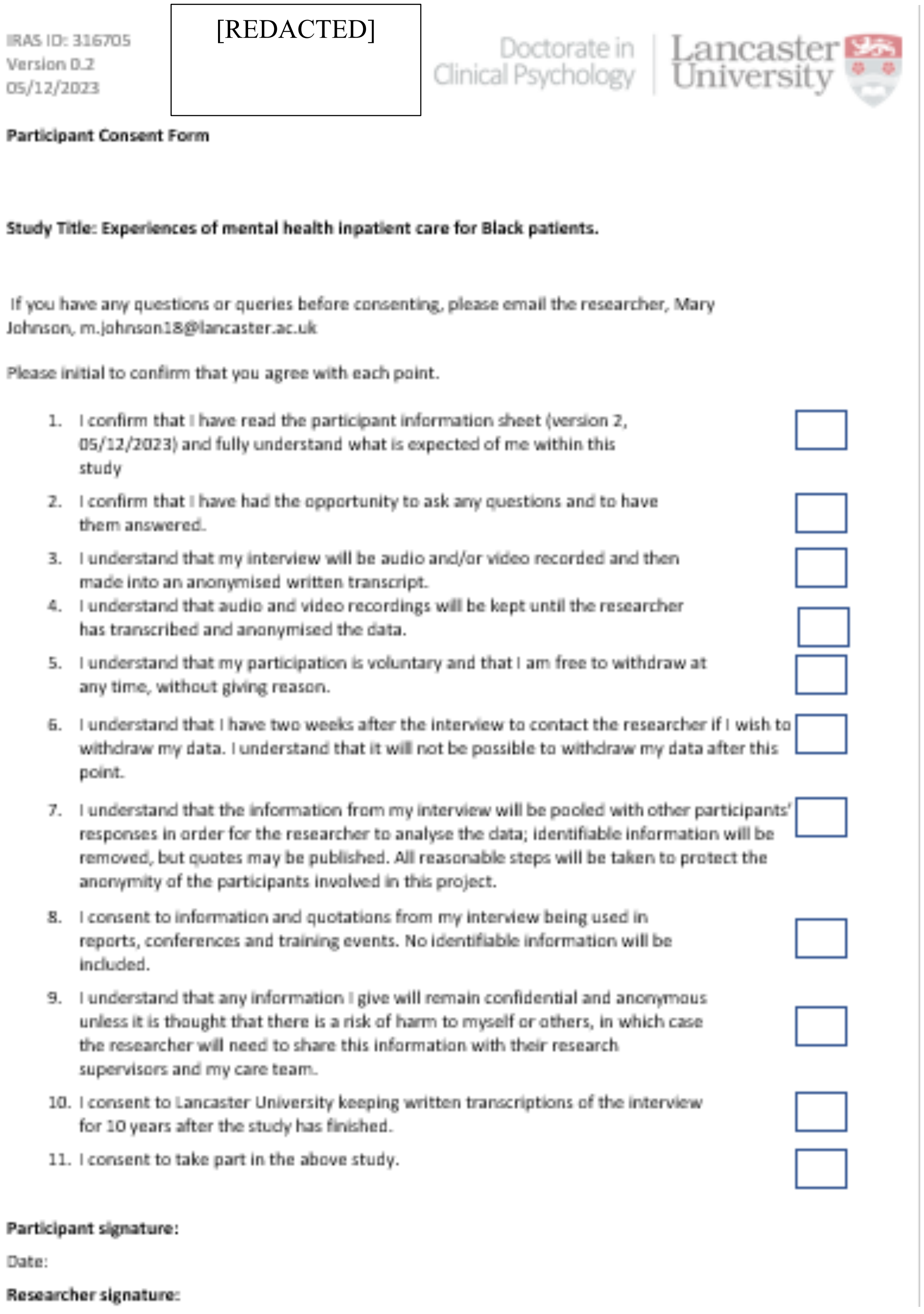
If yes, please leave your preferred contact telephone number (this can be the ward number):

……………………………………………………………………………………………

Date:

Appendix 4-H

Participant Consent Form



IRAS ID: 316705
Version 0.2
05/12/2023

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Doctorate in Clinical Psychology
Lancaster University

Participant Consent Form

Study Title: Experiences of mental health inpatient care for Black patients.

If you have any questions or queries before consenting, please email the researcher, Mary Johnson, m.johnson18@lancaster.ac.uk

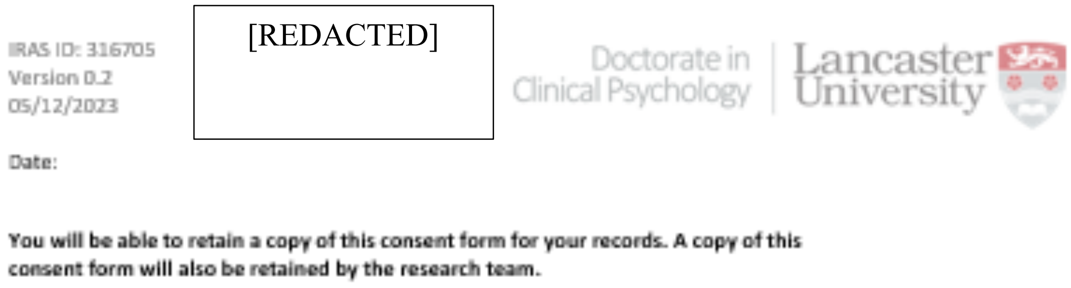
Please initial to confirm that you agree with each point.

