Survival and Resilience: Ethnic Minority Narratives of Navigating Mental Health and Criminal Justice Systems

Shaquilla Tiana Komani Linton

University Of East Anglia (UEA)

Doctorate In Clinical Psychology

Faculty of Medicine and Health Sciences

Candidate Registration Number: 100413557/1

Submission Date: 18th March 2025

Primary Supervisor: Dr Bonnie Teague

Secondary Supervisor: Dr Sheri Oduola

Thesis Portfolio Word Count (excluding tables, figures and appendices): 34,386

Portfolio Abstract

Background

Mental health inequities are commonly experienced by people from an ethnic minoritised background in western contexts. Ethnic minority people are more likely to be given a diagnosis of a severe mental illness (SMI). Black people, especially Black men, are likely to enter mental healthcare through the pathway of the Criminal Justice System (CJS), which are reported to be discriminatory and non-therapeutic environments, potentially exacerbating psychological distress leading to poor mental health outcomes. However, the perspectives of these mental health inequities and experiences have rarely been voiced by the ethnic minority people experiencing them.

Methods

A qualitative systematic review of 20 papers using narrative synthesis was conducted to understand the perspectives and experiences of personal recovery outcomes for ethnic minority people with SMI. Empirical research conducted with six Black men using semi-structured interviews was used to investigate their experiences of accessing mental health services (MHS), through the CJS. The interviews were analysed using a narrative inquiry approach.

Findings

The systematic review revealed three themes: *i) The Family as a Supportive and Obstructive System; ii) Faith as the Foundation for Hopefulness and iii) Discovering Identity through Agency and Social Interactions*. These themes included the facilitators and barriers of personal recovery for ethnic minority people with SMI. In the empirical paper the following four themes emerged from the Black men's narratives: *The Perfect Storm* (life adversity), *Surveillance under the CJS* (life within the CJS), *Accessing Mental Health Support* (receiving psychological care) and *Lessons and Moving Forward* (personal growth and the future).

Conclusion

Finding purpose and meaning in life can be compounded by systemic inequities such as personal and experienced trauma, racial discrimination, social disadvantage and care that is not tailored to ethnocultural identity. Implications for Clinical Psychology and future research opportunities are highlighted to ensure mental health inequities are minimised.

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Acknowledgements

“I can do all things through Christ who strengthens me” (Philippians 4:13)

First and foremost, I give thanks to the Lord Almighty who continually supported me to complete this milestone. From the beginning until the end, Christ has given me the wisdom and power to overcome any challenge that came my way. My faith assures me that I can put my mind to anything, when I rely on the Lord to see me through it.

To Dr Bonnie Teague and Dr Sheri Oduola, thank you for reminding me of my strengths. Your confidence in my abilities when I did not feel qualified encouraged me to persevere during the really tough seasons of the research process. When I did not understand something, you were both there to educate and direct me to where I could obtain that knowledge. It would not have been possible to complete this work without your insights and expertise, I appreciate all the support you offered me.

I can only express my deepest gratitude to my parents who have unconditionally loved and supported me throughout this journey. Even when the odds were against me, my parents did not see this as a limiting factor for my success. Their determination to see me excel, only motivated me to push through hard times. They have witnessed me go through every academic stage in my life and watched me pursue my dream of becoming a Clinical Psychologist, to them I am forever thankful. Thank you to the rest of my family and friends, who provided a space for peace and restoration. Your presence highlighted the importance of preserving moments of joy and laughter even during the moments of pressure and self-doubt.

I would like to give a final thank you to the Black men who participated in the empirical research. Your bravery and vulnerability greatly affected me and inspired me to tell your story so that others may be impacted.

Chapter One: Introduction to Thesis Portfolio

Word count: 3,714

Groundbreaking contemporary literature highlighting the intersection between social injustices and mental healthcare has been targeted as a critical focus for professionals and policymakers, interested in reducing mental healthcare system inequalities. Whilst they appear to be separate issues, it is suggested that global societal ideologies such as stigma and discrimination associated with mental illness, and mental healthcare systems that are not social justice orientated, may contribute to negative mental health outcomes (Bhugra et al., 2022). The focus within this thesis is to specifically gain an understanding of how such phenomena, within the context of mental healthcare, has been experienced by ethnic minority people.

Ethnic Minority

In UK health systems and research, the term ‘ethnic minority’ is commonly used to describe groups of people that do not identify as White British (e.g., Black and Asian), including White minorities (e.g., Gypsies, Irish Travellers and Roma) (GOV.UK, 2024). The term has been scrutinised for its inaccurate homogenous presumption that all ethnic minorities experiences are identical (Commission on Race and Ethnic Disparities, 2021). Alternative terms such as minority ethnic and racially minoritised have attempted to minimise such issue by honouring the structural oppression experienced by this population (The Law Society, 2022). However, the overemphasis of the word ‘minority’ can be experienced as disempowering. In recent times, the term ‘People of the Global Majority’ (Bryan, 2024) has been praised for its robust and encouraging approach to describe ethnic minority people in the UK. Furthermore, it provides an accurate universal definition which recognises efforts to decolonise language and systems (Campbell-Stephens, 2021). Albeit, due to the terms lack of empirical use in research studies to date, the literature outlined within this thesis will primarily describe the population of interest as ‘ethnic minority’.

Distinguishing Ethnicity, Race and Culture

Commonly the terms ethnicity, race and culture have been used synonymously within literature. Whilst there is a conceptual overlap in their definitions, there are nuances between the terms that are important to recognise. Both ethnicity and race are socially constructed terms, but race is grounded in people’s physical features, specifically skin colour, and is a relatively modern concept (Acharya, 2022); whereas ethnicity refers to social influences such as geographical location, traditions, history, language and religiosity that shape a person’s identity which may correlate with a specific race (Bulatao & Anderson, 2015). As such culture is ingrained within ethnicity and produces shared norms, beliefs, values and behaviours with a defined community or country cultivating a sense of belongingness (American Psychological Association, 2023). However, some scholars have highlighted inconsistencies in how culture is defined across the literature arguing whether culture is generated via cognitive processes and/or through social learning (Heyes, 2020; Jahoda, 2012; Raeff et al., 2020). Therefore, a concrete definition of culture is often implausible and intangible. Nonetheless, there are similarities between ethnicity, race and culture, however acknowledging their distinctions is pertinent because they will inform and provide context to the issues discussed throughout this thesis.

Social Injustice

The UK government have designed systems (e.g., education, healthcare, employment, financial aid and housing) to support the welfare of people with the perspective of promoting social justice (Department for Work and Pensions, 2012).

However, it is suggested there are inequalities to accessing these services and characteristics such as gender, ethnicity and disability may lead to greater disadvantage (Department for Work and Pensions, 2012). These social injustices are particularly relevant for ethnic minority people who are more at risk of experiencing systemic and/or direct racism and discrimination, creating further barriers to access (Braveman et al., 2022). These barriers have been found to induce disparities in education, employment and family functioning outcomes (The Centre For Social Justice, 2020). Outcomes like this are believed to be closely linked to social deprivation (Edmiston, 2022). For example, a report by the Institute of Race Relations (2024) highlighted entrenched socioeconomic variables including persistent poverty, insufficient housing and employment, and overwhelming debt experienced by ethnic minority people, which have been found to increase health disparities (Marmot, 2010). The overarching outcomes of this report represent the harsh realities ethnic minority people may face in order to access their basic needs.

Mental Health Outcomes

The consequences of racism, discrimination and social deprivation have unequivocally harmed ethnic minorities physical and mental health, leading to poorer health outcomes (Raleigh, 2023). More specifically, the harm from these experiences have been found to increase ethnic minorities susceptibility to the onset of mental illness (Kirkbride et al., 2024). Mental illness refers to the decline in psychological well-being, negatively impacting cognitive, emotional and behavioural functioning (Njoku, 2022). The severity of mental illness can range from common mental health conditions like anxiety and mild depression, to more complex cases like psychotic disorders, bipolar disorder, major depressive disorder, personality disorder/complex emotional needs and eating disorders which are considered severe mental illnesses

(NHS England, 2024). Compared to the White ethnic population, ethnic minority people are more likely to be diagnosed with severe mental illness (SMI), possibly increasing their risk of experiencing poorer mental health outcomes (Bansal et al., 2022).

The relationship between ethnicity, SMI and social deprivation in regard to mental health outcomes, has been investigated empirically. In one example, a longitudinal study conducted by Griffiths et al. (2023) investigated clinical recovery outcomes for people with psychosis. The sample included various ethnic groups, and the degree of social deprivation was measured as a covariable. The findings indicated participants from an Asian and Black ethnic background had poorer clinical recovery outcomes compared to the White ethnic group, and this also correlated with higher levels of social deprivation, especially for the Black ethnic sample. The presence of deprivation in the Black ethnic sample appeared to precipitate the onset of psychosis as well as maintain a bi-directional relationship between the rate of psychotic symptoms and ultimately further deprivation, which likely explained the poorer health outcomes. Similarly, a systematic review and meta-analysis by Halvorsrud et al. (2019) investigated risk of diagnosed SMI across ethnically diverse groups. The findings revealed risks of schizophrenia were highest amongst ethnic minorities, but especially higher in the Black African and Caribbean group. The authors stressed the importance of more research being needed to explore how ethnic minority characteristics are impacted by mental health inequalities.

Even though the literature tends to describe these issues as health *inequalities*, a stronger descriptor for these experiences would be *inequities*. Although often used interchangeably, the term inequality is a concept that explains the broader disparities in mental health outcomes, whereas inequity specifically considers the underlying mechanisms of the disparities (Reidpath & Allotey, 2007). Quite often these health disparities, are a result of the unjust structural systems, that keep marginalised groups oppressed (Arcaya et al., 2015). Therefore, for consistency and to reflect the evidential social injustices, the term health inequities will be used throughout this thesis.

Personal Recovery

Social justice is integral to positive mental health outcomes, as it acknowledges the responsibility and moral duty mental healthcare systems have in promoting not only health but psychosocial functioning in people experiencing mental illness (Bhugra et al., 2022). Psychosocial functioning is an important component of personal recovery which seeks to establish a sense of connection, meaning, identity and empowerment in one's life despite the presence of mental illness (Treichler et al., 2019). Currently a robust understanding as to how personal recovery is experienced by ethnic minority people with SMI through qualitative approaches is limited in the literature (Karadzhov, 2021). Therefore, clarity on whether the systems surrounding ethnic minority people (e.g., healthcare services, socioeconomic structures) could be perpetuating mental health inequities and/or enabling personal recovery, needs addressing.

Mental Health Service Inequities

One of the key drivers of mental health inequities in ethnic minority groups are differences in how the groups access and experience mental health services (MHS) and support. This is supported by a rapid evidence review of 74 studies completed by Kapadia et al. (2022) that identified ethnic inequities in relation to accessing MHS. Six themes emerged, including disparities in perceptions of help-seeking, accessing primary and secondary care, experiences of talking therapies, outpatient services, inpatient services and Children and Young People (CYP) services. Overall, the review found that hesitancy in help-seeking was prominent across the ethnic minority population primarily because of a mistrust towards MHS and fear of discrimination from healthcare providers. Additionally, ethnic minority people were less likely to be offered psychological therapies for SMI from primary and secondary care, compared to White ethnic groups. Furthermore, there were noticeable disparities in involuntary hospital admissions for ethnic minority people and the treatment of care was perceived as abusive, specifically in the Black ethnic population.

In the UK, involuntary hospital admissions are facilitated through detainment under the Mental Health Act (MHA) (1983). This legislation restricts the liberty of people who require urgent mental health treatment, due to increased risk of harm either to themselves and/or others (NHS, 2022). Further evidence of mental health inequities regarding hospital admission for ethnic minority people is supported in a systematic review and meta-analysis by Barnett et al. (2019), who investigated instances of involuntary hospital admissions under the MHA in ethnic minority people, and migrants within the UK and internationally. The authors found that whilst the Black ethnic group’s risk of involuntary hospital admission was highest, this risk was also present for the South Asian, East Asian, unspecified ethnic minority and migrant populations compared to their White counterparts. This evidence identified inequities in pathways into care, seen across ethnic minority groups in the most serious cases of mental illness.

The Criminal Justice System

A number of studies examining health inequities in ethnic minority groups (Barnett et al.,2019; Kapadia et al., 2022) have explored pathways into MHS through the Criminal Justice System (CJS). The CJS is a cluster of institutions (e.g., police, crown courts and prisons) whose purpose is to promote justice against criminality (Clark, 2023). The CJS can inform punitive interventions that institutionalise people in the hope that it will deter them from committing another crime. However, it also acknowledges the publics' right to protection and safety (Hoddinott et al., 2023). Whilst the government hold the right to authorise laws and policies for rationale reasons, its implementation has resulted in disproportionate penalties for ethnic minority people (Commission on Race and Ethnic Disparities, 2021). According to the Ministry of Justice (2024) ethnic minority people appear to be comparatively over-represented throughout different stages in the CJS. For example, people from a Black ethnic background are 9.7 times the rate to be stopped by the police in comparison to White ethnic people (Robertson & Wainwright, 2020). Furthermore, it is reported ethnic minority people overall have fewer positive experiences whilst in prison compared to White prisoners and in particular, 68% of Black prisoners served the largest portion of their agreed sentence compared to other ethnic groups (Ministry of Justice, 2024).

Interestingly ethnic minority people, specifically young Black men, are 40% more likely to receive mental health treatment through the CJS (National Institute for Health and Care Excellence [NICE], 2017). Explanations for this may point back to previous understandings around reluctancy in help-seeking in the ethnic minority population. Additionally, from the male perspective, help-seeking may also be viewed as demasculinising, because it contradicts societal beliefs around men needing to remain strong and not display emotional vulnerabilities (Dera, 2021).Taken together, males from an ethnic minority background are increasingly at risk of experiencing stigma associated with mental illness, which contributes to negative help-seeking attitudes, thus delaying potential mental health treatment (Clement et al., 2015). The consequences may make mental ill-health symptoms much worse, possible resulting in criminal activity and the police intervening at the point of crisis (Williams & Bunn, 2024). Whilst the police are trained to respond to mental health crises by facilitating the transition to a place of safety (GOV.UK, 2018), this narrative may differ for ethnic minority men, particularly Black men, who have described their experiences as non-therapeutic, discriminatory and punitive (Prasad, 2023). This may lead to physical restraint which is reportedly experienced higher by men from Black, Mixed and Other ethnic minoritised groups (Watson & IOPC, 2024). It is likely such interventions will exacerbate mental health distress and in some cases the exertion of force during the restraint has resulted in fatalities (Lamble & McElhone, 2023; Prasad, 2023). The likely trauma from these experiences is possibly amplified since there is a strong chance the individual will be detained under the MHA (GOV.UK, 2018; Williams & Bunn, 2024) which may involve further incidences of physical restraint (Bignall et al.,2019).

The current literature relating to the experiences and voices of men from ethnic minority groups with mental health needs accessing the CJS is scant. There is a need to gain an empirical understanding of the lived experience of these iatrogenic consequences from the perspective of ethnic minority people. The implications will mean understanding these experiences of care and detainment, which may provide important insight into how mental health support at earlier stages may prevent poor mental health, and criminal record outcomes in ethnic minority groups.

Aims and Objectives

There remain complex and system inequities for ethnic minority people in relation to their interactions with MHS and the CJS which can have harmful effects on their mental health outcomes. However, the evidence lacks the perspective, stories and voices from these individuals. This thesis portfolio aimed to address such a gap in the literature by putting the voices of ethnic minorities at the forefront of the research.

The first objective was to conduct a systematic review synthesising the available literature related to personal recovery outcomes for ethnic minority people with SMI. As evidenced in the literature, ethnic minority people's mental health is much more likely to be adverse. But a pivotal goal for all public sectors associated with mental health should be optimal recovery; this reduces costs and strain for the professionals involved. Much of the general focus has been on clinical recovery, which prioritises the lessening of symptoms that reflect psychiatric illness. Whereas personal recovery focuses on the individual regaining their sense of identity and agency to lead a meaningful life, which is a particularly important approach for ethnic minority people who are living with SMI, where their identity, sense of belonging and autonomy may be lessened or disrupted by the societal systems in which they are trying to survive. By learning what helps and hinders personal recovery, it will create a compelling argument as to why professionals and policymakers need to consider these issues and develop actions in response to the outcomes to minimise health inequities.

Whilst disparities are prevalent across the ethnic minority groups, Black ethnic groups have fundamentally more issues regarding their mental health and difficulties within the CJS. Therefore, the second objective was to explore the narratives of Black Men accessing MHS through the CJS. Since the current literature primarily focuses on the statistical evidence and government reports related to social injustices, insight into how these incidents are experienced is scarce. Through empirically investigating this issue, it facilitates the opportunity to hear about lived experienced and the freedom to express without fearing possible negative repercussions. Having this space is critical for those who have been historically silenced. Listening to their stories will be imperative and could enhance strategic changes for professionals working in the CJS and MHS where required.

Research Questions

For the first objective, the following research questions were examined: (1) what are the perceptions and experiences of personal recovery for ethnic minority people with SMI, (2) what are the facilitators and barriers to personal recovery for ethnic minority people living with SMI and (3) were there any strategies used to overcome barriers that potentially inhibited their ability to experience personal recovery.

The second objective's focus was to obtain past, present and future perspectives, therefore the following research questions were addressed : (1) what were Black men's experiences of transitioning from the CJS into MHS, (2) how did Black men perceive their interactions with professionals' in the CJS and/or MHS and (3) were there any unique unmet therapeutic needs for Black men accessing MHS through the CJS.

Research Paradigm

The methodology for this thesis was guided by ontological and epistemological assumptions using the Braun and Clarke (2013) paradigm. Additionally, the thesis was structured around a theoretical framework relevant to the thesis aims and objectives.

Ontological Assumption: Relativism

Ontology is interested in understanding the nature of reality, that is whether reality can be viewed objectively or subjectively. The researcher positions themselves subjectively on the ontological spectrum, assuming a relativist stance. This perspective argues reality is not objectively measured as it does not involve a single 'truth' or reality, and rather people's multiple realities are contextually constructed by socio-cultural and historical events. For the context of this thesis that means each perspective is justifiable and valid, because it is based on individual personal experiences and socio-environmental influences.

Epistemological Assumption: Social Constructionism

Epistemology refers to the way knowledge is acquired and understood and points to the meanings behind personal experiences. The researcher believes that for the purpose of this thesis, a social constructionism position reflects the proposed research questions. Taking this stance suggests that knowledge and meaning of different realities is constructed through social interactions and cultural understandings. This approach is appropriate for this thesis portfolio given that the work will be examining reflections and interactions of health services and the CJS, by people whose culture and identity is shaped by their perceived 'differences' to others as an ethnic minority group. Thus, the researcher, who themselves is from this background, is part of the process of generating and interpretating knowledge through their interactions with the person whose experiences are being investigated.