1. I confirm that I have read the participant information sheet (version 2, 05/12/2023) and fully understand what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio and/or video recorded and then made into an anonymised written transcript. ☐
4. I understand that audio and video recordings will be kept until the researcher has transcribed and anonymised the data. ☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐
6. I understand that I have two weeks after the interview to contact the researcher if I wish to withdraw my data. I understand that it will not be possible to withdraw my data after this point. ☐
7. I understand that the information from my interview will be pooled with other participants' responses in order for the researcher to analyse the data; identifiable information will be removed, but quotes may be published. All reasonable steps will be taken to protect the anonymity of the participants involved in this project. ☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events. No identifiable information will be included. ☐
9. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researcher will need to share this information with their research supervisors and my care team. ☐
10. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐
11. I consent to take part in the above study. ☐

Participant signature:

Date:

Researcher signature:



IRAS ID: 316705
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05/12/2023

[REDACTED]

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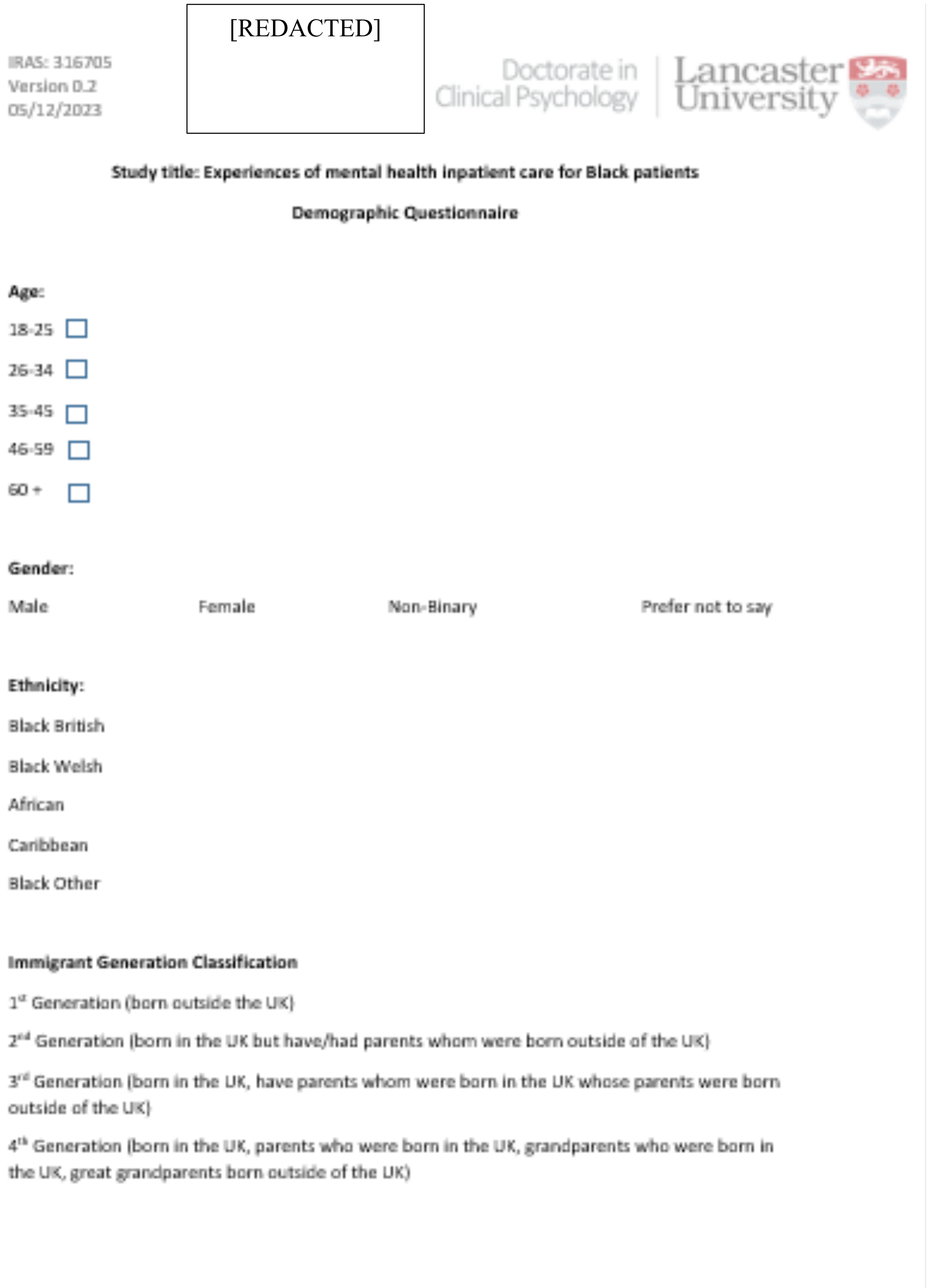
Date:

You will be able to retain a copy of this consent form for your records. A copy of this consent form will also be retained by the research team.

Appendix 4-I

Demographic Questionnaire



IRAS: 316705
Version 0.2
05/12/2023

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Doctorate in Clinical Psychology | Lancaster University

Study title: Experiences of mental health inpatient care for Black patients

Demographic Questionnaire

Age:

18-25 ☐

26-34 ☐

35-45 ☐

46-59 ☐

60 + ☐

Gender:

Male	Female	Non-Binary	Prefer not to say

Ethnicity:

Black British

Black Welsh

African

Caribbean

Black Other

Immigrant Generation Classification

1st Generation (born outside the UK)

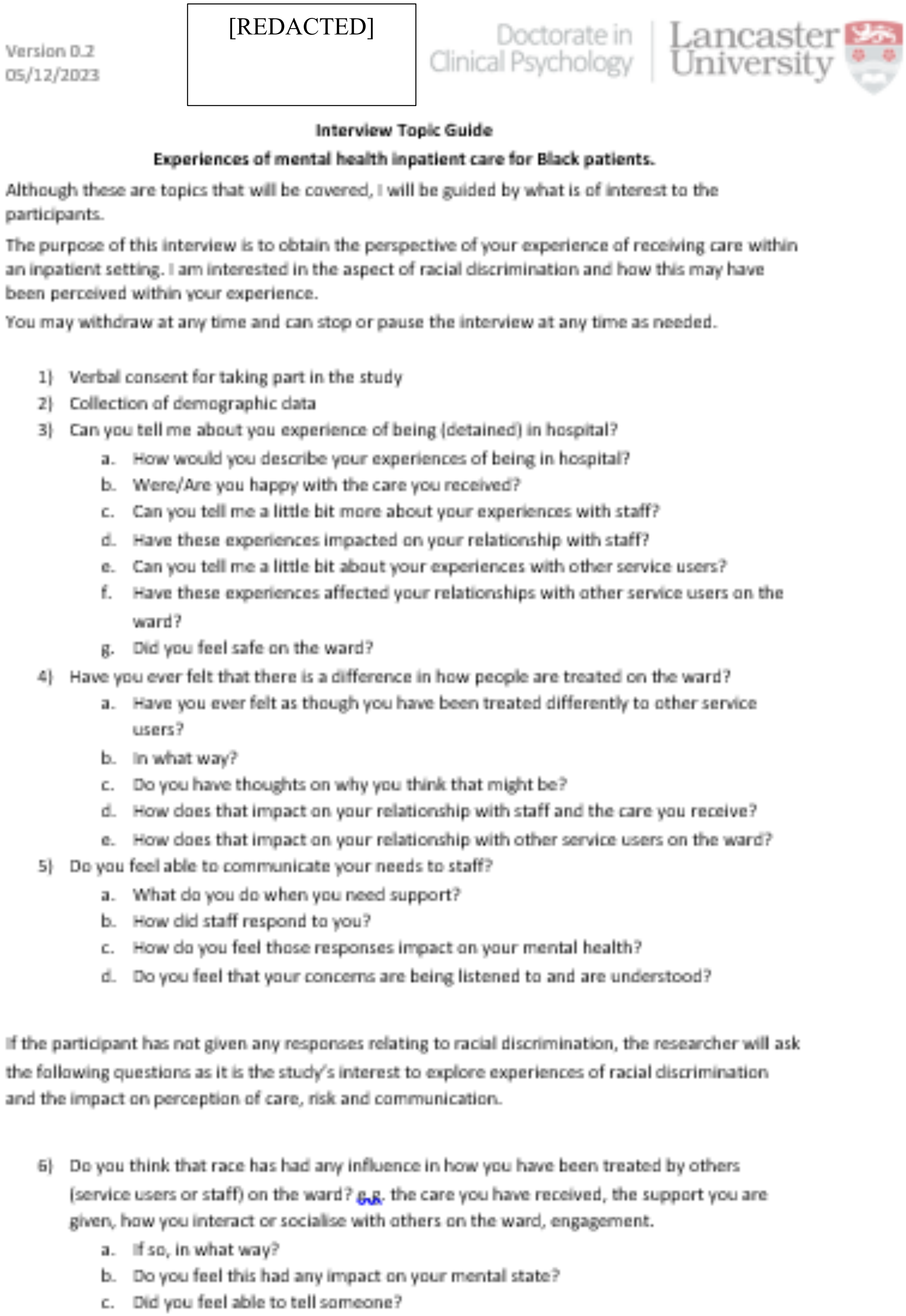
2nd Generation (born in the UK but have/had parents whom were born outside of the UK)

3rd Generation (born in the UK, have parents whom were born in the UK whose parents were born outside of the UK)

4th Generation (born in the UK, parents who were born in the UK, grandparents who were born in the UK, great grandparents born outside of the UK)

Appendix 4-J

Interview Topic Guide



Version 0.2
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Interview Topic Guide

Experiences of mental health inpatient care for Black patients.

Although these are topics that will be covered, I will be guided by what is of interest to the participants.

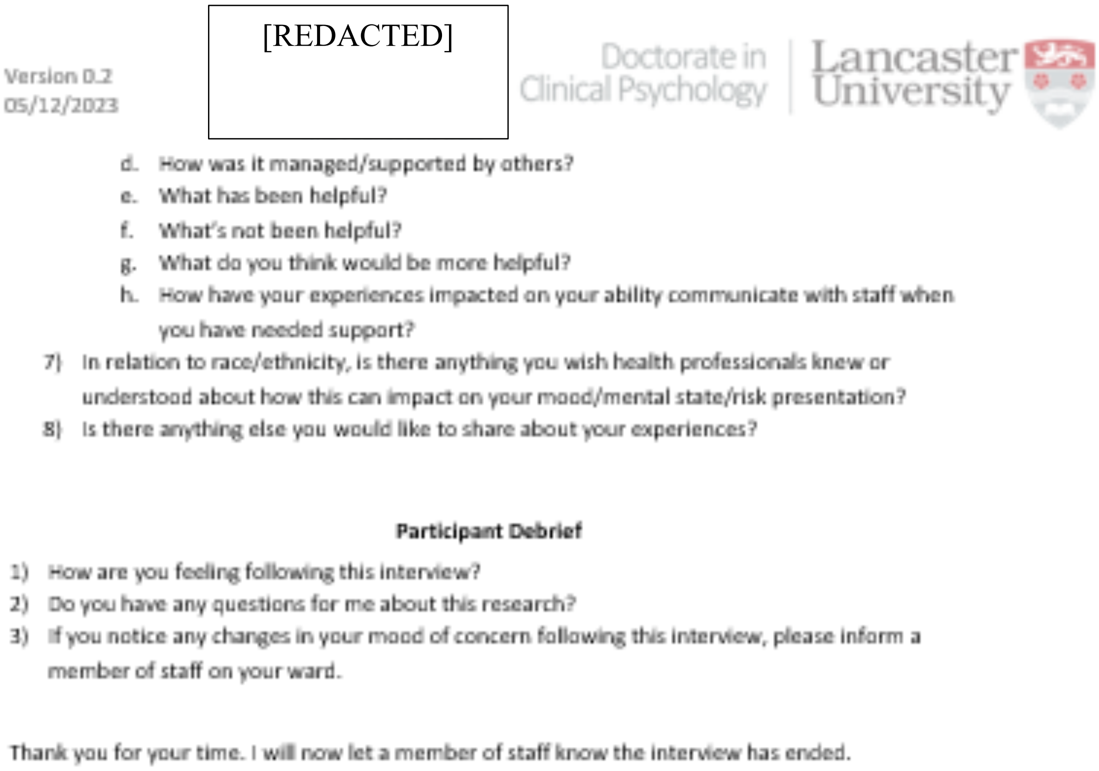
The purpose of this interview is to obtain the perspective of your experience of receiving care within an inpatient setting. I am interested in the aspect of racial discrimination and how this may have been perceived within your experience.