Theoretical Framework: Intersectionality Theory

Since the researcher is passionate about reducing health inequities and social injustices, this thesis used intersectionality theory as a theoretical framework. Intersectionality is a critical theory that suggests multiple coexisting instances of oppression amongst socio-political characteristics (e.g., ethnicity, gender and socioeconomic status) can contribute to social injustices (Crenshaw, 1989). The framework will be of particular importance for this thesis, because it places a stronghold of needing to understand the complexities and effects of marginalisation, from the perspectives of the people experiencing them, within the context of socio-economic power and privilege (Atewologun, 2018). As highlighted previously, social injustices are closely tied to mental health equities; preliminary findings have shown that applying intersectionality as a framework to inform policy and clinical practice may challenge and overcome some of the structural inequalities that are likely maintaining health inequities (Holman et al., (2021). Therefore, this theory aligns with the aims and objectives for this thesis which sets out to understand ethnic minorities experiences within the structure of MHS and the CJS.

Based on the above assumptions, the thesis leans towards a qualitative methodological approach. The researcher believes they are embedded within the research and was reflexive throughout the research process. Reflexivity is strongly encouraged when conducting qualitative research as it minimises the potential for bias and likely increases the trustworthiness of the findings (Noble & Smith, 2015). Whilst it is expected the findings will identify multiple realities and perspectives, it is hoped the knowledge elicited will contribute to the transformation and advancement within current practices that are perpetuating the social injustices and health inequities evidenced within the literature.

Relevance to Clinical Psychology

By maintaining a critical perspective regarding social determinants of mental health, Clinical Psychology has evolved into a discipline that recognises its position within the socio-political world. As evidently exhibited in the literature, mental health inequities and social injustices are ubiquitous for ethnic minority people. Therefore, as Clinical Psychologist’s we should be striving to advocate for social groups that are detrimentally impacted by their mental health and social circumstances. Despite the disciplines efforts to ameliorate these intersectional experiences such as implementing guidance on building cultural competence (Health and Care Professions Council [HCPC], 2023), whether practitioners understand the importance and can confidently implement this competency into their clinical practice is unclear.

The real question is whether practitioners are well-informed about ethnic minorities and cultural differences. The Clinical Psychology field is primarily a White profession, but the need to diversify the profession has been raised (Jameel et al., 2022). Whilst this initiative can close the gap in gatekeeping the profession from prospective ethnic minority practitioners and ensure representation, the burden is then put on those ‘representative’ practitioners to cater to the needs of ethnic minority service users. All practitioners need to respond in a culturally competent and sensitive way. There are proposed strategies to promote such critical thinking in psychological practice, such as the anti-racism framework (e.g., Patient and Carer Race Equality Framework [PCREF]) that sets out to encourage practitioners to tackle issues related to mental health and racism (NHS England, 2023). Additionally, culturally adapting evidence-based treatments like Cognitive Behavioural Therapy (CBT) (Silveus et al., 2023) and family-based interventions (Edge et al., 2018) for mental health conditions has shown promising prospects in making psychological therapies more feasible, and accessible to ethnic minority people. However, this work is only the beginning in resolving the ongoing disparities, and the literature indicates a need for further training and education for policymaker’s and professionals working in MHS and the CJS in order to minimise the prevalence of the health inequities and social injustices.

Furthermore, Clinical Psychologists’ clinical practice is rooted in the existing evidence-base, therefore it is imperative to also contribute to that evidence-base acting as scientist-practitioners. Practitioners should be eager to investigate the strategies and policies needed to alleviate psychological distress for populations that are further implicated because of systemic issues beyond their control. To fill the gap in knowledge, these experiences cannot be passively accepted, nor can practitioners remain stagnant in their clinical practice.

Proceeding Chapters

The following chapters will aim to provide robust evidence for the proposed research questions. Chapter two will present the findings from the systematic review exploring the perceptions and experiences of personal recovery for ethnic minority people with SMI. Before presenting the findings from the primary research, chapter three will discuss how the systematic review findings are relevant to the empirical work outlined in chapter four which will discuss the narratives of Black men who have accessed MHS through the CJS. The subsequent chapter will be an extension of the empirical research methodology and design, including a reflexive account from the researcher. The final chapter will conclude with a general discussion and critical evaluation of the overall thesis. This will include recommendations for future research, clinical practice and policy development.

Chapter Two: Systematic Review

Perceptions and Experiences of Personal Recovery for Ethnic Minority People with Severe Mental Illness: A Qualitative Systematic Review

Written in accordance with the Journal of Racial and Ethnic Health Disparities

Author guidelines are reported in Appendix A

Word Count (excluding tables, figures and appendices): 7,175

Word Count for Journal Submission (excluding abstract and references): 7,472

Abstract

Background

Ethnic minority people living with severe mental illness (SMI) can experience very poor mental health outcomes. Mental health services are increasingly embedding recovery-focused approaches, or personal recovery models, within their systems. Personal recovery focuses on creating social connections, building hope, establishing an identity, finding meaning and feeling empowered while living with SMI [7]. However, how personal recovery is defined from the perspective of ethnic minority people with SMI is not well understood across the literature.

Methods

To address this gap in knowledge, a systematic review of qualitative literature was conducted to investigate how ethnic minority people with SMI perceive and experience personal recovery. Using the PRISMA guidelines, searches for the existing literature were completed through three databases (MEDLINE Ultimate, APA PsycINFO and CINAHL Ultimate). Studies that met the inclusion criteria were analysed using narrative synthesis.

Findings

Twenty studies were included in the review, from which three themes were generated: i) The Family as a Supportive and Obstructive System; ii) Faith as the Foundation for Hopefulness and iii) Discovering Identity through Agency and Social Interactions. Across the three themes, facilitators and barriers of personal recovery were identified. The findings indicate the need to focus on minimising the impact of barriers, so that ethnic minority people with SMI can live meaningful lives. This review provides a robust account of personal recovery outcomes, that will serve to enhance healthcare professionals’ knowledge regarding care initiatives and any adjustments required for ethnic minority populations.

Key words: *Ethnic minority, Severe Mental Illness, Personal recovery, Health Inequities*

Introduction

The personal recovery approach to mental illness can be defined as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness.” [1]. In other words, personal recovery focuses on the individual experience of reclaiming purpose and meaning in one’s life despite the challenges of their illness. It can also be thought as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” [2].

In contrast, the traditional bio-medical model approach to recovery from mental illness takes a clinical perspective only, such as the stabilisation or decrease in psychiatric symptoms with treatment adherence [3]. This is usually monitored with the use of outcome measures. However, the trajectory of clinical recovery is rarely linear and encompasses a wealth of challenges individuals may experience along the way [4]. Indicators of recovery may include symptom reduction; however, it has been argued that individuals, their supportive network as well as healthcare professionals should look beyond clinical recovery [5].

Whilst clinical recovery symbolises successful treatment outcomes, it lacks the opportunity to see the individual holistically. Slade [6] argued healthcare services should make personal recovery an integral part of care provision to promote overall well-being as this will in effect facilitate clinical recovery. With that in mind, personal recovery can be thought of shifting the focus from symptom reduction to creating a sense of hope, identity and empowerment in one’s life.

These concepts are best outlined in a systematic review that investigated personal recovery in relation to mental illness [7]. From the authors synthesis of the literature, they developed a conceptual model outlining 13 components of personal recovery processes, summarised across five themes collectively called the CHIME (Connectedness, Hope, Identity, Meaning and Empowerment), framework. *Connectedness* refers to interactions with others such as family and peers, *hope* includes being future orientated, *identity* reflects making sense of themselves, *meaning* encourages individuals to find purpose, and *empowerment* offers the opportunity for individuals to feel autonomous throughout their walk in life. The model identified the role spirituality and stigma played in determining personal recovery outcomes for ethnic minority people. However, these findings were only based on six studies, only one of which was conducted in the UK.

It is reported that ethnic minority people are more likely to receive a diagnosis of a severe mental illness (SMI), face adversity through treatment pathways and experience poorer health outcomes compared with other majority ethnic groups [8]. SMI includes psychosis-related disorders, severe mood disorders, personality disorders and eating disorders [9]. Additionally, ethnic minority people's perceptions of mental health can often come from a place of stigma and cultural misunderstandings, resulting in delayed help-seeking and treatment [10]. One emerging field of research is around the importance of ethnic identity and the role this plays in experiences and concepts of mental health. Empirical research exploring the relationship between ethnic identity and personal recovery has been investigated on a sample of ethnic minority people with SMI [11]. The authors found that stronger associations with the person's ethnic identity facilitated personal recovery. Finding value in ethnic identity encouraged engagement with other people from the same ethnic group which enhanced social connection. These findings reinforce the importance of identity and connectedness in supporting personal recovery. Given the iatrogenic harms that ethnic minority people living with SMI can experience from the healthcare system [1], and the important role of personal identity in personal recovery models, understanding concepts of ethnic identity in ethnic minority people is an important consideration in recovery-focused treatments and care.

Currently, there is a paucity in the literature to understand how personal recovery is experienced by ethnic minorities with SMI and the role that ethnic identity, hope and empowerment may play in regaining a meaningful life. Therefore, this systematic review sought to explore current literature reporting on how ethnic minority people with SMI perceive and experience personal recovery. Furthermore, the review aims to evaluate the facilitators and barriers of personal recovery and what strategies (if any) were used to resolve such barriers. The review will potentially support recovery-focused approaches within mental health services when supporting ethnic minority people with SMI and provide strategies for reducing barriers to personal recovery.

Methods

Protocol Registration

The systematic review protocol was submitted and accepted by the International prospective register of systematic reviews (PROSPERO) (Registration number: CRD42024572389) [12].

Design

This systematic review adopted a qualitative synthesis approach to understand and synthesise lived experiences of personal recovery from the perspectives of ethnic minority people living with SMI. The conduct of the review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses

(PRISMA) 2020 checklist [13]. See appendix B for a summary of the PRISMA checklist outcomes.

Search Strategy

The primary reviewer completed preliminary hand searches to understand the scope of the literature and construct a research question. Following this, an exhaustive list of search terms was developed relevant to the study aims (Appendix C). For precision and maximisation search terms were developed using Boolean operators. This included “AND/OR” between terms as well as quotations (“”) to cluster terms together and asterisks (*) for term variation. Three databases were used to carry out the searches: MEDLINE Ultimate, APA PsycINFO and CINAHL Ultimate. Searches were completed on 29 October 2024. In addition to the research databases, the primary reviewer also completed grey literature searches through library and university repositories, hand searches and citation chaining on 11 November 2024.

Eligibility Criteria

The inclusion and exclusion criteria were developed by the primary reviewer and thoroughly revised with the research team. Studies met the inclusion criteria if they were a) qualitative or included a qualitative component; b) peer-reviewed studies that included the perspectives and/or experiences of personal recovery for ethnic minority people with SMI or studies reported outside of traditional commercial publishing (i.e. grey literature); c) studies conducted in high-income countries, defined by the World Bank income groups [14] and d) studies that included data from participants categorised as an ethnic minority in the country the study was conducted in. The exclusion criteria were categorised as a) quantitative studies; b) studies that included common mental health conditions (e.g., mild depression and anxiety-specific conditions) and c) studies that included trauma-based conditions (e.g., Post-traumatic Stress Disorder (PTSD) and Complex Post-traumatic Stress Disorder (CPTSD)).

Study Selection

Search results from each research database were exported to Endnote, a reference management software. Following this, the results were amalgamated and exported to Rayyan, a software used for screening papers used in systematic reviews [15]. Firstly, the primary reviewer removed all duplicates from the pool of papers identified through the searches. Next, the existing papers title and abstracts were screened against the eligibility criteria. Finally, the remaining papers full texts were screened by the primary reviewer to establish if they would be included in the final review. Any papers that the primary reviewer identified through the preliminary searching stage that were not included in the database search results were also included for full text screening. To ensure rigour, 20% of the selected full-text papers were independently screened by a second reviewer. The primary and second reviewer compared and discussed the outcomes of the screening process and were agreeable in papers that met the inclusion and exclusion criteria.

Data Extraction and Synthesis

The data were extracted from studies meeting the inclusion criteria using a standardised data extraction sheet that included study characteristics (e.g., author, country, study aims, study design, methods, analysis, study outcomes and author recommendations). In order to synthesise the data, first order interpretations (key themes), direct quotes and second order interpretations (authors explanations) were analysed following the narrative synthesis approach [16]. The narrative synthesis method is a four-stage process beginning with i) the development of a theory ii) synthesising the data; iii) comparison within and between the studies and iv) critically evaluating the strength of the synthesis. Stage two of narrative synthesis included translating the data using thematic analysis [17]. The primary reviewer used line-by-line open coding to develop codes using the software application NVivo 14, which generated themes. The primary reviewer reflected on their biases throughout the analysis and considered if it influenced what data was selected from the included papers. Codes and themes were discussed and confirmed with the second reviewer to minimise the potential for bias. The themes were then analysed further in stage three of narrative synthesis. The studies in each theme were compared using framework analysis [18].

Quality Assessment

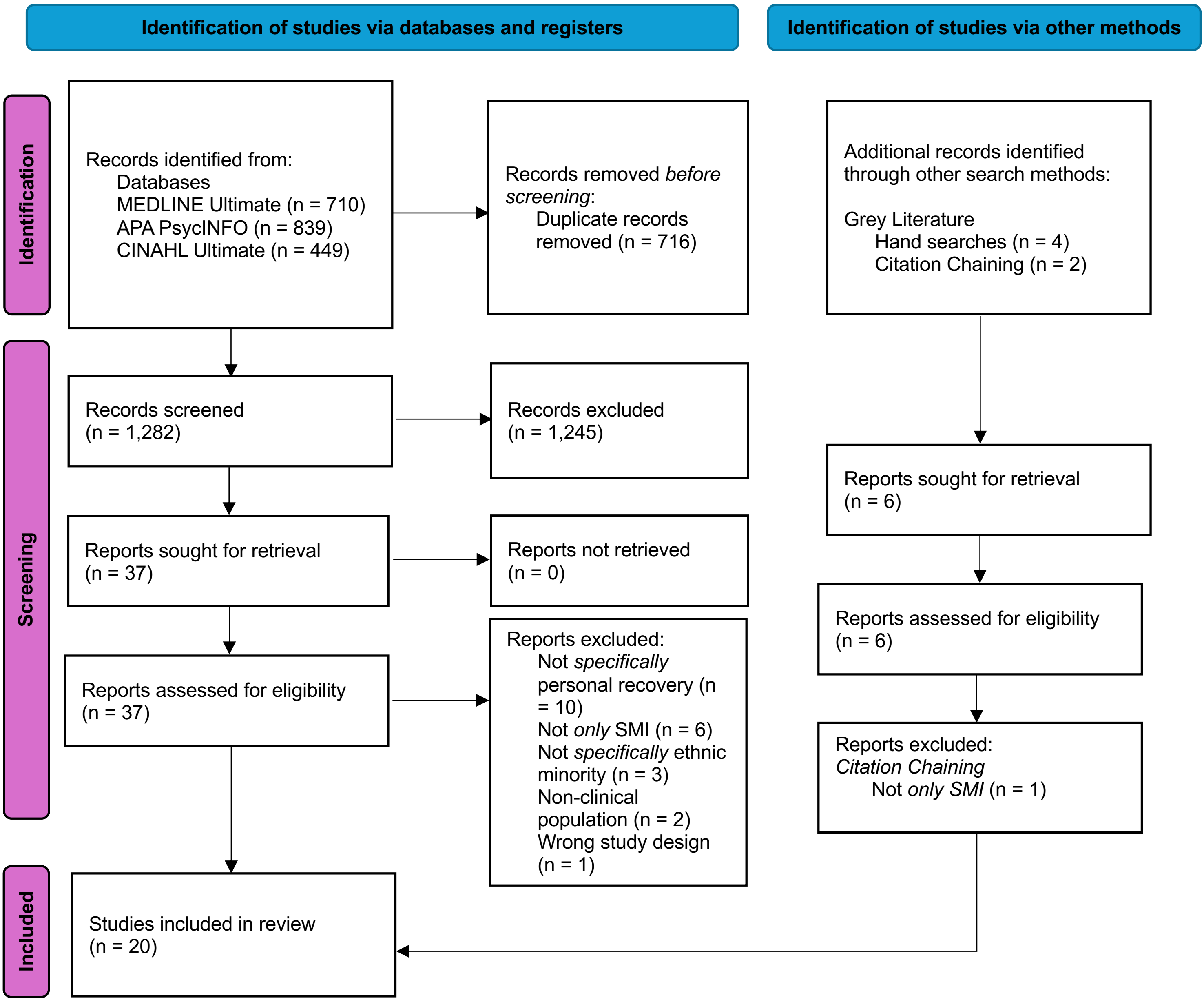
The included papers were critically appraised by the primary reviewer using the Specialist Unit for Review Evidence (SURE) quality assessment tool [19]. The SURE quality assessment tool is robust and ensures a rigorous evaluation of methodological quality for qualitative research papers. At least 20% of the included papers were independently critically appraised by a second reviewer. Any discrepancies between reviewers were discussed and resolved. Papers were not implicated by the outcome of their quality assessment, therefore remained included in the systematic review.

Results

Overall, the database searches yielded 1,998 results. After duplicates were removed this left in total 1,282 papers. Once the primary reviewer completed the screening title and abstract process, 37 papers were remaining for full-text screening. Altogether there were four papers identified through hand searches, with two additional papers being identified through citation chaining by the primary reviewer. The search results and selection process are outlined in Figure 1. In total, 20 papers were included within the systematic review, this included five papers identified through grey literature searches and 15 papers identified through the research databases.

Figure 1

PRISMA Flowchart



Study Characteristics

A summary of the characteristics for each study are outlined in Table 1. Thirteen studies were conducted in the United States [20-32], three studies were conducted in the United Kingdom [33-35], two were conducted in New Zealand [36, 37] and two were conducted in Canada [38, 39]. All studies were qualitative except for two which used mixed methodology [27, 38]. The ages ranged from 16-73, however two studies did not report participant ages [31, 32]. SMI diagnoses included Schizophrenia Spectrum Disorders, Bipolar Disorder, Major Depressive Disorder, Mania and Eating Disorders. Four studies [21, 26, 29, 31] included participants with co-morbidities but only the SMI-related findings are reported here. The ethnic minority groups included African American, Black, Black Caribbean, Black African, Caribbean-Canadian, Māori, Arab American, Asian American, Chinese, South Asian, Hispanic, Native American, Non-British White and Multiracial.

Quality Appraisal

Appendix D provides a summary of the quality assessment for each study. All 20 studies outlined a research question(s), selected a suitable data collection method and clearly described the sample strategy. However, nine of the authors did not address how interacting with the research participants influenced their findings [21, 22, 23-26, 37-39]. This suggests a lack of reflexivity in their method. All but two studies explicitly stated how they obtained ethical approval [20, 28]. For the two that did not, it questions the studies integrity and transparency with the participants. All the studies discussed their findings using an appropriate analytical framework and summarised their findings cohesively, describing the clinical implications of the outcomes. It was unclear from nine of the studies if there was any conflict of interest [20, 21, 24, 28, 31-34, 38], and two of the studies failed to discuss any limitations regarding the methodology [28, 31]. This possibly reduces the studies rigour and credibility.

Table 1

Summary of Study Characteristics

Author(s), year	Country	Aims	Study Design	Participants				Key Findings	Theme Contributions
				N	Age	Gender *male(m), female (f)*	Diagnoses		
Armour et al. (2009)[20]	USA	Understanding African American's experiences of living with severe mental illness	Qualitative (interviews), Hermeneutic phenomenological, secondary data analysis	9	25-54	M (4), F (5)	Schizophrenia (5), Bipolar 1), Schizoaffective (1), Major Depression (2)	- Participants were eager to pursue normalcy. - Through this process it involved overcoming obstacles, taking responsibility for their illness and utilising external systems for support.	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions
Clark et al. (2024) [36]	New Zealand	Experiences of recovery for Māori with	Qualitative (interviews), Kaupapa Māori design,	15	16+	Not reported	Anorexia Nervosa, Bulimia Nervosa or	- Recovery was perceived to enhance	**Theme 1:** The Family as a Supportive

		eating disorders	Thematic analysis				Binge Eating Disorder		empowerment and participants looked beyond their illness and towards a brighter future.	and Obstructive System **Theme 3:** Discovering Identity through Agency and Social Interactions
Habhab (2016) [21]	USA	Explored social factors that influence recovery in Arab Americans accessing a clubhouse	Qualitative (interviews), outcome measures (Recovery Assessment Scale), Grounded Theory	15	26-72	M (7), F (8)	Major Depressive Disorder (7), Schizoaffective Disorder (3), Anxiety Disorder (2), Bipolar Disorder (2), Post Traumatic Stress Disorder (1)	-	Psychosocial factors such as culture, family, treatment adherence, gender differences were found to influence recovery outcomes and experiences	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions
Jankowski et al. (2023) [22]	USA	Exploration of the impact of stigma and racial	Qualitative (focus groups), Thematic	7	18-27	M (4), F (3)	Psychosis	-	Recovery included taking ownership	**Theme 3:** Discovering Identity through

		discrimination on young Black people	content analysis					of one's life, and resisting the negative stereotypes associated with having psychosis.	Agency and Social Interactions
Lawrence et al. (2021) [33]	UK	Understanding experiences of using services and living with psychosis	Qualitative (interviews, experience-centred research, Thematic Narrative analysis	35 Black Caribbean (17), White British (15), Non-British White (3)	21-50	M (17), F (18)	Primary Diagnosis Schizophrenia (22), Mania (8), Depression (5)	- Recovery was harder because of participants experiences with the services, which limited their ability to seek personal recovery	**Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions
Lee (2012)[23]	USA	Understanding social relationships in the context of living with severe mental illness as an Asian American	Qualitative (interviews), Phenomenological data analysis	12	21-64	Not reported	Schizophrenia or Schizoaffective Disorder	- Family relationships served to advance recovery, but they could also hinder recovery at times. - The importance of culture greatly	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering

								impacted participants perspectives regarding their role within the family unit and how their illness shouldn't affect it	Identity through Agency and Social Interactions
Lee et al. (2015) [24]	USA	Exploring Asian Americans experiences of family included in their recovery	Qualitative (interviews), secondary data analysis	8	28-60	M (4), F (4)	Schizophrenia	- Family played an important role in offering emotional and instrumental support. - Sometimes family struggled to understand medical interventions.	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 3:** Discovering Identity through Agency and Social Interactions
Misra et al. (2020) [25]	USA	How has childhood adversity influenced the perception of family support through recovery	Qualitative (interviews), Modified, Grounded Theory Approach	20 White (9), Black (6), Asian (4), Multiracial (1)	23-69	M (10), F (9), Transgender (1)	Schizophrenia (16), Schizoaffective Disorder (4)	- Participants with limited adversity reported feeling connected and supported by their family	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 3:** Discovering Identity

								through recovery - Participants who experienced adversity reported having limited family support, as well as being rejected by their family because of their illness	through Agency and Social Interactions
Mohsin et al. (2024)[26]	USA	Investigating the perception of different systemic factors influencing South Asians experiences of recovery	Qualitative (interviews), deductive and inductive Thematic analysis	36 Patients (21), Family (11), Clinicians (4)	20-72	Patients M (6), F (14), Non-Binary (1)	Bipolar disorder (4), Complex Post-Traumatic Stress Disorder and Severe Major Depressive Disorder (3), Severe Major Depressive Disorder (7), Schizophrenia (5) Delusional disorder (1), Schizoaffective disorder (1)	- Family involvement was necessary to facilitate recovery, however family also prohibited autonomy. - Participating in activities that allowed for personal development and connecting with others were an	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions

								important indicator to personal recovery	
Moore et al. (2024) [27]	USA	Exploring the relationship between ethnicity and recovery experiences	Mixed-methods (outcome measures and interviews, Explanatory sequential design, Directed content analysis	44 Hispanic/Latine (18), Black, Non-Hispanic/Latine (15), Multiracial (11)	19-29	M (28), F (16)	Schizophrenia Spectrum (25), Depressive (15), Bipolar (4)	- Being aligned with their ethnicity helped to empower participants despite their illness - Participants were conscious of the stigma that prevailed through their ethnicity, making it harder to rely on systems (e.g., family), to assist with recovery - Participants reported negative experiences using services	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions

Myers et al. (2016)[28]	USA	Understanding African American with psychiatric disorders experiences of recovery	Qualitative (Ethnographic observations and interviews), Analysis unspecified	Observations (65), Interviewed (20)	18-60	M (53), F (12)	Psychotic Disorder (59), not reported (6)	- Authors reported two case studies that outlined experiences of social defeat and powerlessness in the face of illness, which was discouraging to their recovery	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 3:** Discovering Identity through Agency and Social Interactions
Pahwa et al. (2018)[29]	USA	Exploring formerly homeless individuals with severe mental illness and substance misuse experiences of social re-integration	Qualitative (interviews), Grounded Theory and Case Study analysis	34 Black (22), White (5), Hispanic (3), Native American (2), Asian American (1), Native American/Cuban (1)	29-73	M (26), F (8)	Severe Mental Illness (unspecified), Substance Use Disorder	- Connections to others, especially family and the local community, were imperative in facilitating recovery. - Limited connection to others, perspectives around illness including stigma hindered	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions

								successful recovery and the ability to re-integrate back into society	
Saunders et al. (2023) [30]	USA	Understanding Latina/Hispanic women with eating disorders experiences of recovery in relation to cultural influences	Qualitative (Participatory action research framework of PhotoVoice and interviews- SHOWeD method), Secondary data analysis, Thematic analysis	17 White Hispanic (12) Brown Hispanic (4) Black Hispanic (1)	18-25	F (17)	Anorexia Nervosa (11), Bulimia nervosa (4), Binge Eating Disorder (1), Other specified feeding and ED (1)	- The prevalence of stigma internally and externally made it harder to recovery - The family system acted as a facilitator to recovery - Societal gender roles, were perceived as a barrier to pursuing aspects of life beyond what was expected in the culture	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 3:** Discovering Identity through Agency and Social Interactions
Tuffour (2020) [34]	UK	Exploring the role of religion	Qualitative (interviews),	12	19-57	M (3), F (9)	Schizophrenia (6), Paranoid	- Participants discussed	**Theme 1:** The Family

		in facilitating recovery in Black African service users with mental illness	Interpretative Phenomenological Analysis	Sierra Leone (5), Zimbabwe (4) Zambia (1) Ghana (1), Ghanaian parents (1)			Schizophrenia (4), Organic delusional (schizophrenia-like) disorder (N 1), severe depressive episodes (1)	how their relationship with God provided them with reassurance and comfort whilst experiencing their illness - Engaging in religious activities, provided opportunities to connect with others - Sometimes religion made their symptoms worse	as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness
Tuffour et al. (2019)[35]	UK	What are Black African service users, perceptions of recovery from mental illness	Qualitative (interviews), Interpretative Phenomenological Analysis	12 Sierra Leone (5), Zimbabwe (3) Zambia (2) Ghana (2)	19-57	M (3), F (9)	Schizophrenia (7), Paranoid Schizophrenia (4), Organic delusional (schizophrenia-like) disorder (N 1)	- Participants reported that finding purpose, religiosity, adherence with medication and integrating into society were important	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness

								for enabling recovery, however internal struggles sometimes prohibited participants from implementing them into their life	**Theme 3:** Discovering Identity through Agency and Social Interactions
Virdee et al. (2017)[38]	Canada	Exploring South Asians experiences of living with Schizophrenia	Longitudinal, Mixed methods (interviews and ethnographic), Charmaz's coding strategy and Grounded Theory	7	30-62	M (4), F (3)	Schizophrenia spectrum	- Factors related to immigration such as assimilation and exclusion, influenced experiences of recovery, specifically relating to identity - Experiences of family involvement and religion varied amongst participants	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions

Wang and Henning (2012) [37]	New Zealand	Understanding the relationship between Chinese people with Bipolar Disorder and their family	Qualitative (interviews), Content and Thematic analysis	9	20-56	M (4), F (5)	Bipolar Disorder	- Family support was vital for positive recovery outcomes - Support was emotional and instrumental - Support sometimes limited participants interests’	**Theme 1:** The Family as a Supportive and Obstructive System
Whitley (2012)[31]	USA	What role does religion play in recovery for African Americans with dual diagnosis	Longitudinal, qualitative (focus groups and ethnographic), Thematic analysis	50 African American (45), Unspecified (5)	Not reported	M (10), F (40)	Schizophrenia, schizoaffective Disorder, Bipolar Disorder, Major Depression and Substance Use Disorder	- Participants emphasised God’s role in the process of their recovery - Engaging in religious activities, acted to encourage fellowship and connectedness	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions

Whitley (2011) [32]	USA	How does living in high crime environments impact recovery for African American women with severe mental illness	Longitudinal, qualitative (focus groups and ethnographic), Thematic analysis	50 African American (45), Unspecified (5)	Not reported	M (10), F (40)	Schizophrenia, schizoaffective Disorder, Bipolar Disorder, and Major Depression	- Living in social deprivation was perceived as a barrier to personal recovery, however the participants sought to resist this defeat and persevered by overcoming hardships so that they can achieve recovery	**Theme 1:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering Identity through Agency and Social Interactions
Whitley (2016)[39]	Canada	Comparing perceptions of recovery across different ethnicities with severe mental illness	Purpose-driven comparative study, qualitative (interviews), Thematic analysis	47 Euro-Canadian (28) Caribbean-Canadian (19)	Euro-Canadian (20-69) Caribbean-Canadian (22-62)	M (24), F (23)	Schizophrenia, Major Depression, Schizoaffective Disorder, Bipolar Disorder	- Recovery meant being able to engage in daily activities as usual - Barriers included stigma, low socioeconomics and hospitalisation	**Theme 1:** The Family as a Supportive and Obstructive System **Theme 2:** Faith as the Foundation for Hopefulness **Theme 3:** Discovering

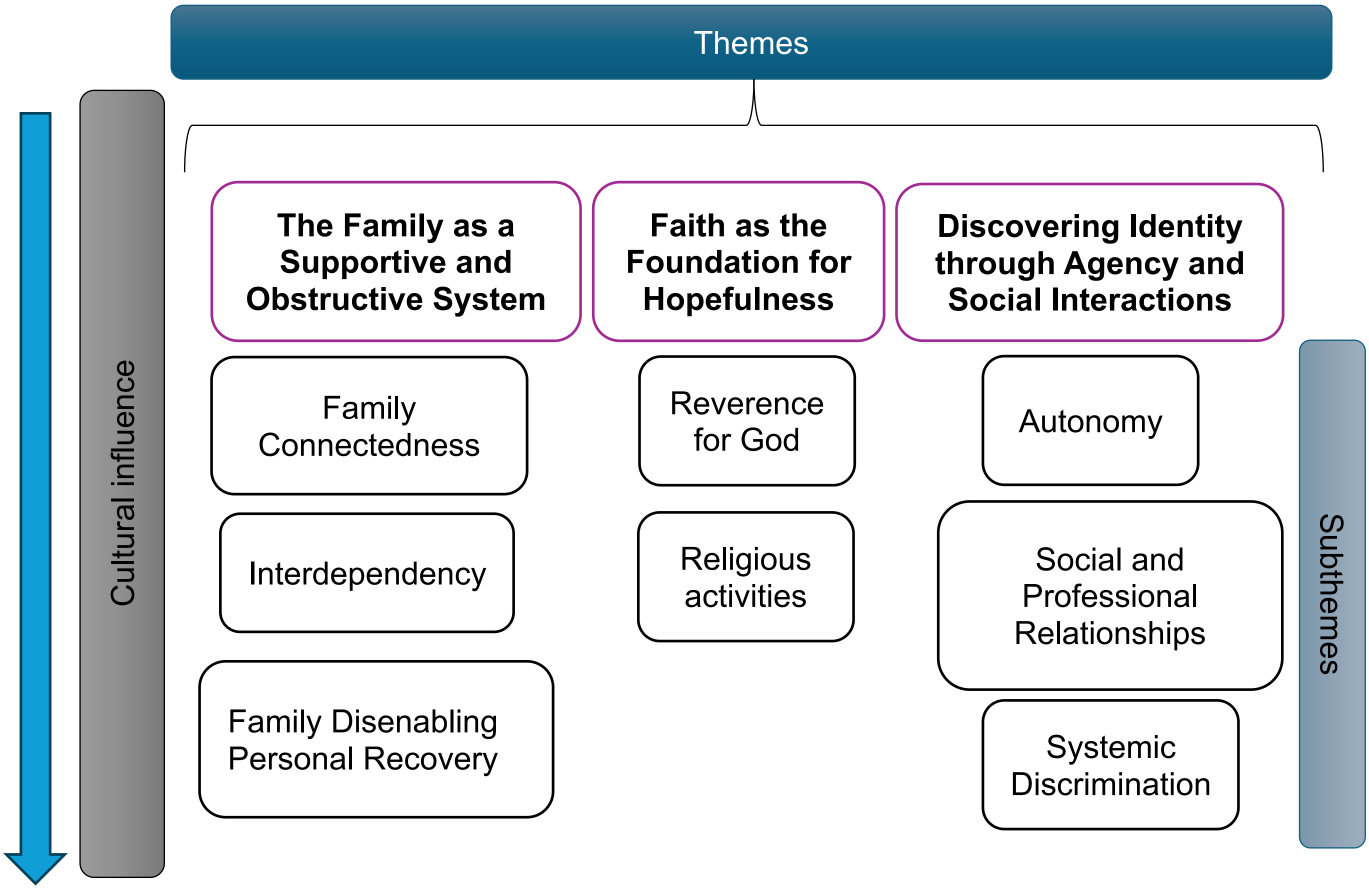
	- Facilitators included having belief in a higher power and being proactive	Identity through Agency and Social Interactions

Narrative Synthesis

Following the narrative synthesis approach three themes were generated i) The Family as a Supportive and Obstructive System, ii) Faith as the Foundation for Hopefulness and iii) Discovering Identity through Agency and Social Interactions. Underpinning each of these themes were specific cultural influences, facilitators and barriers to personal recovery. Figure 2 outlines the emerging themes and subthemes.

Figure 2

Summary of Personal Recovery Themes



The Family as a Supportive and Obstructive System

Family played a large role in shaping participants personal recovery experiences. Almost all the studies discussed how family acted as a facilitator, specifically how they offered emotional and instrumental support [20, 21, 23-31, 35-39]. However, 11 studies discussed how poor family relationships presented as an obstacle towards personal recovery [21, 23-26, 29, 30, 31, 34, 35, 38].

Family Connectedness. Participants highlighted the benefits of receiving care from their family. The presence of emotional support improved many participants well-being. “My parents are my biggest support throughout all of it. They’ve known everything and they’ve never said like the wrong things. They’ve always just been trying to help me…” [30, p.343]. There was a clear emphasis on the value of instrumental support, which sometimes surpassed the presence of emotional support, which involved practical support to the participants such as financial help, goods, accommodation and transportation. This was heavily influenced by cultural expectations, whereby families from certain ethnic or country backgrounds hold a cultural responsibility to take care of each other. This is demonstrated here by an Asian American participant: “My mom helps me with that; she says, ‘I’ll pay you,’” and “They come and visit me at [the hospital], and they brought me money and goodies to relax me.” [24, p.274].

Additionally, instrumental support consisted of medication monitoring which was interlinked with clinical outcomes. For example, an Arab American mother discussed how her son supported her with managing her illness: “...my son always drives me here (to the clubhouse), picks up my medications and takes me to my doctor appointments.” [21, p. 57]. The participants valued the support they received from their family making them feel less isolated and more connected throughout their personal recovery journey.

Interdependency. Whilst reliance on family was imperative for personal recovery, several studies highlighted reciprocal roles within the family unit and how participants found this valuable [20, 21, 23, 36, 29]. Cultural traditions, such as responsibility for taking care of elders, was viewed as positive and helped with personal recovery. For example, an Asian American participant reflected on their perspective of cultural values within the family:

> "When people grow old, like, parents....you can't just put them in a, like um, a hospital, nothing like that in our country. It's a duty or, it's, um, responsibility to take care of parents when they get old. It's like, mostly it's like a heart thing, conviction." [23, p.63]

Furthermore, interdependency provided a mutual benefit between them and their family members. This included offering practical and social support to their families, which only enhanced their ability to see beyond their illness and find purpose in their life. Additionally, participants reflected on their parental role and how this enhanced their personal recovery. One African American participant expressed her need to keep her child at home until it was safe: "I won't let her go nowhere. I gotta keep her with me until she be . . . ready to push out." [20, p.614]. In contrast, the authors [20] outlined participants needing to rely on other family members sometimes to watch over multiple children, to relieve some of the pressure. In turn, this helped build stronger bonds between the family, increasing a sense of connectedness between the participant and family members.

Family Disenabling Personal Recovery. Sometimes family were perceived as a barrier to personal recovery. Ten studies discussed how a family's lack of understanding about the severity of SMI and limited family support, could make the process of personal recovery much harder [21, 23-26, 29, 30, 31, 34, 35, 38]. Unsurprisingly, cultural bias about mental health, influenced families' responses to participants, which often left participants feeling rejected and misunderstood by their family leading to increased isolation. For example, a South Asian participant describes how their family responded to their illness: “My siblings [and] my parents know [about my mental condition]...All my family members knew that I have this disease...But they were not cooperative. Not encouraging people.” [26, p.6]**.** Some participants were neglected by their family and left to manage their health on their own, again creating an isolating experience. Furthermore, some studies discussed the significance of family expectation and the negative consequences of this. For example, a South Asian participant discussed how she was struggling with her mental health, but she was pressured to comply with the role of a Muslim women: “… I did all the cooking and cleaning of the house when I lived with my family… I had no support… They just accused, accused, accused.” [38, p.154]

Similarly, several studies highlighted perceived stigma around SMI from family members. For example, an Anglo-Caribbean woman described how her daughter distanced herself and kept contact to a minimum: “My daughter views mental illness as something she should keep away from and avoid… She is ashamed…so when she sees me, she will see me in places that are very, very remote places…” [39, p.344]. In contrast, other studies discussed how stigma around SMI was ingrained within their culture, which sometimes transpired into self-stigma. One example by a Hispanic participant shared how the cultural beliefs in her family prevented her from getting help: “…Cause in Hispanic families that is just not… believable. Like, no one is really mentally ill, or anorexia doesn’t really exist when you’re Latina. I didn’t seek treatment…” [30, p.342]. For this Hispanic participant the idea of disclosing their SMI to her family would have meant her experiences being invalidated and possibly ostracization from her family.

Faith as the Foundation for Hopefulness

Thirteen studies discussed how connecting with their faith and religion facilitated their personal recovery [20, 21, 23, 26, 27, 29, 31-35, 38, 39].