You may withdraw at any time and can stop or pause the interview at any time as needed.

1) Verbal consent for taking part in the study
2) Collection of demographic data
3) Can you tell me about you experience of being (detained) in hospital?
    a. How would you describe your experiences of being in hospital?
    b. Were/Are you happy with the care you received?
    c. Can you tell me a little bit more about your experiences with staff?
    d. Have these experiences impacted on your relationship with staff?
    e. Can you tell me a little bit about your experiences with other service users?
    f. Have these experiences affected your relationships with other service users on the ward?
    g. Did you feel safe on the ward?
4) Have you ever felt that there is a difference in how people are treated on the ward?
    a. Have you ever felt as though you have been treated differently to other service users?
    b. In what way?
    c. Do you have thoughts on why you think that might be?
    d. How does that impact on your relationship with staff and the care you receive?
    e. How does that impact on your relationship with other service users on the ward?
5) Do you feel able to communicate your needs to staff?
    a. What do you do when you need support?
    b. How did staff respond to you?
    c. How do you feel those responses impact on your mental health?
    d. Do you feel that your concerns are being listened to and are understood?

If the participant has not given any responses relating to racial discrimination, the researcher will ask the following questions as it is the study's interest to explore experiences of racial discrimination and the impact on perception of care, risk and communication.

6) Do you think that race has had any influence in how you have been treated by others (service users or staff) on the ward? e.g. the care you have received, the support you are given, how you interact or socialise with others on the ward, engagement.
    a. If so, in what way?
    b. Do you feel this had any impact on your mental state?
    c. Did you feel able to tell someone?



Version 0.2
05/12/2023

[REDACTED]

Doctorate in Clinical Psychology

Lancaster University

   d. How was it managed/supported by others?
   e. What has been helpful?
   f. What's not been helpful?
   g. What do you think would be more helpful?
   h. How have your experiences impacted on your ability communicate with staff when you have needed support?

7) In relation to race/ethnicity, is there anything you wish health professionals knew or understood about how this can impact on your mood/mental state/risk presentation?
8) Is there anything else you would like to share about your experiences?

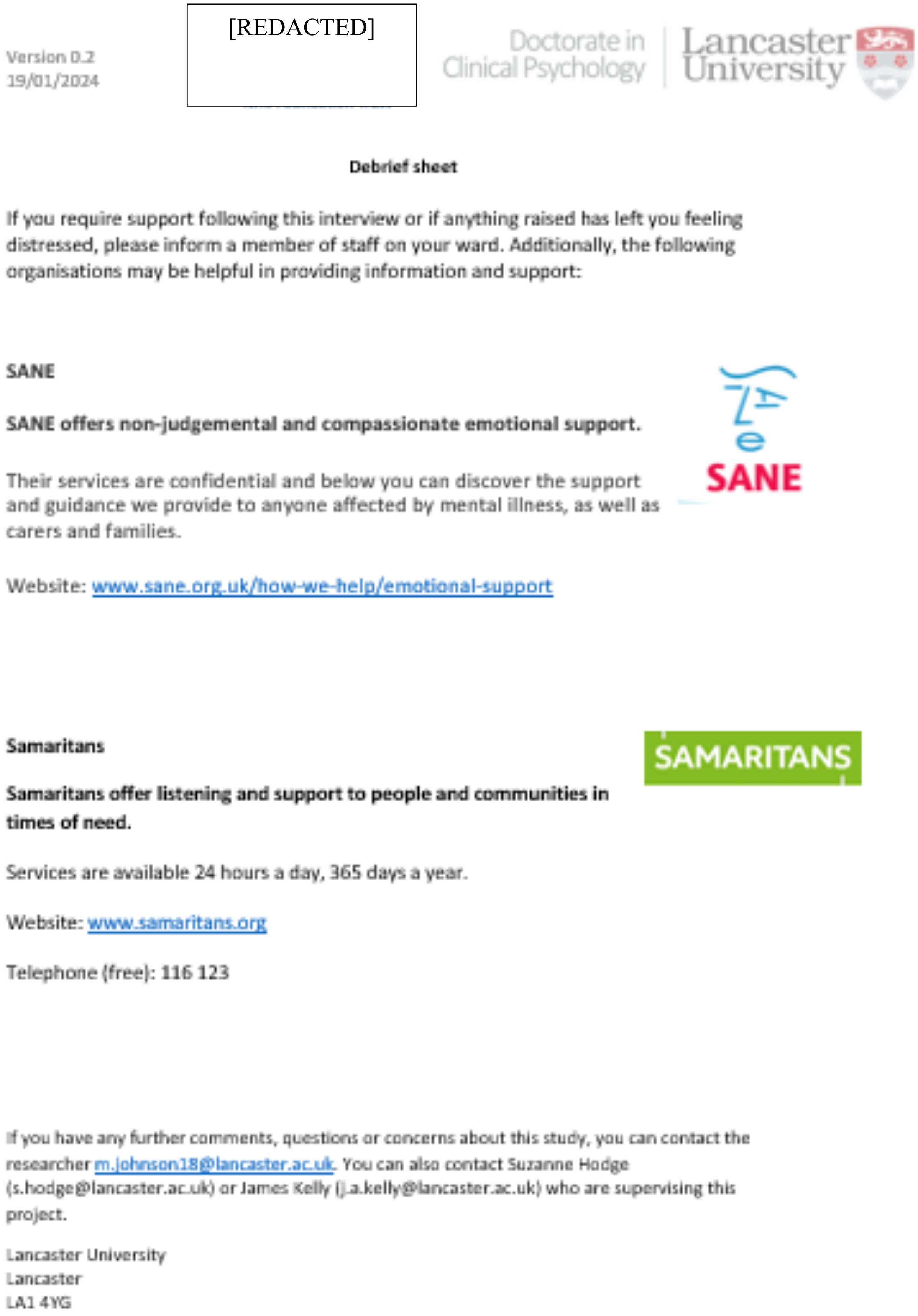
Participant Debrief

1) How are you feeling following this interview?
2) Do you have any questions for me about this research?
3) If you notice any changes in your mood of concern following this interview, please inform a member of staff on your ward.