Reverence for God. Many religions were discussed across the studies, primarily Christianity and Islam. Consistently, participants reflected on their relationship with a higher power, and this was exampled through the act of prayers and worship. Through these actions, participants felt a sense of healing, support and hope regarding their illness. This was demonstrated by an African American participant expressing their love for God: "… You know. I can talk to God. I can pray, and can feel so comforted. You know, and I calm down. But, I have to pray. I pray and cry…" [31, pp. 93-94]. In contrast, some participants described it as a spiritual experience that assisted with their recovery, rather than referring to a specific God: "For me it was a spiritual journey, it was a massive spiritual journey" (Paula, Black Caribbean). [33, p.6].

Religious Activities. Several studies discussed how the presence of God was palpable by attending places of worship. Through fellowship with other believers, participants received prayers from others, which signified a form of encouragement and connectedness through the recovery process. For example, a Black African participant reflected on their relationship with the church congregation: "…I received a lot of support from others…The church people came to pray for me…" [34, p.356]. Evidently, belief in a God was highly regarded amongst participants as a method of restoring hope and connection. It seems this was specific for ethnic minority participants as Whitley [39] discussed that the Euro-Canadian participants hardly mentioned the importance of God throughout their recovery process.

Discovering Identity through Agency and Social Interactions

Almost all the studies discussed the importance of achieving agency and building social connections as a process in personal recovery [20-33, 35, 36, 38, 39]. However, disempowerment, social exclusion and discrimination prohibited personal recovery [20, 23, 27, 28, 35, 38, 39].

Autonomy. Having choice was appealing to the participants. Several of the studies perceived clinical symptom management as an integral part of achieving personal recovery. Symptom management was described as adherence to medication, as well as developing strategies to cope with their illness. For example, an African American participant explained a technique they use, when they recognise the onset of their illness: “If I feel depression coming on, I’ll start thinking very positive things and I’ll just keep saying it over and over in my mind until it really sinks in.” [20, p.609]. Learning how to manage their symptoms provided freedom, but it also reflected a sense of resilience. Fourteen studies demonstrated how participants endured adversity throughout their illness, but perseverance and self-determination encouraged them to get better [20-23, 27, 28, 30-33, 35, 36, 38, 39]. Through their courage and commitment, they were able to view their SMI as empowering rather than impeding on their life. For example, a young Black person, described how an alternative perspective about their illness, changed their life: “Once I realized that I have an illness but I’m not the illness…things started getting better” [22, p.5]. Externalising their SMI, provided the opportunity to develop a sense of identity.

Social and Professional Relationships. Developing connections with peers, the wider community, and healthcare professionals was crucial for many participants. For example, an Arab American summarised the benefits of attending a clubhouse, which enabled them to build supportive networks with other people with SMI: “I feel like my condition has become much better since attending the clubhouse –the changes have been positive” [21, p.56]. Contrastingly, some participants sought to build connections with people who did not have a SMI in order to achieve a sense of normalcy: “So like I’m trying to make friends that are like more, like normal, and where I can learn from them.” [23, p.62]. Here the participant was striving to integrate themselves back into society by associating themselves with people external to their mental health community. They perceived this opportunity to cultivate an identity external to their SMI. This was further evidenced by a Black African participant who found value in not discussing his SMI in his voluntary football role: “…I don’t talk about mental health with them and I think that’s a positive thing because it’s a separate thing away from my health.” [35, pp.108-109].

Similarly, there was a desire from the participants to give back to the SMI community, by volunteering to support other service users. A Native American/Cuban women described the positive elements of her peer supporter role: “I share, I listening, which is key for me, and I uh, I give back, I give back, just being who I am.” [29, p.1317]. Many participants described having empathy for others with SMI and felt that their purpose in life was to help them in whatever capacity they could.

There were diverse perspectives regarding relationships with healthcare professionals. Several studies discussed the invaluable support participants received from healthcare services and professionals [20, 21, 23, 29, 32, 33, 36, 38, 39]. In one example an African American participant expressed their appreciation for their service coordinator which provided a sense of hope and connection: “[She] wanted the change. She wanted to see you get better and her support and her being there . . . She never forgot my birthday.” [29, p.1317]. However, several studies found contradictory experiences with healthcare professionals [20, 23, 27, 28, 33, 35, 38, 39]. Some participants felt that healthcare professionals solely focusing on clinical recovery, undervalued the importance of personal recovery. For example, a Black Caribbean participant described being disappointed by the psychiatrist's lack of curiosity regarding her background and identity:

> One of the things I need to do which is one of the things the psychiatrist never actually clocked on to, which is quite bizarre, is that I'm adopted, so that is like a very large segment of my life." [33, p.6]

There was a noticeable lack of cultural sensitivity when engaging with professionals from other ethnicities, which made it harder to build rapport and be vulnerable due to the disregard of ethnic identity. A participant shared the exhaustion they experienced whilst searching for a suitable therapist: "…the way that I dealt with it was finding a therapist that had the same cultural background, but that is not at all easy to find…" [27, p.8]

Systemic Discrimination. Systemic discrimination and stigma in relation to socioeconomic barriers (e.g., housing, employment, finances) appeared to prevent social connectedness, hope and impacted ethnic identity [20, 23, 27, 38, 39}. For example, an Anglo-Caribbean participant described their perspective on the absence of finances in the Black community: "There ain't no black person from the Caribbean who has money here. With money you would get shit done!..." [39, p.344]**.** They evidently felt disempowered and frustrated by these circumstances. There is a belief that because of their ethnicity they don't experience equal access to financial resources. Feelings of disempowerment where also amplified when participants associated their SMI with no prospects. Participants felt that their SMI diagnosis limited them, and they were often viewed as incapable. An account from a Black participant highlighted how they were often judged because of their illness: "…I was not included within what was going down in family court. To me I didn't' have a voice. I was seen immediately as incompetent because I had a mental illness." [29, p.1318). Here, from the participants' perspective, their SMI overshadowed their identity, which likely made them feel dehumanised, and created a sense of powerlessness.

Discussion

This systematic review explored the perceptions and experiences of personal recovery for ethnic minority people with SMI. More specifically, it identified the facilitators and barriers to personal recovery as shared by this clinical population. The findings of the synthesis indicated three themes that correlated with personal recovery: i) The Family as a Supportive and Obstructive System; ii) Faith as the Foundation for Hopefulness and iii) Discovering Identity through Agency and Social Interactions. Ethnocultural values and attitudes were intrinsically linked to all three themes. All three themes replicated personal recovery outcomes associated with the CHIME framework [7].

Family involvement, including emotional and instrumental support, facilitated personal recovery as it provided social connections, mitigating feelings of loneliness. This finding supports previous reports that have qualitatively explored the role family play in assisting personal recovery [40, 41, 42]. Feelings of connection was also created when ethnic minority people could reciprocate help towards their family, which generated a sense of empowerment. Previous research has investigated the significance of reciprocity in family support for people with SMI [43], however there is little existing evidence that addresses the significance of ethnocultural influences and traditions that may have encouraged reciprocity [44], which were highlighted as key influences from some of the studies in this current review. Evidently family involvement is a crucial aspect for the personal recovery process, however the ethnic minority people in this systematic review were at a particular disadvantage when they lacked support from their family. The absence of help from family, could possibly be explained by negative cultural beliefs associated with SMI which can result in stigma and ultimately, rejection and social isolation [42]. In the ethnic minority population, there is the possible fear that by acknowledging the existence of a SMI, it could bring shame on the family [8, 45). Some resolutions to this gap in support and knowledge have been suggested, such as providing psychoeducation to families, to challenge potential biases towards SMI and offering opportunities to learn about mental illness [42, 46].

Intimacy with God and congregating with other religious believers provided reassurance and hope. The process of engaging in fellowship with other believers also enabled connections. These findings replicate outcomes from previous systematic reviews [8, 47, 48] that specifically identified positive faith-based experiences facilitating personal recovery. One interesting finding highlighted by Whitley [39], was that faith-based beliefs and activities was an important process for ethnic minority people in achieving personal recovery. Similar reports have suggested ethnic minority people rely heavily on their faith as it promotes resilience through adversity and the community aspect with other believers generates a sense of belonging, thus shaping ethnic identity [49].

The participants valued the feeling of autonomy in their life. When they began focusing on the attributes associated with personal recovery such as self-determination, changing their attitude towards their illness, pursuing goals and building strong connections, their life became more meaningful, they felt empowered, and they established their identity. Similar to Slade [6] who argued striving towards personal recovery effectively decreases the impact of the clinical symptoms associated with SMI.

Whilst some participants described experiencing positive relationships with healthcare professionals as it provided a sense of hope [50], this was less achievable for participants who faced negative experiences with healthcare professionals. This included views that healthcare professionals were not recovery-orientated in their practice, and culturally insensitive. The consequences impacted regaining a sense of ethnic identity. Existing evidence suggests that services/healthcare professionals that do not consider ethnic identity for ethnic minority people with SMI as part of recovery-orientated practice, will likely interrupt experiences of mental health treatment and outcomes as ethnic identity is a fundamental characteristic that facilitates personal recovery [11].

Additional barriers to personal recovery included systemic inequities such as social deprivation and discrimination associated with their ethnicity and SMI, supporting previous findings [51]. However, there is some existing literature that suggests stigma and discrimination towards SMI is not specific to ethnic minority people [39], but the intersectionality component is more detrimental to the ethnic minority population, since they are more likely to experience health inequities associated with their ethnic identity. Despite these prevailing obstacles, a possible way to encourage personal recovery may include the implementation of evidence-based community recovery-orientated approaches such as peer support, individual work placements, supported accommodation and wellness activities [52, 53]. These approaches have been found to be effective at reducing stigma, creating purpose and strengthening personal identity.

Clinical Implications

These findings highlight the need to integrate personal recovery approaches into clinical practice. This ethnic minority focused recovery-orientated approach will encourage ethnic minority people living with SMI to recognise they are more than their illness, but also practitioners will be better prepared to support patients achieve purpose in their life in ways that are meaningful to them and their ethnic identity. Within the ethnic minority population specifically, focusing on culture aspects that hinder personal recovery will be crucial, so their experiences can be validated. This may involve initiatives to educate families and the ethnic minority communities about mental health so stigma and discrimination can be reduced. Similarly, it was noted within the review that practitioners will need to become culturally competent to facilitate personal recovery processes like ethnic identity for ethnic minority people.

Future Research

Given the focus on spirituality facilitating social connectedness and hope in personal recovery for ethnic minority people, future research may focus on the integration of faith-based approaches as a recovery-orientated community-intervention for ethnic minority people living with SMI. Social deprivation was highlighted as a barrier to personal recovery. A previous scoping review investigated experiences of personal recovery for people living in low and middle in-come countries with SMI [54], however this has not been explored in Western countries. It would be interesting to empirically investigate the relationship between social deprivation and personal recovery for ethnic minority people.

Limitations

Several studies omitted important methodological aspects such as reflexivity which is critical when conducting qualitative research. The term ‘severe mental illness' was defined using the UK National Health Service (NHS) definition, however many of the studies included in the review were outside of the UK, therefore the criterion for a SMI in those countries, may be different to the ones outlined in the NHS. This may limit this reviews transferability to other Western countries, as they may have categorised diagnoses as severe that were excluded from this review. Furthermore, the review did not highlight the nuances in experiences between and within the different ethnic groups. Finally, there was a huge age range between participants included in the studies and it is unclear whether perceptions and experiences of personal recovery change over the life span.

Conclusion

Overall, this systematic review aimed to synthesise empirical evidence to answer three questions: how do ethnic minority people with SMI perceive and experience personal recovery and based on this, what are the facilitators and barriers to personal recovery, and where there any strategies to overcome perceived barriers. The studies included in the review found that family support, faith and religion, seeking agency and social interactions promoted personal recovery. Whereas lack of family support due to cultural biases regarding SMI, weak therapeutic alliances because of ineffective cultural understandings, and systemic discrimination associated with ethnicity and socioeconomic factors, hindered personal recovery. The systematic review captured multiple, albeit cohesive perceptions and experiences, that provide an understanding of what health inequities need to be addressed in order to reduce the persisting barriers. Healthcare professionals would benefit from referring to this review so that they remain cognisant when working with ethnic minority people with SMI.

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Chapter Three: Bridging Chapter

Word count: 848

Evidently, personal recovery journeys are important to understand in ethnic minority people with severe mental illness (SMI). However, as it was highlighted in the introduction, there needs to be a level of caution when grouping people from varying ethnicities under one umbrella term. The dangers of this can result in experiences by groups who are more marginalised than others within society being underacknowledged. Some of these disparities amongst ethnic minority groups include the prevalence of specific severe mental illnesses. For example, in the UK incidence of schizophrenia is more profound across ethnic minority groups compared with White British groups, however the rate is considerably higher for Black African-Caribbean people (Kirkbride et al., 2012). SMI like schizophrenia can be debilitating and interfere with psychosocial aspects of one’s life without appropriate treatment and wider support, limiting the ability to experience personal recovery.

A systematic review by Pinto et al. (2008) was interested in identifying possible explanations for the high incidence rates of schizophrenia in the Black African-Caribbean population within the UK. Seven hypotheses emerged from the review however, the authors highlighted potential fallacies across several of the hypotheses such as a lack of empirical data, and inconsistencies in the findings. One of the most robust and plausible explanations included genetic risk, which was considered to increase more with first-degree relatives who had a diagnosis of schizophrenia. Another strong predictor included psychosocial factors such as social disadvantage and racial discrimination, which appeared to have further implications for migrants with perceived darker skin complexion, possibly creating feelings of social exclusion. Misdiagnosing schizophrenia was another compelling argument that is likely the result of prejudice from psychiatrists whereby symptoms are misunderstood, as well as cultural differences in how schizophrenia is expressed in

Black African-Caribbean populations. There is also evidence that has suggested Black populations being over diagnosed with schizophrenia (Morgan et al., 2017). Additional attempts to explain this disparity have considered whether poor attributional style which may act a response to life adversity, is exhibited more in Black populations, increasing their vulnerability to psychosis-like symptoms (Sharpley et al., 2001).

Gender disparities also exist in relation to schizophrenia incidence rates and experiences of treatment. The onset of schizophrenia appears to occur earlier for men, compared to women (Faber et al., 2023) and furthermore, men that identify as Black-Caribbean presenting with psychosis-like symptoms are likely to be put in police custody which may be perceived as coercive (Darko, 2021). Statistically, over one-third (39%) of people under police custody have a known mental health condition, suggesting many people entering the Criminal Justice System (CJS) are experiencing poor mental health and given the rates of undiagnosed mental health problems, are likely to mean that numbers are much higher than reported (National Institute for Health and Care Excellence [NICE], 2017).

Currently within the UK there are existing system relationships between the CJS and mental health services (MHS) to effectively treat people with SMI (Kamin et al., 2022). Integrating systems to deliver mental health support would be ideal if experiences across the systems were perceived as equitable for ethnic minority people (Yasin & Sturge, 2020). However, ethnic minority people are disproportionately stopped and searched by UK police, compared to White British people. The Home Office (2024) reported that across England and Wales, all Black ethnic categories including ‘Black’, ‘Black African’, ‘Black Caribbean’ and ‘Black Other’ were overall stopped and searched more compared to all other ethnic categories. The rates suggest for every 1,000 people, 92 from the ‘Black Other’ ethnic group were stopped and searched compared to the ‘Asian Other’ ethnic group which was 18.9 people and the ‘White Other’ ethnic group which was 9.9 people. Similarly, the arrest rate was disproportionate for Black ethnic people (GOV.UK, 2024). For every 1,000 people 4.3 people from the Black ethnic group were arrested, compared to every 3 people from the White ethnic group. This discrepancy was higher for men from the Black ethnic group which found the rate of arrest to be 38.2 per 1,000 people, compared to 16, for White ethnic men.

Explanations for these findings suggest the racialisation and criminalisation of Black men by the police, as well as the lack of diversity within the police force, may contribute to this disparity (Shankley & Williams, 2020). Whilst an encounter with the police may be a less than ideal situation, it can be seen as a pathway to receive mental health support from services if this was not accessed prior to police intervention (NICE, 2017), this is especially relevant for young Black men. Black people live within a complex environment of increased risk of SMI, difficulties accessing MHS, and the overwhelming presence of the CJS in their communities and lives. These overlapping concepts have primarily formed its evidence-base from available statistical data collected by authorities; however, the limited empirical evidence has not sufficiently provided a clear understanding as to how systems or institutions like the CJS and MHS may be viewed and experienced by Black men, and the impact – both positive and negative – that these systems may have on their mental health outcomes. The following chapter addresses this gap in the literature.

Chapter Four: Empirical Paper

A Qualitative Study Exploring the Narratives of Black Men Accessing Mental Health Services through the Criminal Justice System

Written in accordance with the Journal of Ethnic and Migration Studies

Author guidelines are reported in Appendix E

Word Count (excluding tables, figures and appendices): 9,137

Word Count for Journal Submission (excluding tables, diagrams and online appendices): 9,121

Abstract

Black men are increasingly at risk of accessing mental health support through adverse pathways like the Criminal Justice System (CJS). However, it is unclear from the literature how these pathways into care are experienced. A qualitative semi-structured interview study design explored Black men's experiences of accessing Mental Health Services (MHS), through the Criminal Justice System (CJS). A narrative inquiry approach was used to organise and analyse the data.

Six men across the UK that ethnically identified as Black were recruited through the UK National Health Service (NHS) and non-NHS pathways such as social media and non-governmental organisations. Four primary themes were generated: (1) The Perfect storm- early life determinants that resulted in poor mental health and involvement from the CJS; (2) Surveillance Under the CJS- discriminatory experiences within the CJS; (3) Accessing Mental Health Support- experiences of receiving appropriate care and (4) Lessons and Moving Forward- how these experiences shaped their current life and worldviews. This is the first study to shed light on the lived experience of these mental health disparities from the perspectives of Black men who have entered MHS through the CJS. Recommendations for professionals and policymakers as well as considerations for future research opportunities are discussed.

Key Words: *Criminal Justice System, Mental Health, Black Men, Health Inequities*

Introduction

Compared to other ethnicities, Black men in the UK are more likely to enter mental health services (MHS) through the Criminal Justice System (CJS) (Keating, 2009; Lammy 2017). Young Black men specifically, are at least 40% more likely to receive support from MHS through the CJS compared to their White counterparts (National Institute for Health and Care Excellence [NICE], 2017). Pathways into the CJS typically begin with police intervention and depending on the severity of the crime, can escalate to court proceedings and sentencing (Ryan, 2022). Statutory MHS are a combination of inpatient, outpatient and specialist services commissioned to treat mental health conditions. In the UK they are primarily delivered through the National Health Service (NHS), but care can also be delivered through private or other non-governmental organisations (NGOs).

However, there are reported mental health disparities in Black ethnic populations in accessing this care. It has been argued Black ethnic populations are mistrusting of MHS which has been found to correlate with delayed help-seeking behaviours (Birmingham and Lewisham African and Caribbean Health Inequalities Review [BLACHIR], 2021). The consequences of delayed help-seeking may mean mental health concerns remain unmet and therefore likely become worse (Clement et al., 2015). As well as mistrust, additional obstacles such as stigma, mental health illiteracy, and linguistic barriers are also highly associated with delayed help-seeking behaviours in Black ethnic populations and are likely contributing to the mental health inequities (Devonport et al., 2022). Similar help-seeking attitudes have been exhibited in Black male trauma survivors (Motley and Banks, 2018), but the repercussions for delayed intervention in this population could compound existing mental inequities.

For instance, Black men are three times more likely to be diagnosed with a psychosis-related condition compared to their White male counterparts and are at risk of experiencing poorer mental health outcomes (Morgan et al., 2005). According to Keating (2009), the likelihood of developing psychosis is increased for Black males who have been predisposed to early life social disadvantages such as racial discrimination, social deprivation, school exclusion, and exposure to crime and substance use. These experiences, whether direct and/or indirect, can be traumatising (Kirkbride et al., 2024; Varese et al., 2012; Williams et al., 2019). Another argument points to the role of masculinity as this promotes the narrative of needing to remain *strong* and self-reliant, and the perception that disclosing vulnerabilities or seeking help is a sign of *weakness*. Such attitudes have been found to correlate with Black male perspectives regarding help-seeking (Cloud, 2024; Meechan et al., 2021; Watkins & Neighbors, 2007). The intersection of Black masculinity norms and pre-existing trauma may then increase the likelihood of Black men experiencing a longer duration of untreated psychological distress, which may be expressed in adverse ways (McLaughlin et al., 2007), possibly leading to involuntary detention under the Mental Health Act (MHA). The MHA (1983) is a UK legislation for people with severe mental health conditions who are deemed to be at risk to themselves or others, and require treatment and care within an inpatient facility (NHS, 2022).

Overrepresentation in Inpatient Services

According to NHS Digital (2022) ‘Black or Black British’ ethnic people are 4.5 times more likely to be involuntarily admitted under the MHA, compared to White ethnic people. Furthermore, Black men are having longer hospital stays and are eight times more likely to receive a Community Treatment Order (CTO) compared to

White ethnic men (Care Quality Commission [CQC], 2023). A CTO is the continuity of care from MHS in the community following the release from the hospital. Empirical evidence has found Black men are more likely to experience restrictive interventions whilst detained under the MHA, such as seclusion and physical restraint compared to White men (Payne-Gill et al., 2021; Smith et al., 2021). Another empirical example by Solanki et al. (2023) explored the experiences of detention under the MHA from the perspective of Black adults. The findings revealed that despite participants recognising the rehabilitative benefits of being in hospital, they also experienced disempowerment, depersonalisation and racial discrimination. Another finding included participants noticing the resemblance between the hospital and what they imagined prison to feel like. Such environments may possible amplify already existing psychological distress and this could be re-traumatising (Hennessy et al., 2022).

Experiences of the Criminal Justice System

Black men reportedly also hold high levels of mistrust towards the CJS, reporting discrepancies in how they are treated compared to White people (Brooks & Hopkins, 2017; Robertson & Wainwright, 2020). This includes Black men being perceived as violent and dangerous (Brown, 2023), resulting in being criminalised by the police (Darko, 2021). Additionally, receiving excessive use of force and restraint (Keating and Robertson, 2004) and punishments from the courts, such as longer sentences, compared to their White counterparts (Race, mental health and criminal justice: Moving forward, 2017). Such experiences are likely to compound traumatic experiences and create iatrogenic harm (Ray, 2022). These outcomes have been visible across the media, increasing public awareness of discrimination, with the relatively recent Black Lives Matter movement highlighting institutional racism within the police force (Fix, 2024). When the police's approach is informed by perceptions of prejudice and hostility, this will likely exacerbate longer-term mental health distress (Alang et al., 2021).

Clinical Implications for Black Men

NICE (2017) have recommended professionals deliver culturally sensitive care for people with mental health concerns within the CJS, however evidence suggests that professionals are failing to deliver this care (Bignall et al., 2019). Culturally sensitive care includes acknowledging a person's cultural and ethnic identity and understanding how it may play a significant role in formulating and delivering treatment (Tucker et al., 2021). The consequences of not having culturally sensitive care make it harder for Black men to build therapeutic relationships. Therapeutic relationship building with professionals will ultimately contribute to effective treatment outcomes, thus reducing contact time with services. However, until this is addressed, mental health inequities for Black men within MHS and the CJS are likely to persist.

The Current Study

Evidently, there are internalised and structural obstacles for Black men in accessing appropriate psychological care when transitioning through systems. There is little empirical evidence to understand how Black men navigating through MHS and the CJS perceive their interactions with the two institutions and their mental healthcare outcomes. The voice of Black men remains minimal within the literature and there is evidence to suggest they have been discouraged to share their views (Wagstaff et al., 2016). This current study aimed to counteract this narrative by exploring how Black men openly appraise their experiences of transitioning from the CJS to MHS. To our knowledge, this is first study that has empirically explored the lived stories of Black men accessing MHS via the CJS. The researchers aimed to answer the following questions: *What were Black men’s experiences of transitioning from the CJS into MHS? How did Black men perceive their interactions with professionals in the CJS and/or MHS? Were there any unmet therapeutic needs for Black men accessing MHS through the CJS?* It is hoped the research will reveal current care provision and spotlight any improvements in care, if they are identified as suboptimal for Black men, so their mental health needs are met. If these issues arise from the research, then it would be imperative to provide recommendations for policymakers and professionals to support the reduction of health disparities for Black men.

Methods

Design

The socio-constructivist research paradigm for the study was informed by epistemological and ontological assumptions. The lead researcher posits a relativist ontological assumption, suggesting multiple realities or truths exist and are constructed within a socio-cultural and historical context of those realities. From a constructionist epistemological position, knowledge is subjective and co-created between the person with lived experience and researcher. Based on this assumption the lead researcher took a reflexive approach to make sense of the individual participant experiences. Along with this, it was important to understand the participants experiences through a critical theoretical lens to acknowledge the relevance of the powerful systems that were likely influencing their experiences. A qualitative methodology was selected as it was best suited to meet the research paradigm and study aim to explore the perceptions, experiences and beliefs of Black men accessing MHS through the CJS. The consolidated criteria for reporting qualitative research (COREQ) checklist (Tong et al., 2007), was used as a guideline to meet the standard requirements for carrying out qualitative research (Appendix F).

Participants

The participants were recruited through purposive sampling. Participants were identified using an inclusion and exclusion criteria. To meet the inclusion criteria, participants needed to identify as male, belong to one of the following ethnic groups: Black Caribbean, Black African or Black other, and be at least 18 years old or older. Furthermore, they needed to have experienced accessing MHS through a criminal justice route. Finally, the participant needed to be able to meaningfully reflect on their experiences and feelings. Participants were only excluded if they lacked capacity to consent to participate in the research, and if they lacked access to a computer for the conduct of an online interview.

Recruitment was completed through NHS and non-NHS pathways. Participants that came through the NHS pathway were identified through medium and low secure inpatient settings, as well as in community mental health settings. The non-NHS recruitment methods included advertising the study poster (Appendix G) through social media such as LinkedIn and Instagram. Other methods included sharing the study poster and contacting NGOs that interact with and serve individuals who corresponded with the sample characteristics (e.g., Clinks, McPin Foundation).

In total, six participants were recruited into the study. Three were recruited from social media, one was recruited from an NGO and two were recruited from inpatient settings. The participants socio-demographic characteristics are reported in Table 1. The participants ages ranged from 26-42 years old (M= 30.5, SD= 5.9). Five out of the six participants were situated in urban areas, and two of the participants that identified as *Black African* had recently migrated to the UK. All the participants obtained GCSEs (or equivalent), and 33.3% of the participants completed higher education. Half of the participants were unemployed, and the other half were in employment.

Table 1

Participant Socio-demographic Characteristics

Participant	Age	Ethnicity	Highest level of education	Employment Status	Geographical Location
1	26	Black African	Postgraduate degree	Full-time employment	Manchester
2	31	Black African	A-Levels (or equivalent)	Full-time employment	Birmingham
3	29	Black Caribbean	GCSE (or equivalent)	Unemployed	Birmingham
4	27	Black African	Undergraduate degree	Part-time employment	Norfolk
5	28	Black African	GCSE (or equivalent)	Unemployed	Peterborough
6	42	Black Other	GCSE (or equivalent)	Unemployed	Birmingham

The researchers aimed to recruit more participants, however after exhausting all the avenues for recruitment, there were extensive barriers through gatekeeping and non-responders that were beyond the researchers' control. Despite this, the number of participants recruited into the study were sufficient for the chosen analysis method. Challenges related to recruitment are discussed further in the additional methods chapter.

Materials

The materials for the research included a socio-demographic questionnaire (Appendix K) completed by the participants prior to the interview and an interview schedule (Appendix H). The interview schedule was developed through a combination of reviewing the existing literature and identifying the gaps in knowledge. The interview schedule was refined by collaborating with clinical practitioner advisors who were members of a professionals group working as part of the Advancing Mental Health Equality (AMHE) Programme for Black men's mental health care. Feedback from this advisory group led to revisions of the interview schedule. Further details regarding the development of the interview schedule are discussed in the additional methods chapter.

Procedure

Participants were provided with a study promotion poster. If they expressed interest in participating in the research, they were then provided with an information sheet (Appendix I). To make sure they understood the aims and terms of the study and were willing to participate, they were asked to provide written or verbal informed consent (Appendix J). Prior to the interview, participants were asked to complete the socio-demographics questionnaire. The interviews were conducted by the lead researcher remotely online between August and December 2024.The length of the interviews ranged between 30-39 minutes and were audio-visual recorded. The lead researcher followed the semi-structured interview schedule, including asking follow-up questions and additional prompts wherever relevant. After completing the interview, participants received a £20 e-voucher to reimburse them for their contribution and time, and were provided with a debrief sheet (Appendix L). The debrief sheet summarised the aims of the research and signposted the participants to further mental well-being support, if applicable.

Data Analysis

The audio-visual recordings were transcribed verbatim. The analysis was completed by organising the data using the software application NVivo 14. The data was analysed using the narrative inquiry approach which focuses on *temporality, spatiality* and *sociality* as a framework to re-tell the participants stories (Clandinin and Connelly (2000). Narrative thematic analysis was the narrative inquiry technique chosen to analyse the data as it involves using the content of the text to shape the life stories and narratives of individuals (Butina, 2015). Narrative inquiry is a contemporary analysis that draws on the importance of using stories to inform policy and practice (Pino Gavidia & Adu, 2022). and is used to explore the role of a person's identity, culture, former experiences through an oral history shared and constructed with a researcher (Lieblich et al., 1998). Therefore, given that this study was exploring the intersection of ethnic, social and gender identity and life experiences in light of healthcare interactions and experiences, this was felt to be a particularly appropriate lens in which to conduct the work.

The process of narrative thematic analysis included completing line-by-line open coding by the lead researcher following the Braun and Clark (2006) thematic analysis approach. The development of codes was an iterative process, including several discussions with the research team for congruency. Narrative themes were generated by chronologising the data into common or shared themes that represented the key events that occurred through each participant's personal story, relating to their system experiences. Further details on code and theme development, can be found in the additional results chapter.

Researchers, Reflexivity and Rigour

The researchers were conscious of their identity throughout the research process. The research team included three females, each with varying degrees of research experience. The lead researcher identified as a Black-Caribbean British female, therefore their lived experiences of growing up in the UK as a Black person was valuable for relationship building with the participants. However, because of this, it was imperative for the lead researcher to challenge any unconscious beliefs that could have influenced the findings to reduce the risk of bias. To supplement this process, the lead researcher documented the data collection process by keeping a reflective diary. This aimed to increase the transparency and credibility of the data collected (Noble & Smith, 2015). Details of how the reflective diary informed the findings can be found in the additional methods chapter. Finally, the lead researcher engaged in post-interview discussions with their research team who had diverse ethnicities, enhancing opportunities to reflect and query initial interpretations of the data.

Ethical considerations

The researcher obtained NHS ethical approval from the Health Research Authority (HRA) and Health and Care Research Wales (HCRW) research committee (Appendix N). REC reference: 24/WA/0064. All participants provided informed consent, interviews were anonymised, and names were pseudonymised to maintain confidentiality. Further details on ethical considerations are outlined in the additional methods chapter.

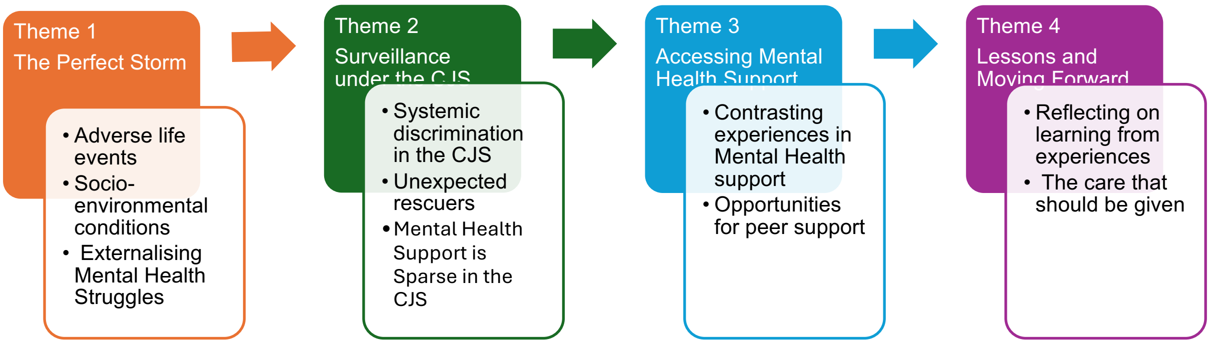
Results

Narrative Inquiry

The themes generated represented the most significant aspects of the participant's journey from before their first contact with services, through to their lives today. Some participants were heavily impacted during their time in the CJS and focused on this aspect of their story, whereas some participants tended to focus on their experiences of accessing mental health support. Overall, all the participants offered insights into their experiences across both systems. Four themes emerged from the data: (1) *The Perfect Storm;* how predisposing factors shaped the participants development, (2) *Surveillance Under the CJS;* how issues within the CJS correlated with mental health, (3) *Accessing MH Support*; opportunities to receive appropriate support and (4) *Lessons and Moving Forward*; beneficial gains from experiences and areas for improvement within the systems. Figure 1 shows the underpinning subthemes and movement between the main themes to capture the storytelling process.

Figure 1

The Story of the Black Men going through Criminal Justice and Mental Health Systems



Theme 1: The Perfect Storm

This theme provided the backstory as to why participants became involved with the CJS and MHS in the first place. The stories shared highlighted psychosocial issues experienced across the life span and the damaging impact it had on their life trajectory.

Adverse Life Events. All the participants reflected on what their life was like before going through the CJS and MHS. Adversity, either during their childhood and/or adult life, was prevalent for all the participants. These events included exposure to horrifying incidents such as witnessing multiple murders, witnessing family and friends enter the CJS, grief after the death of loved ones, sexual abuse by a relative, seeking asylum from their home country, and everyday life stressors relating to employment and housing. Almost all of participants were able to retrospectively acknowledge that the adversity they experienced subsequently led to the onset of their mental health struggles and criminal activity. One participant described how overwhelmed they felt by the loss of multiple family members and the effect it had on their life:

> I mean the challenge is I think it was, it was during the time where I lost my umm, I lost my grandmother, and I also lost an auntie. Then I lost a cousin. So, it was just all of them in a span of one year. And it was just a lot, a lot of stress. (Black African, 26)

Another participant bluntly described the realities of growing up in a neighbourhood where violence and criminality commonly occur and the consequences of this: “So, I have friends who are in prison for murder. I have friends who are dead. Family members who are dead. I have family members who have been in prison for a very long time…” (Black African, 31)

Many of these participants described their experiences as traumatising and at the time of the events, did not recognise the impact they could have on their own behaviours and attitudes.

Socio-environmental Conditions. Almost all the participants correlated their adverse life experiences to other socio-environmental factors such as financial strain and social circumstances. At least two of the participants explained how instability in their home environment led to a disconnect between them and their parental figures. They both described instances where they felt they were parentified, often taking on their parent’s distress, which consequently limited opportunities to express their own emotions. They felt it was their responsibility to raise themselves, despite the chaos in their home, so that they could survive. One participant recalled the difficulty of not being taught the importance of prioritising his mental health:

> …nobody really teaches you things [Mental Health] when you grow up or when you grow, especially in the black community. And I guess I kind of semi raised myself so it… like all these things were, they weren't really relevant to me. Like I didn't think there were any importance like, so growing up, I didn't speak to people about stuff. I just dealt with it in my own way. Like traumatic events, again, just dealt with it in my own way. (Black Caribbean, 29)

Similarly, another participant explained how whilst they wanted to express their feelings with their parent, their previous experiences of this, often left them feeling unheard and misunderstood:

> That's one of the hardest things to kind of navigate. I don't, and I think now… my mum doesn’t really understand me, and I don't blame her because I I know I'm, I'm very unique person so I'm very much hard to understand,

> especially if you don't spend time talking to me. So that kind of impacts the relationship even more. (Black African, 31)

He went on to describe the absence of dialogue between him and his mum when he was growing up and how this impacted his ability to form a close relationship with her. His blameless approach towards his mum, speaks to something much more than parent-child interactions, such as issues regarding generational norms. Here, he spoke about his cultural upbringing: "…I come from an African household… kids should not be heard…". The participants commentary alluded to a sense of having no one to confide in during such a turbulent time in his life, when he evidently needed his family. In fact, four participants shared that they had not disclosed their mental health struggles with their family. One participant referred to needing to remain strong during their hardships "…I mean around family. Try to keep it… try to keep your composure." (Black African, 26). This reinforced the presence of isolation. Similarly, there was a perspective centred on societal expectations for Black men and managing their emotions. One perspective included: "I think it's when you grow up as a, especially as a Black male, it's not seen as tough to talk. We're more designed to just punch, fight, jump run…" (Black African, 31). This societal belief ultimately resulted in the Black men suppressing their emotions.

Externalising Mental Health Struggles. During the timing of these events, almost all the participants shared that they did not have insight as to how their hardships impacted their mental health. Rather participants noticed changes in their behaviour and actions, which was regarded as threatening towards other people. One participant residing in a medium secure unit described how the deterioration in his mental health was recognised externally by others: "I wasn't really making much sense… was shouting a lot. Umm I wasn't quite normal anymore… wasn't not engaging in conversation very much anymore…" (Black Other, 42). A lack of insight also meant delays in receiving help. For a few participants, the consequences were detrimental to their life. For example, a participant who was seeking asylum in the UK, described how they ignored their immigration lawyers' advice for them to get help with their psychotic symptoms from their GP: "They said I should, I should seek support from the doctor, but I didn't." (Black African, 28). As with other participants, deteriorating symptoms resulted in physical harm to another person or wider criminal activity. Consequently, this instigated involvement from the CJS.

Theme 2: Surveillance Under the CJS

Unfortunately, because of the participants life experiences making them less likely to acknowledge or remain unaware of their worsening mental health, this delayed receiving help from MHS. Instead, they received attention from the CJS, which was experienced as initially hostile and discriminatory.