Thank you for your time. I will now let a member of staff know the interview has ended.

Appendix 4-K

Debrief Sheet



Version 0.2
19/01/2024

[REDACTED]

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Debrief sheet

If you require support following this interview or if anything raised has left you feeling distressed, please inform a member of staff on your ward. Additionally, the following organisations may be helpful in providing information and support:

SANE

SANE offers non-judgemental and compassionate emotional support.

SANE

Their services are confidential and below you can discover the support and guidance we provide to anyone affected by mental illness, as well as carers and families.

Website: www.sane.org.uk/how-we-help/emotional-support

Samaritans

SAMARITANS

Samaritans offer listening and support to people and communities in times of need.

Services are available 24 hours a day, 365 days a year.

Website: www.samaritans.org

Telephone (free): 116 123

If you have any further comments, questions or concerns about this study, you can contact the researcher m.johnson18@lancaster.ac.uk. You can also contact Suzanne Hodge (s.hodge@lancaster.ac.uk) or James Kelly (j.a.kelly@lancaster.ac.uk) who are supervising this project.

Lancaster University
Lancaster
LA1 4YG

Appendix 4-L

Recruitment Poster

Doctorate in Clinical Psychology | Lancaster University

RESEARCH OPPORTUNITY!

Have you had experience of inpatient care for mental health treatment in the last 10 years? Do you identify as Black British, Black African or Black Caribbean?

I WANT TO HEAR FROM YOU!

My name is Mary-maria Johnson, I am a Trainee Clinical Psychologist at Lancaster University, and I want to give you the opportunity to share you experiences of inpatient mental health treatment, as part of my research for training.

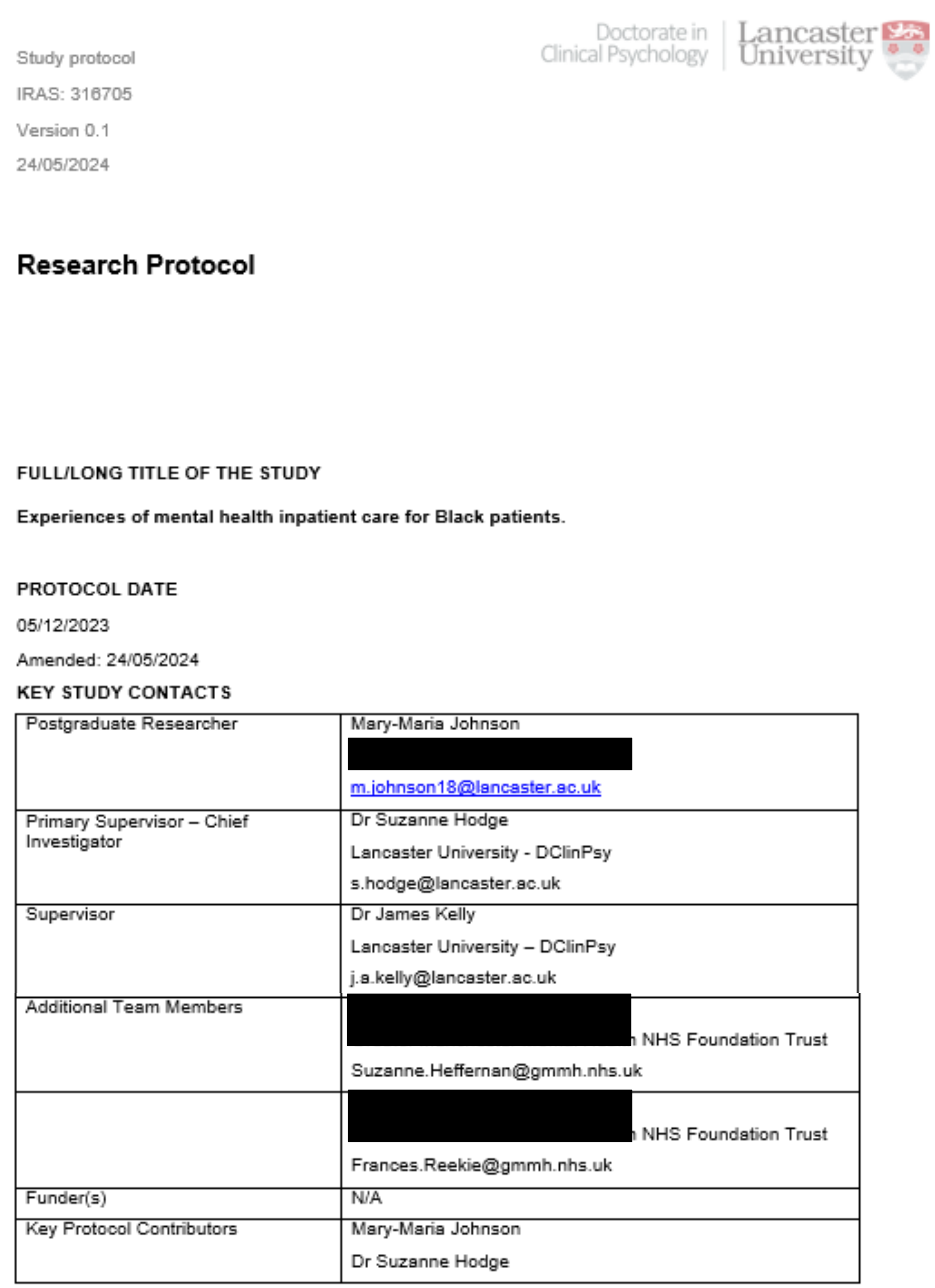
Participating in this research will involve completing a short questionnaire, and then an interview (up to one hour long) if you meet the inclusion criteria. Interviews can be held via Microsoft Teams or telephone.