Systemic Discrimination in the CJS. Each participant's route into the CJS varied and the degree of the *crime* had different repercussions; however, their shared experiences of treatment within the CJS was spoken similarly by all participants. All the participants shared their experiences of discrimination whilst they were in the CJS. The most common incidents included direct and indirect racism, as well as prejudice because of their suspected criminal offence. One participant shared their experiences of being racially stereotyped by the police:

> When I got stopped by the police, the first one that asked was are you smoking? They didn't even ask me if I was drinking or anything. They just asked me am I, have I, have I taken any substances whatsoever? (Black African, 26)

Another participant who was considered an illegal immigrant at the time of his entry to the CJS, described his shocking first encounter with the CJS staff when he experienced racism for the first time:

> So, we have never been like, not that exposed to racism. So then, talking about 2022, when I came to the UK, so it was just new. Everything was just entirely new to me, like the treatment… (Black African, 27)

In contrast, a participant with a similar background, described experiencing discrimination, but they did not necessarily name the hostility they received as racism: "…why did you choose to come to UK and all those things? And they ask us when are you going back to your country?…I didn't really feel, feel welcome to when I came when I arrived." (Black African, 28). These instances highlighted the mistreatment experienced by the participants. Some participants described living in fear and recognised the imbalance of power between them and the CJS staff. For example, one participant highlighted their lack of choice when he was forced by the prison staff to move to a different prison wing in the middle of the night without receiving an explanation: "…literally a lot of them feel like they can literally control your life, however, they see, if they deem fit. It's kind of like a power trip." (Black Caribbean, 29).

Unexpected Rescuers. Whilst the participants expressed issues of bias once entering the CJS, all the participants mentioned at least one individual in the system that identified their need for mental health support. These *heroes,* who were not necessarily mental health professionals, put their subjective biases to one side and showed empathy for these participants. One participant reflected on how his lack of understanding about his mental health was recognised by his solicitor who informed the courts about his presenting mental health struggles:

> I remember my solicitor calling me, saying “Yo, are you okay?”
>
> I was like, I don't know, I remember, I was like, I don't know because at that time I didn't know anything about anxiety, didn’t know anything about mental health, didn't know anything about that if you're not feeling okay, it's not always… that there's ways to deal with it or whatever, but as you try, I remember my solicitor saying it to like the courts and that like he’s a young boy, he’s got a lot going on. (Black African, 31)

Unexpectedly, this presence of an advocate changed at least four of the participants perspectives about the CJS staff and it allowed them to form positive relationships with them. For example, one participant discussed how a prison officer was initially hostile, but by attempting to befriend the prison officer, the participant was able to change the prison officers’ attitude towards him. This eventually opened the opportunity for him to access help from a psychiatrist within the facility. The participant described the amicable relationship he built with the prison officer following this: “… And from that day he was nice. His personality just changed, like… So those, that racism, that, it stopped like it's… I just stopped getting that vibe.” (Black African, 27). If the participant did not try to initiate a relationship with the prison officer, it is uncertain whether he still would have received support for his mental health from the doctor.

Mental Health Support is Sparse in the CJS. Despite there being a recognition for mental health input, the CJS lacked the resources to offer adequate mental health support at the time. Many of the participants believed their needs were not met and at least four of the participants felt that their mental ill-health was exacerbated through their interactions with the CJS. One participant explained the difficulties of spending almost the whole day in a prison cell: “Umm… it was quite an uncomfortable time. I mean they sorted out my medication, which was important. Being in a cell was really stressful.” (Black Other, 42). Even though this participant received medication to treat his mental illness, he believed the confinement of his prison cell was impacting his mental health. This related to other issues raised by the participants such as not meeting their basic needs as well as a lack of consideration to manage their mental health. For example, one participant described how they desperately needed something to self-regulate:

> Sometime I wanted radio to listen to music 'cause I feel like music sometime they help me with my mood. Yeah, but they didn’t, and I was asking if I can have MP3. They said that's not allowed in prison. (Black African, 26)

The prison was aware of his mental illness, but were unable to provide suitable facilitates to alleviate his distress.

Theme 3: Accessing Mental Health Support

The initial professionals in the CJS that recognised the Black men’s mental health need, assisted with the referral to the appropriate services that offer mental health support. From the Black men’s perspectives, there was a huge difference in the care and support they received with their mental health, compared to how they were treated by the CJS.

Contrasting experiences in Mental Health Support. Not all the participants received support from MHS through the traditional referral pathway into the NHS. Some were initially offered services embedded within the CJS and then later transferred to an inpatient facility, whereas others received support within the community. Most participants regarded the support they received for their mental health as a positive experience, whether it was provided by an NHS multi-disciplinary team or from NGOs. Here, one participant shared their experience of having someone to talk to about their mental health*:* “…even though it's like a brief encounter again, it was good to, like, talk to somebody about it because again, it's my first time in prison.” (Black Caribbean, 29). Some participants shared the significance of receiving care from a clinician from a similar ethnic background. For example, one participant acknowledged the usefulness of having a black counsellor and how it challenged their prior views about MHS: “Having the opportunity to speak to and work with a black counsellor was very helpful because it changed the whole, it just changed my whole view on the system.” (Black African, 26). However, for two participants there was ambiguity as to whether receiving support from ethnic minority healthcare professionals improved their mental health.

Although experiences within the MHS were considered overall more positive than within the CJS, almost all the participants provided caveats to their experiences. Participants expressed ways in which the MHS provided insufficient support, that did not always meet their needs. This ranged from the nature and standards of care being inadequate, to the availability of resources (e.g., materials, staffing, proficiency, activities).

One interesting finding included two participants who received support for their mental health within prison and were then transferred into specialised inpatient MHS. They both mentioned the differences in care provision in the CJS, which was perceived as non-therapeutic and felt their needs were neglected. One of the participants highlighted how they received appropriate therapeutic care when they transitioned to the inpatient facility:

> ….But because the prison was only a very small wing….so where I am now, I think I'm getting the treatment that I need because I'm in the right place, surrounded by the right people all of the time. (Black Other, 42)

Opportunities For Peer Support. Three of the participants mentioned that being in the MHS offered them the freedom to connect with other peers which was almost impossible under the CJS. They found the experience to be invaluable and vital for managing their mental health and well-being. In one example, a participant described the contact they received from their friend: “I have a small phone where my friend use to call me and he supports me as well. Just encourage me to be strong and and stay strong.” (Black African, 28). He also mourned what his life was like before, when the support from his friend was much more accessible. This points to possible feelings of loneliness and social isolation whilst in MHS.

Theme 4: Lessons and Moving Forward

The majority of participants reflected on how going through this process transformed their previous beliefs and understanding about mental health and highlighted to them the importance of prioritising their mental health. Rather than viewing their experiences as negative, they perceived it as an opportunity for personal growth and development.

Reflecting on Learning from Experiences. Five participants described mental health as something that requires continuous learning and perseverance; they acknowledged it is their responsibility to manage their mental health and identify when they might need support. One participant described how it took him a while to process his experiences and get a better understanding about his mental health. He now considered his mental health to be a fundamental aspect of his life:

> Mental health and well-being is that it's super important, like for me personally, it's like the foundation because I like to think of health as like a table. And if one of the legs disappears then you kind of, you've got nothing left to fall back on. (Black Caribbean, 29)

He then went on to explain that he's seen a difference in how he maintains and restores his interpersonal relationships, after accessing mental health support.

Two participants who were still under the care of inpatient services, admitted the care they received gave them better insight regarding their mental health, but they were worried about their future. Both participants highlighted their fears surrounding accommodation once they leave the facility and how uncertain this was for them. One participant referred to being stigmatised because of their mental illness, when they re-enter back into the community: "I suspect that the next time there'll be a time to be judgmental, anything like that sort of thing…Is when I get out, really- what happens then?" (Black Other, 42). The other expressed their fears about being deported back to their home country where they were a victim of abuse: "Going back to the same place where I came from, it also just worries me every time." (Black African, 28). Ultimately, these participants were conscious about the limited control they had over their lives and possibly less hopeful about their experiences leading to self-development.

The Care That Should Be Given. There was a general consensus from the participants that the treatment they received across the CJS and MHS was not optimal, and they gave suggestions on what they would have preferred to have experienced. One issue highlighted by two participants was the CJS staff failing to see the participant as an individual and investigating their background more rigorously before making assumptions about them. They both argued that the CJS are required to explore the wider systemic issues surrounding the individual and reflect on why it could be influencing their behaviour. One participant explained that sometimes engaging in criminal activity is not down to individual choice, but the alternative for survival:

> So sometimes we think ohh why should this person sell drugs or why do you have to sell drugs? But sometimes the questions is… what happens if you don't sell drugs? Are you gonna eat tonight? I are you gonna be able to get up tomorrow and clothe yourself? Like ah, how do we know? (Black African, 31)

Two other participants shared their views on how the CJS as an institution need to have designated safe spaces to talk about their mental health. They described that the hostility of the environments they were in, did not account for this and it made it difficult for them to manage their mental health. Reflecting on his experience in prison, this participant suggested a helpful initiative that would have helped him and his fellow prisoners: “You know, like even like little group sessions, like once every other week and to the prison, it seems like that's a lot to facilitate, but I think it's like it's a, it's a small thing.” (Black Caribbean, 29). The participants were very vocal about change and exhibited an expert by experience perspective when discussing the challenges seen across these systems.

Discussion

The voices of marginalised groups to inform changes within clinical practice, has been underreported throughout literature. This study sought to provide a platform for one of the most under-researched groups, Black men. The main aim of the study was to understand Black men’s stories and experiences of accessing MHS through the CJS. Additionally, to understand how Black men perceived their interactions with the professionals working in the systems, and whether there were any unmet therapeutic needs. To our knowledge, this is the first study to-date that has investigated such phenomena. The stories shared by the Black men in this study were intricate and rich; their bravery and candour to share their experiences must be appreciated. The findings revealed four main themes that represented the participants' narrative.

The first theme, 'The Perfect Storm' provided the foundation as to why the participants lives were interceded by the CJS. This included experiences of socioeconomic disadvantage, early life adversity and trauma, migration, and social isolation, prior to the Black men's first contact with the CJS. Such experiences align with the social determinants of mental health model (Kirkbride et al., 2024) and can increase the risk of developing a mental health condition. This was further compounded by the Black men's limited knowledge and awareness of their possible mental health problem, until they had contact with services. This outcome was unsurprising, replicating similar findings on 'detachment' from awareness of mental health problems previously reported by Black men (Meechan et al., 2021). Furthermore, the Black men's ethnic identity and views of masculinity presented as additional barriers to understanding their mental health in needs, resulting in delayed help-seeking and they recognised this likely contributed to their externalised distress (Cloud, 2024).

Ultimately, the Black men were subjected to 'Surveillance under the CJS'. The Black men in this study regarded their experiences within the CJS to be overly hostile, punitive and discriminatory (Carvalho, 2019; Prasad 2023). The saliency of perceived racial discrimination experienced by the Black men contributed to feelings of depersonalisation (Solanki et al., 2023), and it is possible treatment like this can lead to race-based trauma (Carter, 2006). There is insufficient evidence to understand what precipitates and maintains racial discrimination within the UK CJS (His Majesty's Inspectorate of Constabulary and Fire & Rescue Services, 2023), and without this information, areas for change and improvement are difficult to identify.

The Black men who were more familiar with the British culture, were not surprised they were racially discriminated by the CJS. A possible explanation for this lies in the marginalisation of Black people which is more prevalent in Western regions of the world and is more readily recognised as discrimination by Black ethnicities living in those countries (Reino, 2020). Whereas, the two migrant Black African men were less familiar with racism, so their experiences of racial discrimination were more perplexing to them. This nuance between the Black men was an interesting finding and highlights the need to understand Black migrants' experiences in the UK. This is a heavily underrepresented research area within the literature (Barnett et al., 2019).

Despite generally negative experiences in the CJS due to the inadequacy of mental health support resources (Turner et al., 2023) and aggravated psychological distress (Alang et al., 2021), the findings show that 'Accessing Mental Health Support' is possible when it is facilitated through competent and compassionate professionals working in the CJS, who can identify, empathise with and validate mental distress. This was the gateway for participants to receive mental health support. Overall, the Black men regarded their experiences of receiving mental health support positively. It was possibly the first instance where they could navigate and make sense of their mental health. Similar findings have shown that Black men in the CJS who've had the opportunity to confide in and build relationships with unbiased professionals, peers and families, has significantly improved their well-being (Being Well Being Equal et al., 2021). However, in this study there were mixed narratives regarding the Black men's experiences of mental health support from services (Meechan et al., 2021), suggesting further opportunities to understand the mental health needs of Black men is necessary.

This study offers a new perspective which emerged from the Black men's stories, as they reflected on 'Lessons and Moving Forward' after receiving mental health support. This encouraged them to reflect on and positively reframe their prior experiences aligning with post-traumatic growth (PTG) theory throughout their narratives. PTG theory (Tedeschi & Calhoun, 1996), focuses on responses to traumatic events or challenging situations that are built on the idea of increased resilience, personal growth and optimism arising from their adversity. The Black men acquired information and meaning about themselves that they could use to fulfil a future they had not imagined for themselves. This learning helped them nurture and begin prioritising their mental health. Despite this positive outlook, two Black men were preoccupied about their future regarding post-discharge plans from the inpatient setting. These fears of the future are not uncommon (Mao et al., 2024), but Black men may fear being returned to environments which negatively impact their mental health.

Clinical Implications

Professionals working in the CJS will need to consider how their attitudes and approaches towards Black men can be experienced and understood to amplify their existing distress. Being aware of personal biases is the beginning to combat this issue, however training for the CJS professionals such as cultural safety training (Hardy et al., 2023), and trauma-informed care (Maguire & Taylor, 2019), could help reduce felt experiences of discrimination and biases. This would include making sure initial interactions are non-discriminatory and non-hostile, attempting to de-escalate as quickly as possible, taking a person-centred approach by assessing psychosocial factors, including any history of mental illness within their family and focusing on their safety rather than being criminalised by re-directing to the appropriate services.

Within the MHS workforce, there should be continuous efforts to adhere to the Patient and Carer Race Equality Framework (NHS England, 2023), an anti-racism framework which aims to reduce race disparities in mental healthcare. Despite the existing NHS commissioned Liaison and Diversion services situated within the CJS to facilitate the identification of people coming through the CJS who may present as vulnerable (Her Majesty's Inspectorate of Probation [HMIP], 2021), the findings suggest there is a gap in interagency working. Therefore, applying the anti-racism framework with professionals in the CJS may promote culturally-appropriate care and reduce mental health inequities experienced by Black men.

Strengths and Limitations

This study provided the opportunity for Black men to discuss in-depth and sensitive topics in a confidential space about issues they had not had an opportunity to talk about before. We hope that their voices and stories will encourage other Black men to share their stories and add to an emerging field about Black men and their mental health care. One limitation to highlight is the relatively low number of participants recruited into the study. It is possible that more participants could have increased the findings generalisability and deeper understanding of experiences and views. Another limitation was that it was a mixed sample of self-reported mental health difficulties and formal diagnoses, likely as a result of the multiple recruitment pathways. A final limitation is that the two inpatient participants were possibly unable to resonate with the idea of positively moving forward after their experiences and as such they were unable to fully contribute to theme four.

Future Research Opportunities

One clear narrative from the finding was that if the participants had earlier access to the resources that would have helped them recognise and reconcile with their mental health, it is possible the trajectory whereby they ended up in the CJS could have been mitigated. Future research should focus on understanding the consequences of access to prevention and early intervention resources for mental health and well-being, and how this informs outcomes for Black males. Another research opportunity would be to address the gap in knowledge regarding Black immigrants' experiences of the CJS and MHS, since their pathway into MHS might differ from those who identify as Black British. Given the finding of post-traumatic growth, and considering that many participants were still receiving care, it would also be valuable to follow up these participants in the future to see how their insights and reflections have changed over time.

Conclusion

These robust qualitative findings have demonstrated how psychosocial indicators that precipitate early psychological distress can increase the risk of intervention from the CJS. However, the CJS is viewed as the entryway to receiving psychological care, opening the door to insight and healing distress, notwithstanding existential uncertainty and wider, negative, discriminatory experiences within the system. We hope these findings add a degree of knowledge to the field of mental health and criminal justice research. The interdisciplinary nature of the findings suggests that in order to reduce health inequities for Black men, both disciplines require action and change at the systemic level, so the possibility of equity is achievable. More opportunities to centre Black men's voices within research will advance our current understanding about their experiences which is underwhelmingly absent from the literature.

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Chapter Five: Additional Methods

Word Count: 3,434

This chapter aims to discuss the key elements of the study design, including changes and challenges that informed data collection. Furthermore, additional details regarding the data analytical process. This was in collaboration and discussed with the research team.

Methodology

During the initial design phases of the research, it was imperative for me as the lead researcher to reflect on my philosophical stance. There was a period of exploring ontology and epistemology as applicable to the research questions. On one hand I had observable knowledge about Black men and the issues surrounding the CJS and mental health. From this perspective, exploring these phenomena objectively appeared to be rationale, possible alluding to a more critical realism stance. However, the problem with informing the research design based on my personal observations, would have been a counterinitiative approach since one of the objectives was to gather data from multiple voices, that had historically been silenced. The assumption that the voices would be identical may have depersonalised the Black men's experiences. Reflecting on this meant challenging my stance and viewing knowledge and reality as being informed by individual narratives. Therefore, based on these reflections, my philosophical stance shifted to a relativist (ontological) and social constructionism (epistemology) perspective. This included being aware of the cultural context the Black men were situated in but making sure that each voice was equally accounted for and valued. The most suitable approach to understand these narratives would be through qualitative methods.

Alternative Data Collection Methods

The research team and I considered focus groups and ethnographic approaches; however, they were not best suited to capture individual stories. Furthermore, the practicalities and possible associated risks of collecting data through those methods, may have resulted in material ethical challenges. Other data collection methods that were considered included playing an exerpt from a song and asking for feedback from the participants on their thoughts about the exerpt (music elicitation) however, there was not scope to include this as a data collection method.

The Interview Schedule

A semi-structured interview approach was selected because it covered the relevant topics and allowed for flexibility in the discourse between myself and the participant. Additionally, it was imperative to be led by the participants interests and a structured interview approach is not as accommodating. Since this was a new phenomenon we were trying to investigate, there was not any existing theories that corresponded with the research questions. Therefore, the design of the interview schedule was informed by reviewing the available literature, which was primarily government statistics, evidence reviews and empirical findings. We were interested in trying to understand what led them into the two systems in the first place, so asking questions related to life before they experienced contact with the services was important to create the plot for their stories. It was equally as important to understand their subsequent experiences of having contact with the two systems, therefore questions related to their current life circumstances were introduced within the interview schedule. Once a preliminary interview schedule was developed, it was important to liaise with the Advancing Mental Health Equality (AMHE) Black men’s group who were appointed as a method of Public and Patient Involvement (PPI).

Since the group included professionals working within the CJS and MHS, their interest and expertise about Black men were valuable at ensuring the interview schedule was robust. The provisional interview schedule was disseminated to the PPI group via email, and they were asked to provide feedback. The feedback was primarily constructive however, it was recommended for the interview schedule to include a question around systemic relationships. Following this feedback, the interview schedule was revised and finalised with the research team.

Procedure

The procedure for recruiting participants through NHS and non-NHS pathways, slightly differed prior to completing the interview. The participants recruited through the NHS were requested to complete a consent to contact form (Appendix M) to agree for the lead researcher to contact them regarding the research. This was completed through communicating with the participant's responsible clinician. After the lead researcher received a completed consent-to-contact form, they carried out the same process that was completed with the non-NHS participant's.

Ethical Considerations

Preparations to obtain ethical approval began with submitting an ethics application to the Integrated Research Application System (IRAS), which is the official process for obtaining ethical approval to carry out research in the NHS. This also provided the ethical approval to recruit participants through the non-NHS pathway. There were multiple stages prior to obtaining ethical approval. This included preparing the IRAS application form for submission. Within the form it was important to highlight the risks and ethical issues applicable to the participants and how they were going to be mitigated throughout data collection. Furthermore, being clear that the research would be informed by guidance from the British Psychological

Society (BPS) Code of Conduct (2021), BPS Code Human Research Ethics (2021), Good Clinical Practice (NHS, 2018), UK General Data Protection Regulation (GDPR) (Information Commissioner's Office, 2023) and the Data Protection Act (DPA) (UK Government, 2018). These guidelines emphasise the importance of carrying out clinical research competently and preserving the participants data minimising the potential for data breaches.

Once the application was submitted, it was reviewed by the Research Ethics Committee (REC). Following their review, they invited the research team to an ethical review meeting, in which I attended, to query the application and ensure it was legally compliant. During this review period, additional documentation to support claims within the application were requested, which were prepared and sent by myself. Once the REC received all the documentation, they then issued a letter confirming ethical approval. This process took several months, and resulted in a delayed recruitment start date. In order to recruit through the NHS, the ethical approval letters were shared with the selected NHS trusts, which were each appointed as a Participant Identification Centre (PIC). This process was also lengthy since the NHS trusts had their own processes for accepting and reviewing external research projects. This included making sure it was ethically compliant and that a local collaborator within the trust was available to monitor the research. Once we were given the go ahead from the NHS PIC sites, we could begin recruitment, although this was also a slow process.

After a few months of not receiving referrals from the NHS trusts and discussing this concern with the local collaborators, I decided to review the current exclusion and inclusion criteria and discuss it with the research team. We originally excluded people with a forensic background due to risk, however we realised this would be pool of people that would have experienced accessing MHS through the CJS. The decision to remove the exclusion criteria meant an amendment to the research protocol, and therefore the REC needed to be informed about this change as well as the existing NHS PIC sites. So that these changes did not incur ethical dilemmas, it was important to make it explicitly clear that the interviews needed to be completed online to reduce risk. After submitting a request for an amendment, this again was reviewed by the REC. Once approval for the amendment was received (Appendix O), the NHS PIC sites were informed about this approval. This action meant that we could expand the services we could recruit from and helped with the recruitment of more participants.

Throughout the data collection process, it was imperative to remain ethically competent. This meant being aware of any ethical dilemmas that may arise during the completion of the interviews. Having a procedure following the completion of the interview to report any concerns was crucial in safeguarding the participants, if it was applicable. These procedures included signposting participants to resources that could offer emotional support if they were distressed by completing the interview. Furthermore, offering follow-up calls if the participant found it necessary for processing the information they shared. For the participants that were recruited through the NHS, any ethical dilemmas could be escalated and discussed with their responsible clinician.

Recruitment Challenges

There were several challenges related to recruiting participants into the study. Originally, the goal was to recruit and interview between 10-12 Black men. Unfortunately, the recruitment target was not met. The process from eligibility to obtaining consent and then subsequently completing the interview was not a straightforward process. Despite there being two recruitment pathways, there were parameters to recruitment, that could not be overcome.

Non-NHS Recruitment Pathways

Over 23 non-governmental organisations (NGOs) supporting Black men, mental health and criminal justice users received the study poster via email. Whilst a handful responded to the advertisement and agreed they would share the poster with users of the organisation, this did not stimulate a wave of interest. A few organisations who were conducting their own research on Black men, highlighted the current drought in recruiting Black men into mental health research. Learning about their struggles meant identifying alternative recruitment strategies. An Instagram account was created to share the study poster through social media. With the option to pay for advertisement, I was optimistic that this approach would draw in participants. Despite the study poster being viewed by 1,150 people, having 24 followers with whom I interacted with and following accounts that appeared to be related to the criminal justice system and Black men's mental health, recruitment remained static. One of the dangers of recruiting through this pathway was the risk of pseudo people claiming they met the eligibility criteria. I received multiple emails from either one or a group of people with false identities expressing their interest to participate in the studies. How this was discovered was because of similarities in text used in the different emails. Before completing disregarding the emails, I informed the research team, and they also reviewed the contents. We agreed that their expression of interest was likely of a fraudulent nature and therefore did not progress with recruitment.

NHS Recruitment Pathway

As mentioned above, obtaining ethical approval to recruit from NHS trusts was a slow process. However, once the approval was obtained, there was now opportunity to recruit from the NHS trusts. I liaised with the local collaborators at each NHS trust, and they were eager to identify eligible Black men within the services they worked in.

The challenge of recruiting through this pathway, was that there were limitations in how I could interact with the eligible Black men. Having to go through their responsible clinician became a barrier and whilst they identified a handful of Black men that met the inclusion criteria, there were several that declined to participate in the research. The feedback from the clinicians to explain the reasons why the participant declined participating in the research, was not always clear. This appeared to be another barrier to recruitment. Further reflections and suggestions as to why recruitment in this population appears to be difficult are outlined in the general discussion chapter.

Analysis

The initial analytical framework that was considered was Interpretative Phenomenology Analysis (IPA). Firstly, this approach is suitable for qualitative research that may include idiosyncratic experiences, which we anticipated would be the case for the participants recruited into this study. Secondly, IPA aims to understand lived experiences, but from the perspective that it can be interpreted in a multitude of ways. The caveat to this approach is that the research questions clearly suggest experiences of transitioning. If an IPA approach was used to analyse the data, it might have missed the opportunity to explore this transition and there may have been more focus on specific aspects of the Black men’s experiences, thus not capturing the whole story. Essentially with an IPA approach there was the possibility of gaps in the narratives. The narrative inquiry approach appeared to be more fitting to this study because it aims to explore lived experiences through a storytelling process. Additionally, it emphasises the importance of chronologising the data, which matched the concept of transitioning from one system to another and emphasising the oral history and reflective approach of the inquiry. Oral histories and verbal narratives are widely used in qualitative research involving marginalised and underserved groups of people, such as indigenous communities, who experience complex, traumatising and systemic health inequalities (Povey et al., 2023). This approach worked very well within the context of Black men who experience similar inequities. The narrative inquiry approach looks at lived experience holistically by acknowledging stories occur within a time period, within an environmental space and through social interactions, which were all relevant for the research questions we were aiming to answer.

Transcribing Process

The interviews were recorded and transcribed verbatim using Microsoft teams. Once the transcription was available it was re-transcribed on Microsoft word, to account for any inaccuracies. Each interview was transcribed immediately after the interview. The purpose of this was to identify when an inaccuracy occurred, or when the recording did not transcribe audible speech. This also provided the first opportunity to read through the transcript. The first read through also meant re-watching the video recording to note any additional observations such as pauses in speech and adding references to topics, when this was not specified by the participant. Additionally, removing any data that would breach confidentiality such as names, locations and replacing them with pseudonyms. At this point I began noticing the different themes that were emerging from the interviews, which helped with the beginning of data analysis. At various points in the interview, some participants used various forms of slang, which was also interesting at the data analysis stage. Some unfamiliar phrases needed to be researched so what the participants shared could be contextualised.

Analytical Process

The length of the interviews meant that analysing the data was a time-consuming process. After several readings of the first few transcripts, I started briefly thinking about the narrative recalled by the participants. These preliminary ideas were reported in my code and theme development logbook. Examples included: *‘Sacrifices to get by: needing to go to extreme measures to survive because don’t have the knowledge of what resources are available.’*, and *‘Internalized stigma and helping seeking within the community; fear of showing vulnerability to caregivers when they should be the safest place to be vulnerable, what does that say about black men and their upbringing?’* (27.09.2024)

Whilst these were some initial interpretations of the data, the more formal process of analysing the data included line-by-line open coding. This inductive approach to analysing the data was selected since the findings were not framed around any existing theories. Coding the data was an iterative process, primarily because a multitude of codes were generated and subsequently revised. The purpose of revising the codes was to ensure they reflected the textual data and additionally making sure the codes were relevant to the research questions. The initial codes I developed were discussed with the research team and this led to further revisions of the existing codes. This method of triangulation enhanced the analysis by promoting a comprehensive account of the participants lived experiences. Furthermore, having multiple perspectives interpret the findings likely mitigated the risk of bias and gave more credibility to the generated themes.

Once the codes were put into categories, this is when the narrative inquiry approach began shaping and labelling the themes. This meant applying the findings to the tripartite model (*temporality, spatiality and sociality).* By looking at the findings from a *temporality* perspective the structure of the narrative needed to be within a time continuum. It was evident from the findings that there were significant time points throughout the Black men's stories. This included the time before the CJS and MHS, the time during the contact with the services and a time to learn and reflect on these experiences. This timeline existed within a cultural and environmental context, and therefore the *spatiality* that the Black men were situated in acted as precipitators and perpetuators throughout this period. The themes also had to reflect the *sociality* nature of narrative inquiry, which meant identifying where in the narrative do the Black men make sense of their relationships and interactions with the people they had contact with, across the different time points and environments. However, to ensure a robust narrative, these concepts were refined and elaborated on with another researcher within the research team. At this stage, a thorough review of the codes and preliminary themes were finalised. Structuring these findings into a chronology presented the narrative for Black men accessing MHS through the CJS. Below is an example of codes generated during a meeting with a second researcher:

Supervision: 15/11/2024

Codes developed using BLKM0102:

- *Accessing support from mental health services*
- *Bias from professionals*
- *Elements of well-being*

- *Exposure to criminal activity*
- *Externalising behaviours*
- *How services should respond*
- *Knowledge about access to services*
- *Needing to survive in the face of adversity*
- *Processes in the criminal justice system*
- *Services not caring*
- *Variability of mental health and well-being*
- *Vicarious response to parental stress*

Reflexivity

As the lead researcher, it was important to think about my position throughout the data collection and analysis process. Also identifying as a Black ethnic person meant that my personal experiences might have aligned with the stories shared by the participants. The idea of sharing certain characteristics (e.g., ethnicity, language, culture, faith) with research participants is known as “insider” research (Ganga and Scott 2006). There are benefits and caveats in having this role, therefore it was imperative to acknowledge them when they arose during the interviews. One example is when the participants expressed issues related to racial discrimination. On one hand I could empathise with the participants, having experienced racial discrimination myself, despite it being within a different context. I believe the participants perhaps felt more comfortable sharing this insight because of our shared characteristics. However, the risk of acknowledging our shared experiences could have meant losing my professional composure as a researcher, and this could have disrupted the flow of the interview, possibly jeopardising data collection. Whilst there were some similarities, I also recognised the differences between myself and the participants. One difference in particular was between myself and the two Black African migrant participants. In an extract from my reflective journal, I highlighted some of my initial thoughts when completing the interview with one of these participants and some unconscious biases that needed to be challenged:

> …Another bias I acknowledged, was judgement towards participants whose first language wasn’t English. In some way, this correlated with my understanding of the literature, which excludes many people not born in English speaking countries, regardless of race. A particular participant was able to share with me their experience of seeking refuge in the UK and how daunting that journey was for them. I had never thought about how the experience of an immigrant could feed into the stories about black men accessing mental health services through the criminal justice system. This is ironic, due to the fact that a lot of black people cited in the literature, are British born, but their grandparents, if not parents are themselves immigrants. Perhaps there was a fear that I would not understand their accent and misunderstanding what they were saying. Maybe, I worried that their experiences wouldn’t fit into the narrative I was already developing based on my previous interviews, or his experiences weren’t as valuable because they weren’t through the typical route of accessing these services. What I really learnt through this encounter with this particular participant was that every story matters, and the unpredictability about his story is what makes the outcomes of this project ever more authentic. (October 2024)

I was moved after hearing the participants stories. Even after several readings of each participants transcript, the narrative they expressed was palpable. During the analysis, it was important to not make too many inferences about the findings, again linking this back to my role as an insider researcher. Instead, I focused on using the verbatim text from the participants to tell the narrative. This verbatim text was informed by the questions within the interview schedule, but also the follow-up questions I asked out of curiosity that were separate to the schedule. I realised during the analytical process that I offered some great follow-up questions, but I also identified moments in the transcript where I could have asked a follow-up question to extract more data, and I did not. In my code and theme development logbook, I noted this and made sure that in subsequent interviews I took the opportunity to ask further questions if they were relevant to the research questions. This approach heavily influenced the data that was collected and thus my role as a researcher in this study was relevant to the findings.

Chapter Six: General Discussion and Critical Evaluation

Word count: 6,143

This chapter will evaluate the research carried out in the previous chapters of this thesis portfolio. The systematic review and empirical paper will be the primary focus however, this chapter will also critically appraise the whole portfolio. The structure of this chapter will be as follows: (i) overview of the systematic review and empirical paper findings and linking to the relevant literature, (ii) a critical appraisal of the systematic review and empirical paper, (iii) the implications of the findings to the field of Clinical Psychology, (iv) future research opportunities, (v) reflecting on the research process and (vi) conclusions regarding the outcomes of the thesis portfolio.

Summary of Findings

Before summarising the findings from the systematic review and empirical paper, I will restate the research questions which aimed to be answered. The systematic review was interested in understanding the perceptions and experiences of personal recovery for ethnic minority people with severe mental illness (SMI) and from this, what facilitated and prevented personal recovery. Furthermore, if there were barriers to personal recovery, where there any methods used to overcome those barriers in order to experience personal recovery. The research questions for the empirical paper included understanding Black men’s experiences of transitioning from the Criminal Justice System (CJS) into Mental Health Services (MHS), learning about Black men’s perceived interactions with professionals working within these systems, and if Black men believed there were any unique unmet therapeutic needs during their time of transitioning within these systems.

Systematic Review Findings

The findings from the systematic review provided evidence relevant to the research questions. Firstly, personal recovery is possible for ethnic minority people, despite it initially being unclearly defined within the population. This was identified because the synthesis of the included papers revealed three themes supporting this notion but also identified what makes a personal recovery journey more difficult to navigate. The three themes included: i) The Family as a Supportive and Obstructive System; ii) Faith as the Foundation for Hopefulness and iii) Discovering Identity through Agency and Social Interactions. The main themes represented the personal recovery processes associated with the CHIME framework (Leamy et al., 2011) and were culturally driven with more specific concepts relating to regaining ethnic identity, faith and family as important influences on personal recovery. Another interesting element of the personal recovery process included developing strong interpersonal relationships, which was salient across the three themes. This finding suggests proximal systems are integral for achieving personal recovery.

Empirical Paper Findings

The empirical paper sought to develop a narrative from six Black men to understand their process of accessing MHS via the CJS. The narrative that emerged from the data was illustrated as a four-stage process. This included how life adversity acted as the antecedent to interacting with the CJS *(The Perfect Storm),* the Black men's appraisal of interacting with the CJS *(Surveillance under the CJS),* how mental health support was received (*Accessing Mental Health Support)* and the value these experiences have added to their life as well as ongoing concerns (*Lessons and Moving Forward).*

Relating the Findings to the Literature

Systematic Review

The first theme points to the role of family in the personal recovery process. Family was perceived to facilitate personal recovery because they provided a sense of connection and support. Another prominent finding was engaging in reciprocal support towards family which provided purpose and meaning in life. This finding is interesting since the existing literature has primarily highlighted family support being pertinent for personal recovery (Aldersey & Whitley, 2014), but there is less evidence on the value of reciprocating help towards family, which was equally found to generate a sense of connection. This finding might be applicable to ethnic minority people since they traditionally hold collectivistic cultural attitudes to family and social community. Collectivism is the cultural idea that reliance within the ethnic community is more favourable and more of a valued societal norm, than individuality and independence (Yousaf et al., 2022). This is commonly practiced in non-Western regions of the world (i.e., countries ethnic minority people have migrated from), in contrast to individualism, which is perceived as a more Western ideology. If collectivism contributes towards reciprocal roles for ethnic minority people with SMI, then it is possible family played a role in shaping ethnic identity also. Despite these findings, family were also barriers to achieving personal recovery. The main reason for this was because of the stigma associated with SMI. There is some evidence to suggest belonging to a collectivistic culture increases the likelihood of stigmatising SMI, since it deviates from cultural norms (Yu et al., 2021). This overt stigma is likely then to generate self-stigma, which was also an outcome from the systematic review. This resulted in rejection and isolation, the opposite of personal recovery variables. One finding within the literature that was not strongly associated with the findings from the systematic review, was how conflict arising within the family as a result of the SMI, could disrupt a sense of connectedness (Burger et al., 2024).

The second theme revealed the significance of faith and religion in facilitating personal recovery. This included engaging in religious practices such as prayer, worship, attending holy buildings and fellowship with other believers from the same faith. These processes provided a sense of hope and connectedness. This was achieved through the belief that God can heal and restore, despite the presence of the SMI. Receiving prayers from other believers further established a sense of hope and connectedness. The empirical evidence for these findings is relatively small across the literature, however they suggest the need to incorporate faith-based elements into mainstream treatment to help facilitate personal recovery (Foreman, 2017). However, contrary to these findings, religion and faith can possibly hinder aspects of clinical and personal recovery, due to religious beliefs conflicting with treatment outcomes (Lucchetti et al., 2021). Whilst this argument was not a clearly identified theme from the systematic review, there were some studies included in the systematic review (Tuffour, 2020; Tuffour et al., 2019; Virdee et al., 2017), that alluded to these conflictions which included religion possibly contributing to the onset and maintenance of SMI.

The final theme identified the variables related to identity formation. This included developing agency and building social and professional relationships. Whilst it is likely ethnic minority people come from traditional collectivistic backgrounds, agency and individual autonomy was seen as pivotal for achieving personal recovery. Having autonomy meant not viewing SMI as a limiting factor and learning the power of managing one’s health. Developing these attitudes possibly point to strategies used to overcome the barriers associated with personal recovery like stigma. Stigma resistance is reported in the literature to promote identity formation and empowerment, therefore is positively correlated with personal recovery (Dubreucq et al., 2022). In the systematic review this was actioned by diverging from identifying with the SMI and pursuing personal interests. Some of these personal interests coincided with peer interactions, thus creating connections, further shaping identity and providing meaning to one's life. These findings replicate outcomes from an empirical study that explored whether social interpersonal relationships facilitated personal recovery for people experiencing psychosis (Linde et al., 2022).

Creating relationships with healthcare professionals was also meaningful since it provided hope, however incompatible relationships with professionals inhibited the sense of ethnic identity, thus presented as a personal recovery barrier. By not considering the culturally specific needs of ethnic minority people associated with personal recovery processes, misunderstandings between the patient and healthcare professionals are likely to manifest (Bhui & Morgan, 2007). In the systematic review, seeking psychological support from a healthcare professional that shared the same cultural background was one approach to combat the barrier of ethnic identity development.

A sense of personal recovery was less feasible when ethnic minority people experienced systemic discrimination. In contrast to stigma resistance, ethnic minority people were disempowered when they were excluded from socio-economic processes like financial stability and housing, because of their SMI and ethnicity. This finding replicates outcomes from an alternative recovery model known as the SPICE framework (Social, Prosperity, Individual and Clinical Experiences) proposed by Vera San Juan et al. (2021). Prosperity considers how legal, political and economic recovery is experienced by people with SMI. Employment and financial security were perceived as facilitators for economic recovery, however the model highlighted this being felt to be inaccessible for ethnic minority people.