If you would like to take part, please contact me on the email address below for further information and a copy of the screening questionnaire:

m.johnson18@lancaster.ac.uk

Appendix 4-M

Research Protocol



Study protocol

IRAS: 316705

Version 0.1

24/05/2024

Doctorate in Clinical Psychology | Lancaster University

Research Protocol

FULL/LONG TITLE OF THE STUDY

Experiences of mental health inpatient care for Black patients.

PROTOCOL DATE

05/12/2023

Amended: 24/05/2024

KEY STUDY CONTACTS

Postgraduate Researcher	Mary-Maria Johnson [redacted] m.johnson18@lancaster.ac.uk
Primary Supervisor – Chief Investigator	Dr Suzanne Hodge Lancaster University - DClinPsy s.hodge@lancaster.ac.uk
Supervisor	Dr James Kelly Lancaster University – DClinPsy j.a.kelly@lancaster.ac.uk
Additional Team Members	[redacted] NHS Foundation Trust Suzanne.Heffernan@gmmh.nhs.uk
	[redacted] NHS Foundation Trust Frances.Reekie@gmmh.nhs.uk
Funder(s)	N/A
Key Protocol Contributors	Mary-Maria Johnson Dr Suzanne Hodge

	Dr James Kelly

STUDY SUMMARY

Study Title	Experiences of mental health inpatient care for Black patients.
Internal ref. no. (or short title)	N/A
Study Design	Qualitative research using IPA / TA
Study Participants	Black patients who have experience of receiving care within an inpatient service to support the management of their risk. Patients can have been under a formal or informal hospital admission. I will recruit 6-10 participants aged 18 and over, there will be no maximum age limit for the people partaking. Participants will be asked questions relating to their experiences of care within an inpatient service, although the researcher has a specific interest in the impact of potential racial discrimination, to understand how this has impacted on their safety, care and communication with staff.
Planned Size of Sample (if applicable)	6-10
Follow up duration (if applicable)	N/A
Planned Study Period	2 years
Research Question/Aim(s)	Main question: What are the experiences of inpatient care for Black people and how are these affected by racial discrimination?

PROTOCOL CONTRIBUTORS

Mary-Maria Johnson, Postgraduate Researcher

Responsibilities: Study design, recruitment, data collection, data analysis and interpretation, manuscript writing, dissemination of results. Has the final decision on all aspects of the study.

Dr Suzanne Hodge and Dr James Kelly, Chief Investigators and Research Supervisors

Responsibilities: Supervise study design, data collection, data analysis and interpretation, manuscript writing, dissemination of results.

Dr Suzanne Heffernan, Field Advisor

Responsibilities: Provide consultation surrounding the study design, recruitment and dissemination of results.

KEY WORDS:	Racial discrimination, Black patients, BME, Black and minority ethnic, Risk, inpatient, care

STUDY PROTOCOL

Experiences of mental health inpatient care for Black patients

1 BACKGROUND/RATIONALE

Exploration into the experiences of detention for people of the global majority is sparse, however the research that is available has acknowledged that the experiences of these groups of people are unique (Solanki, 2020). Recent qualitative research by Solanki, 2020 concluded that the experience of detention for people of the global majority is racialised and racist. Research has identified that being subject to acts of discrimination such as racism, can lead to negative physical health and mental health outcomes (Ong et al., 2009; Sellers et al., 2006; Sellers & Shelton, 2003). The association between these poor outcomes and increased risk behaviours such as suicidal behaviour has also been well established within the literature; Walker et al. (2014) explicitly identified that perceived discrimination is related to increased suicide ideation in Black adults, and research since has noted that perceived discrimination is a moderator for increasing suicide capability in Black adults, and not white counterparts (Brooks, 2020). There remains a need to further explore the experiences of racial discrimination for different groups of people. Research exploring these culturally specific experiences and the nuances within discrimination, and how they relate to risk related behaviour, is minimal, and is predominantly quantitative. In addition, current research that has explored this topic has generally been conducted with populations in the United States (US).

There is a need to understand the nuances within the experience of racial discrimination to understand how they relate to a persons lived experience, and how this influences a person's experience of managing distress whilst using care services provided by the National Health Service (NHS). Little research has explored the perspective of those within inpatient settings. In order to further understand the specific relationship between perceived discrimination and the impact on an individual's distress and risk related behaviours, an exploration within a clinical inpatient setting should be conducted. This would allow researchers and clinicians to gain insight into how these experiences shape an individual's perspective of care, and the specific factors that influence their psychological states that increase or decrease risk related behaviours. Obtaining a richer understanding would allow researchers, clinicians and service users to collaborate to develop culturally specific interventions and effective strategies for risk management, in addition to informing policies for prevention.

Therefore, this study will aim to explore the experiences of psychiatric inpatient care for Black people with a particular focus on understanding the role of racial discrimination within these experiences.

Participants in the study will include people who are currently receiving psychiatric inpatient care – formally, or informally, due to their risk status. Participants will be asked about their experiences of being cared for within an inpatient setting. This is to capture their perspective of the interactions and understand how this may have impacted on their relationships with others on the ward, ability to communicate distress and seek support, and their level of risk. Within the interview participants will be asked whether they perceive their race to have influenced any of these aspects, in order for the researcher to gain some insight into the role of perceived racial discrimination.

Understanding patients' experiences of racial discrimination within inpatient settings could help to inform more trauma-informed and culturally sensitive care, formulations and interventions to reduce risk.

2 STUDY DESIGN / METHODOLOGICAL FRAMEWORK

This research will use a phenomenological methodological approach to analyse data from interviews with Black patients, who have experienced racial discrimination - current or previously, and have experiences of receiving support for distress and risk related behaviours in inpatient services. Interview questions will be designed to understand the experience of inpatient care and establish whether racial discrimination has impacted those experiences. This approach will allow us to explore the ways in which people make sense of the relationships between experiences of racial discrimination, their distress, risk related behaviour and support from services.

3 RESEARCH QUESTION/AIM(S)

The research aims to understand the experiences of inpatient care for people Black patients, with a particular interest in understanding how experiences of racial discrimination impact on the individual's level of risk to self or others.

Main question: What are the experiences of inpatient care for Black patients and how are these affected by racial discrimination?

3.1 Objectives

The study objectives are as follows: 1) to explore the experiences of inpatient care for Black patients; 2) To understand the impact of racial discrimination within experiences of inpatient care.

4 STUDY SETTING

Community or Inpatient setting(s). Services that are, or have been accessed for individuals who have been detained under the Mental Health Act (MHA) or admitted informally, due to the severity of their risk presentation where there is concern regarding their safety or the safety of the public.

5 SAMPLE AND RECRUITMENT

5.1 Participants

Participants will be recruited by purposive sampling from NHS trusts that have been approved to be used as recruitment sites.

OR

Participants will be recruited by opportunistic sampling from the general public via advertisement on social media.

5.2.1 Size of sample

Considering the scope and timeline of the DClinPsy, the researcher will recruit up to 10 participants to ensure the researcher sources a range of narratives but is still able to undertake a thorough inductive analysis.

5.1.2 Inclusion criteria

- Any gender identity aged 18 years and over.
- Participants must have experience of receiving care within an inpatient setting within the past 10 years, this can be informal or formal detention under the MHA, past or current.
- Participants must be of Black British, Black Welsh, African or Caribbean ethnicity demographic
- Research participants can be of any socio-economic grouping
- English speaking to conversational ability, and able to communicate via video call/telephone if required.

5.1.3 Exclusion criteria

Individuals who do not speak English or have endured organic brain damage.

Individuals detained in CAMHS, LD, or forensic wards, due to additional medical and legal factors associated with these populations (Solanki, 2020)

Individuals under the influence of any drugs or alcohol at the time of interview.

There are no diagnosis exclusions however individuals who are actively experiencing acute levels of psychosis would not be appropriate for participation in the study.

For participants that have been recruited from an approved NHS recruitment site, the researcher will contact a member of the participants direct care team to confirm no changes to physical health or mental health status prior to interviewing.

5.2 Recruitment & Sample Identification

The researcher will be adopting a staged approach to recruitment.

Stage 1: Recruiting from [redacted] Trust

Stage 2: If the minimum sample is not recruited within 1 month, the researcher will widen to other inpatient units in [redacted]

Stage 3: The researcher will recruit from the general public via advertisement on social media.

For stage 1 & 2: Researcher will provide staff with an information sheet about the research project, with the possibility of additionally attending a staff meeting to discuss the research. Ward staff will raise the opportunity to participate in the research during their community meetings to raise awareness of the study to potential participants.

Potential participants will initially be identified by the MDT or a member of staff from the ward if they fit the eligibility criteria. This member of staff will be an individual that already works with the potential participant. Factors such as mental state of the individual; current level of risk; capacity to provide consent and understanding will be assessed prior to introducing the study with the individual by the care team as part of their usual working activity. A recruitment pack will be given to the participant which contains the participant information sheet, consent to be contacted form, and the demographic questionnaire. If the participant consents to being contacted then they will be contacted by the lead researcher to provide more information regarding the study and invited to partake in an interview. Prior to the interview the researcher will contact a member of the participants direct care team to check for any changes in physical health or mental health status to ensure the participant is appropriate to participate. If a participant is discharged following providing consent to be contacted but prior to the interview date, they will be offered to continue participation via stage 3 recruitment.

For stage 3: Participants will email the researcher on the address given on the research advertisement poster. Following contact from a potential participant, the researcher will respond and provide the participant with the recruitment pack which will include the participant information sheet, consent to and demographic questionnaire to complete. Once this has been returned, if the participant remains eligible according to the information they have stated in the questionnaire, an interview date and time will be scheduled.

5.2.1 Consent

For stage 1 & 2, Consent to contact forms will be included within the recruitment pack and will need be forwarded to the research team for the researcher to then contact the participant to discuss the study further. The participant will have a two week timeframe to consent to being contacted by the researcher, once they have received the form. There will be at least 24 hours from consenting to be contacted before the researcher attempts to make contact.

For stage 3: Consent will be captured verbally prior to commencing the interview.

Following contact by the researcher, the potential participant will be given a minimum of 24 hours to process all the information about the study provided in the participant information sheet, consider and decide whether they consent to participate. The consent form will be given to the participant prior to commencing the interview. For any virtual interviews, verbal consent will be sought prior to commencing the interview; the researcher will use the audio consent form, and consent will be recorded separately to the interview. There will also be opportunities to ask questions both before and after the interview. Before the interview, the participant will be asked if they understand what they will be asked to do and that they are able to stop at any time and how data will be confidential.

Participants will have two weeks to withdraw from the study, at which time the data will have been anonymised and the researcher will begin data analysis. Prior to this, if participants wish to withdraw, this will be permitted and all of their data up to that point will be destroyed.

6 DATA COLLECTION AND DATA ANALYSIS

Data collection: A qualitative semi-structured face-to-face interview lasting up to 1 hour will be conducted with the participant. Online or telephone interviews may be offered if this is more suitable for the participant and service needs.

Interviews will be video/audio recorded and stored on a password-protected laptop, immediately transferred to the Postgraduate Researcher's secure, private Lancaster University OneDrive and removed from the laptop. Recordings will be transcribed by the researcher, anonymised by removing names and other identifying information and saved in a separate OneDrive folder from the recordings.

Data analysis: The researcher will analyse my data using IPA methodology to develop themes from the interview transcriptions of the participants.

Data storage: Personal data and identifying information within the transcriptions will be anonymised. Only the Postgraduate Researcher and research supervisor will have access to demographic information, consent forms, recordings and transcriptions, and these will be kept on the Postgraduate Researcher's secure Lancaster University OneDrive during data collection. Data will be kept for 10 years by the DClinPsy research co-ordinator upon completion, at which point it will be securely destroyed.

7 END OF STUDY

The end of the study is defined as fulfilling the required number of participants, or where the minimum number of participants have been gathered and there are no further potential participants.

8 ETHICAL AND REGULATORY CONSIDERATIONS

8.1 Assessment and management of risk

It is possible that taking part in the study and discussing potentially traumatic experiences of racial discrimination may cause distress for the participant. To manage this, a risk protocol will be used that has been created to assess and manage distress during the study (Appendix 1.). This will discuss ways to support the participant during the study and to help consider whether the participant is able to continue with the study. Following the interview, participants will also be provided with a debrief sheet detailing helplines they can contact if they are experiencing distress or changes in their mood of concern.

For stages 1 & 2: It is also possible that the researcher may become aware of new risk information during the process of the interview that may not be known to the existing clinical team working with the individual. The researcher will inform a member of the participants direct care team of any disclosed information relating to risk so that they can note whether information disclosed aligns with historical information or requires updating of risk information and/or further action. The researcher will use their clinical judgement in the selection of each participant, to ensure they are not at immediate risk of harm to themselves and/or others. If new risk information or information that is indicative of breaches in quality of care, is shared within a contact between the researcher and the participant, permission will be sought from the participant to share this information with their care team. If the participant refuses permission, the researcher will then explain that the confidentiality agreement needs to be broken to ensure the safety of the participant and/or others, and that the information relating to the risk or breach in quality of care, will be shared with the clinical team. Information will be shared in a debrief session that will occur following every contact.

For stage 3: Participants' names, address and date of birth will be taken for the duration of the interview. If imminent risk is indicated, the researcher will act on indications and contact the emergency services to conduct a welfare check. Following the interview, these details will be permanently deleted.

The researcher will also have supervision with the research supervisors regularly throughout the process which will serve as another forum to raise any concerns from interviewing where it may be felt that safeguarding would need to be raised.

8.2 Research Ethics Committee (REC) and other Regulatory review & reports

- Before the start of the study, a favourable opinion will be sought from an NHS REC for the study protocol, informed consent forms and other relevant documents e.g. advertisements. Approval from participating NHS trusts will also be sought via the HRA IRAS system.
- All correspondence with the REC will be retained until the end of the study.
- The Chief Investigator will notify the REC of the end of the study.
- If the study is ended prematurely, the Chief Investigator will notify the REC, including the reasons for the premature termination.

8.3 Peer review

The study was reviewed and approved by independent members of the Lancaster University Doctorate in Clinical Psychology research team. The study was discussed and developed in supervision with the research supervisor and in consultation with a field advisor following an initial scoping review of the literature base that was conducted to further inform the design of the study.

8.4 Patient & Public Involvement

Service user involvement has not been obtained at this time due to the limited nature of the thesis study, however the researcher is consulting with a community mental health organisation to resource service user involvement in the process of disseminating the information. The researcher has sought consultation of the topic guide from another health professional outside of the research team. This health professional is an advocate and facilitates support groups for staff that identify as BAME. Furthermore, the supervisors involved in this project have experience and knowledge of working with inpatients, and have advised on the production and undertaking of this study.

8.6 Data protection and patient confidentiality

The study is compliant with the requirements of the Data Protection Act 1998 and all investigators will comply with the requirements of the Data Protection Act 1998 with regards to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles.

8.7 Indemnity

Lancaster University legal liability cover and NHS professional indemnity cover will apply.

8.8 Data management and access

Only the Postgraduate Researcher and research supervisors will have access to the full final dataset. Data will be transferred to the DClinPsy programme research co-ordinator at the end of the study and will be kept for 10 years in OneDrive. It is not envisaged that the dataset will be used for secondary data analysis.

8.9 Dissemination policy

The research supervisor acts as the custodian for data throughout the life of the project. The dataset will not be made publicly available and cannot be requested by participants.

The findings of the research study will be written up in the research doctoral thesis and will be submitted for publication in a suitable academic journal.

9 AUTHORSHIP

Authorship eligibility guidelines and any intended use of professional writers

The Postgraduate researcher will be first author and the research supervisors – Dr Suzanne Hodge and Dr James Kelly will be second and last author, order yet to be decided. The field supervisor(s) will come after the second author and before the last.

10 REFERENCES

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Appendix 1.

Distress Risk Protocol

The following steps will be taken in the event that a participant demonstrates behaviour or discloses information to the researcher indicative of high levels of emotional distress during the interview.

Stage 1

Proactive Measures

- For stage 1 & 2: In advance the researcher will communicate to the ward staff when interviews are scheduled to take place.
- For stage 3: Participants' names, address and date of birth will have been taken prior to the interview. If imminent risk is indicated, the researcher will act on indications and contact the emergency services to conduct a welfare check. These details will be deleted after the interview.
- Prior to commencement of interview, the participant will be encouraged to inform the researcher if, at any point during the interview, they are experiencing significant distress and need support.
- Participants will be informed before starting the interview if anything raised is difficult for them, it's OK to stop the interview and take a break. They will also be advised that it is up to them how much information they provide, and that it's OK to not answer any question that makes them feel uncomfortable.

Distress

- A participant indicates in the interview that they are experiencing a high level of stress or emotional distress
  OR
- A participant is exhibiting behaviours suggestive that the discussion during the interview is too stressful, e.g., uncontrolled crying, risk related behaviours, shaking etc.

Stage 2

Response

- The participant will be given the option to take a break from the interview, or to end the interview.
- A member of staff on the ward will be informed that the participant is exhibiting behaviours indicating, or expressed high levels of emotional distress.

Review

- If participant feels able to carry on, resume the interview.
  OR
- If participant is unable to carry on, go to stage 3.

Stage 3

Response

- Thank the participant for their contribution and inform them that the interview will be discontinued.
- Inform a member of staff on the ward that the interview has been terminated and provide a brief description of the presentation observed.