Overall, the results of the systematic review seem to support concepts of personal recovery in non-ethnic minority populations as the findings strongly correlated with the CHIME Framework. Even more specifically it replicated the outcomes of the CHIME framework that were congruent with ethnic minority people which included spirituality as a facilitator to personal recovery, and stigma as a barrier to personal recovery. This review has also highlighted the strong reciprocal role of relationships with families and health professionals that can help or hinder personal recovery journeys, which play an important role in connectedness and meaning as well as recovering a sense of identity as an ethnic minority person. However, there were evident culturally specific differences such as religiousness, social disadvantage and impacts on ethnic identity, that will need to be considered when producing recovery-orientated approaches to promote personal recovery processes in the ethnic minority population.

Empirical Paper

The first theme from the qualitative study, ‘The Perfect Storm’ operates as the prerequisite to the transition from the CJS to the MHS. The most shocking finding included the extensive life adversity the Black men experienced. This included direct and witnessed exposure to crime, migration, abuse, bereavement and social disadvantages. At the time, the Black men did not conceptualise how these experiences could impact their mental health however, their experiences resemble traumatic events that are likely to generate unrecognised psychological distress (Bauer et al., 2022; Browne et al, 2021; Chandan et al., 2019; Fowler et al., 2009). Instead, masculinity, cultural attitudes and the unfamiliarity of mental health concepts, overshadowed the possibilities of creating cognitive connections between their adversity and mental health. This finding is consistent with existing literature which suggests this style of thinking is a survival mechanism that has been taught generationally within the Black community, resulting in, intergenerational trauma

(Bailey et al., 2023). The impact of personal and intergenerational trauma meant the Black men not learning how to verbally express themselves including not knowing how to seek help, thus creating a build-up of unresolved psychological distress and inadvertently externalising their anguish calling for police intervention. Externalisation is likely to be a misappraisal of emotional dysregulation, but there is evidence to suggest police are likely unskilled to recognise this in Black men because of the persistent prejudices towards them and therefore criminalisation (Brownlow et al., 2024).

The second theme ‘Surveillance under the CJS’ recognised the problems occurring within the CJS, which included experiences of racial discrimination, likely retraumatising the Black men (Being Well Being Equal et al., 2021). This outcome replicates a report by Thompson et al. (2021) who also highlighted racial discrimination towards Black people occurring in the CJS. The report provided guidance for criminal justice professionals to adopt antiracism frameworks to minimise instances of racial discrimination. Contrastingly, there was a light of hope for the Black men, when a criminal justice professional recognised a mental health need for them. Similar findings have highlighted that referrals to inpatient settings are received more from criminal justice professionals compared to general practitioners (Keating, 2009), however this is only because of the disproportionate number of Black men coming through criminal justice routes to access help for their mental health.

The third theme ‘Accessing Mental Health Support’ highlighted the next stage of the transition, which involved receiving the appropriate care. For many of the Black men, this was the first opportunity for them to identify with and reflect on their mental health, they previously had not identified with. Overall, this was perceived as a positive experience. Although, the pathway to receiving help was complex and could have been mitigated if systems were funded to deliver community-based care, so that Black men could comfortably reflect and express their mental health difficulties (Darko, 2021).

The final theme ‘Lessons and Moving Forward’ provided a caveat to the retrospective negative experiences. Rather, the Black men developed strength and resilience in response to their experiences. It was a learning opportunity that encouraged them to think about the care they would have liked to receive. This finding suggests that Black men are more likely to overcome mental health challenges and thrive when they are provided with sufficient mental health resources. Evidence suggests these outcomes are enhanced when the resources address trauma, stigma related to mental health and are culturally sensitive (DeAngelis, 2021). Another finding from the empirical paper included the Black men that were still under service provision. They remained uncertain about their future, and this made them feel powerless and fearful of what may come if it means returning to the same adversity, they experienced prior to entering services. There is validity in their worries since empirical evidence has shown health inequities for Black people are likely to prevail post-discharge as they are prone to experience socioeconomic disadvantage, isolation, pervasive psychiatric symptoms and impaired psychosocial functioning (Eack & Newhill, 2012; Lawrence et al., 2021).

Synthesising the Findings of the Systematic Review and Empirical Project

Together the findings highlight a longitudinal journey beginning with pre-service exposures and experiences, interactions with the services and post-service reflections that seem to signify a desire to live a fulfilling life. Knowing that interventions from the CJS are likely to occur at the point of crisis i.e., when someone's mental health has severely declined, it is possible that the Black ethnic groups with SMI inclusive of the systemic review also went through similar processes that were not highlighted within the data. Nonetheless, both findings suggest health inequities are pervasive within ethnic minority populations and are occurring as a result of historical and concurrent traumas, as well as systemic discrimination. Despite this, the findings demonstrate resilience within the context of mental health and wider systems, that may have caused iatrogenic harm. There was a strong emphasis on the strength of community in the personal recovery process for ethnic minority people with SMI, suggesting the need to implement community-based interventions to facilitate personal recovery. This also reflects the findings from the empirical paper which suggests the need for earlier intervention methods using community-based approaches, as they have been evidenced to effectively engage Black men in discussions related to mental health (Bauer et al., 2022).

Critical Appraisal

Systematic Review

One evident strength of the systematic review is that it included multiple studies that provided consistent findings, enhancing its reliability and generalisability across settings. However, the quality assessment for some of the studies revealed gaps in the research process that possibly jeopardised the credibility of those studies. Another strength of the systematic review is that it included studies from different countries and represented a variety of ethnic minority groups. The caveat to this is that from those different countries, only three were conducted in the UK. There are some challenges related to this. The first is whether the personal recovery findings are applicable to ethnic minority people with SMI within the UK cultural context. Secondly, this outcome suggests qualitative research investigating personal recovery in ethnic minority populations is likely under-researched within the UK. This finding is surprising as the evidence previously mentioned highlights the disproportionate rate of SMI reported in the UK ethnic minority population (Halvorsrud et al., 2019) yet few studies have examined the role of personal recovery in this population. One possible explanation includes the literature mistakenly conflating clinical and personal recovery, rather than recognising they are two distinct constructs, underpinned by different processes to recovery from SMI (Penas et al., 2021). This can make interpreting the findings of qualitative studies that have not clearly defined the clinical vs personal recovery construct much harder. Whilst the systematic review findings highlighted a relationship between the two recovery processes, the outcomes only related to personal recovery.

The paucity of qualitative UK-based studies in the systemic review, might also be explained by studies evaluating personal recovery using quantitative methods. For example, there are validated personal recovery outcome measures that reflect the components included within the CHIME Framework, such as the Process of Recovery Questionnaire (QPR) (Niel et al., 2009). The 22-item outcome measure has been used to evaluate the effectiveness of recovery-orientated treatment on a sample of Black patients with psychosis (Slade et al., 2011). However, it does not appear to be validated for other diagnoses of SMI, and it has relatively weak psychometric properties (Williams et al., 2015). Despite this, there are two systematic reviews that have evaluated the validity and reliability of personal recovery measures, and the QPR along with the Recovery Assessment Scale (RAS) appeared to have the strongest psychometric constructs compared to the 23 other personal recovery questionnaires (Felix et al., 2024; Shanks et al., 2013). This suggests collecting personal recovery data from ethnic minority people with SMI through quantitative methodology is equally as robust as qualitative methods. Therefore, if I were to conduct this systematic review again, I would have possibly considered a mixed-methodology approach that included UK-based studies only. This may have enhanced the applicability of the findings to the wider UK context.

Empirical Paper

The main strength of the empirical paper is that it is the first study known to the authors to provide an insight of how Black men have navigated criminal justice and mental health systems in the UK. The research provided empirical insights into the working relationship between criminal justice and mental health systems and how this pathway to care was experienced by Black men. Along with this, it is the first to describe experiences for Black African migrants, which was not an expected outcome from the research but will be useful for professionals working with migration populations. Another strength is that this research highlighted the need to strengthen the criminal justice workforce to become culturally and psychologically trauma-informed, as to not further re-traumatise Black men who have already experienced significant hardship and have un-recognised mental health needs.

As previously mentioned, there are various hierarchal structures within the CJS (Ryan, 2022), and because the pathway into and within the CJS was not defined for this research, the perspectives from the Black men were sourced from different pathways within the CJS. It is possible that if the experiences focused on a specific area of the CJS, for example initial police interactions, attending court, prison life, engaging with probation services, then the narrative could have been more in-depth. Furthermore, the recommendations would have been more targeted to the specific pathway. It is likely however, that the research question was broad because this topic had not been investigated before and being the pioneers of the research, would then form the baseline for other researchers to build on the current findings, for example exploring specific pathways in the CJS.

The primary limitation in the research was the small sample size. As discussed in the additional methods chapter, there were several recruitment challenges. The local collaborators were assured the Black men existed within the services they worked in, but there were obstacles to successfully recruiting them. One hypothesis for this recruitment barrier, replicates findings in the literature which suggests Black people are suspicious about participating in clinical research, likely as a result of the historical malpractice and treatment towards Black people in healthcare research (Brandt 1978; Hughes et al., 2015; Scharff et al., 2010). Furthermore, the word *research* is viewed as colonial, too bureaucratic and therefore possibly adds to this attitude of mistrust regarding clinical research. These findings provide possible explanations as to why the Black men in the services declined to participate in the research, and points to considering revolutionary ideas such as decolonialising research to make research participation more inclusive (Denscombe, 2024).

Another hypothesis includes the physical barrier of not being able to directly speak with the potential participants about the research promotion and having to advertise the research through their responsible clinician. This created a disconnect between myself, as the researcher and the person. It made it harder to build a trustworthy connection with the potential participant, which is critical when completing research with this population. It is also possible that when the potential participant was approached by their responsible clinician to participate in the research, they may have been less inclined to agree if they had already formed mistrustful attitudes towards them (Devonport et al., 2022). Evidently trust is a key indicator for successful research participation (Guillemin et al., 2018). These outcomes could also offer possible explanations as to why the evidence-base for Black men, health inequities and the CJS might be limited (Stockwell et al., 2024). This is likely going to maintain the health inequities experienced by Black men since the evidence about these issues are not being empirically investigated. This suggests healthcare professionals and researchers need alternative ways of collaborating, so that Black men are not missing out on research opportunities that are likely to reduce health disparities they are affected by.

The physical dilemma barrier could have possibly been mitigated by recruiting NHS services as recruitment sites rather than Participant Identification Centres. It is likely this would have facilitated direct access with the Black men and opportunities to discuss the research face-to-face. As well as introducing the research to the Black men face-to-face, the interviews could have been completed face-to-face since gathering more observable data might have helped with triangulation, thus strengthening the findings. The only caveat to this is that it may have led to further ethical considerations due to the possible risks to the researcher, which was cited as a concern in the development of the study and in the initial ethical review. An alternative way to triangulate the data that would have involved the participants would have been member-checking, which would have meant sharing the results with the participants and requesting for feedback on whether the results reflected their experiences. This would have enhanced the credibility of the research (Noble & Smith, 2015).

Whilst the Patient and Public Involvement (PPI) group contributed to the research design, there could have been more innovative ways of involving the participants in the research methodology. There are some existing frameworks that include participants in the empirical research process such as the participatory research action (PAR) approach. PAR is action-driven research that seeks to enable societal changes by positioning the participants as the decision-makers throughout the research process from research design, data collection and analysis (Baum et al., 2006). The method seeks to eradicate issues related to power dynamics between researcher and participant, by making the process collaborative. In one example, Keating (2020) used the PAR approach with Black men to collect data regarding their perspectives on mental health using a photovoice technique. The incentive behind the photovoice approach was to encourage participants to take pictures within the community that are meaningful and using them to facilitate conversations related to mental health. This approach is suitable for populations like Black men who may struggle to discuss their mental health. One limitation of using the PAR approach is that it is considered a time-consuming process (Nyman et al., 2022), and requires group interactions, which might make the approach difficult to carry out within the scope of Clinical Psychology training and with this participant group.

Another interesting finding that may be considered a limitation to the research, is that the majority of the Black men where geographically situated in urban regions of the country. The findings were unable to identify whether these experiences would have differed for Black men living in rural areas and whether their outlook post intervention from the services would have reflected the findings from this research. This is especially relevant since the Black ethnic demographic are less populated in rural areas of the UK, and typically access fewer social and health support systems, experience higher rural health workforce turnover which impedes relationship building and may add to the sense of social isolation, impacting their sense of ethnic identity (De Lima and A Race Equality Foundation, 2008).

Clinical Implications for Clinical Psychology

Implications for Theory

As a whole, the findings from the thesis portfolio are underpinned by theories acknowledging the systemic and intra/interpersonal barriers that contribute to mental health inequities for ethnic minority people. Broadly, the ecological systems theory (Bronfenbrenner, 1979), which played an important role in understanding the degree these societal systems influenced the thesis portfolio outcomes. The theory posits individuals are at the centre of a five-tiered systems model that includes the microsystem (e.g., family, friends), mesosystem (interactions within the microsystem), exosystem (e.g., extended family, local community), macrosystem (e.g., government policies, culture) and chronosystem (e.g., pandemics, natural disasters). Noticeably the findings of this thesis highlighted the presence and absence of family at the microsystem level, community-based opportunities at the mesosystem level, unresolved intergenerational trauma at the exosystem level, the influential powers of the MHS and CJS at the macrosystem level and the transitions between pathways into care at the chronosystem level. This seems to strongly align with intersectionality theory (Crenshaw, 1989), which was the theoretical framework used in this thesis to address the overlapping minority characteristics associated with systemic discrimination. Specifically, the findings from the thesis portfolio demonstrated experiences of gender, ethnicity, race, mental health and socioeconomic disparities, suggesting social injustices are multiplied for ethnic minority people.

Whilst these theories recognise barriers to positive mental health outcomes are sustained by social injustices, they do not provide a robust account of the interlinked trauma experienced by the Black men in the empirical paper, which precipitated and perpetuated their mental health inequities. This might be best explained by Critical Race Theory (Bell, 1976) which argues systems like MHS and the CJS are inherently racist. This theory aligns with the possible racial trauma evidence associated with the CJS in the empirical paper, and the barrier to achieving ethnic identity in the systematic review. Although, the model can appear to be rigid only focusing on race and not highlighting the strengths and resilience that did emerge from the thesis portfolio. Post-Traumatic Growth (PTG) theory (Tedeschi & Calhoun, 1996) may explain such outcomes and suggests despite experienced adversity, opportunities to grow and pursue life is still achievable. However, PTG theory may not be applicable to all ethnic minority people highlighted across the thesis portfolio, including the ethnic minority people in the systematic review who continued to face barriers and thus their journey to personal recovery was more challenging, and the anticipated adversity that emerged from two of the Black men in the empirical paper.

Implications for Practice

The findings will be of importance to the Clinical Psychology profession because it highlights the need to address how we can work with the ethnic minority population effectively, to reduce the lived reality and narrative experiences of health disparities exhibited across the thesis portfolio. Firstly, both research projects highlighted the need to implement culturally sensitive care across systems and pathways. Whilst the representation of ethnically diverse professionals' matter and establishes diversity in the workforce, it is not always feasible to allocate ethnic minority people with clinical practitioners from a similar ethnic background. In fact, evidence suggests that cultural competence and a strong therapeutic relationship are highly valued (Li et al., 2024) and that the presumption that ethnic matching leads to better outcomes should be challenged.

However, appearing culturally competent can also mean practitioners easily perceiving themselves as an expert and creating power-imbalances without acknowledging their ignorance regarding various cultural differences (Lekas et al., 2020). Henceforth, practitioners may benefit from adopting a cultural humility stance to advance their skills in delivering culturally appropriate and equitable care. The cultural humility framework proposed by Tervalon and Murray-García (1998) suggests it is the responsibility of the practitioner to actively pursue ongoing self-reflexivity, recognise limitations in their knowledge of cultural differences, critically review personal biases and appreciate and respect ethnic minority people’s cultural values, with the aim of minimising evident health and social inequities they are increasingly at risk of experiencing (Schiavo, 2023). There are several emerging cultural humility toolkits, and online training programmes designed to support healthcare professionals’ continual professional development (Foronda et al., 2022; NHS Scotland Academy, 2024; Ogunyemi et al., 2024), however there is limited empirical findings regarding their effectiveness in clinical practice. It might be useful for Clinical Psychologist’s in leadership to consider how they may integrate and evaluate this framework across the teams and services they are situated in.

Whilst there is evidence of adapting psychological therapies like Cognitive Behavioural Therapy (CBT) to address race-related trauma (Beck, 2019; Metzger et al., 2020), the findings from the thesis portfolio suggest the need to deliver community-based interventions. This is further supported by a report by Duncan et al. (2021) who found community-based interventions are commonly utilised by ethnic minority people. Community-based interventions aim to ameliorate health and social injustices and might include peer support, cultural adaptations, being trauma-informed, providing education and are often prevention-orientated (Castillo, 2020). This is particularly important for Black men, who are almost never offered psychological therapies (Darko, 2021), and therefore there is insufficient data to understand effective psychological treatment for this demographic (Stockwell, 2024).

Some community-based interventions can also be recovery-orientated and there is some empirical evidence that suggests this might be effective for Black men and their mental health (Joseph et al., 2024; National Institute of Health Research: School for Social Care Research, 2019). However, the realities of delivering community-based interventions potentially does not fit with current services and funding within the NHS, which focuses on the individual or family outside of public health promotion. This calls for a reform of the current NHS structure by altering how care is typically delivered in the community, so that care is more accessible, integrated and delivered at the community level. One initiative from the NHS related to the outcomes of the empirical paper includes the ‘health and justice framework for integration 2022-2025: Improving lives – reducing inequality’ (NHS England, 2022). This framework outlines key strategies to reduce health inequities and establish Integrated Care Systems (ICS) for people within the CJS. This is one approach to promote collaborative partnerships between MHS and the CJS for people with SMI. Another interagency working model proposed by Kamin et al. (2022) suggests a six-stage process that incorporates engagement, assessment, planning and treatment, progress monitoring, problem solving and transition at both service levels for smoother transitions and better mental health outcomes.

Future Research Opportunities

Recommendations for future research have primarily been discussed across both research papers. However, the following future research opportunities are focused on building on the findings from the thesis portfolio that may be of particular interest to future Trainee Clinical Psychologists. Understanding the role of identity in ethnically diverse populations is something that requires further exploration. The research within the portfolio has revealed how systemic oppression has tarnished the identities of ethnically diverse people. This is ever-so more detrimental for Black men in the UK. As the existing literature posits, Black men have limited access to psychological therapies, therefore how they experience dynamics in the therapeutic relationship and an understanding of how the therapeutic alliance is perceived, is absent from the literature. It would be interesting to explore the perceived role ethnic identity plays in shaping experiences of psychological therapies for Black men. This might involve interviewing Black men who have received psychological therapies and identifying if ethnic identity was integral to their treatment. Psychometric measures associated with evaluating mental health outcomes and ethnic identity could be delivered to further add to the findings from the interviews. The findings may highlight the need for psychological therapists to incorporate ethnic identity into their practice with Black men, to support the facilitation of personal recovery.

It is important to gather evidence from as many sources as possible when conducting system-level research. As much as the Black men’s narratives were profoundly useful for answering the empirical paper research questions, the perspectives from the professionals were missing from the findings. Another possible research opportunity would be to replicate the empirical paper, however, focusing on the perspectives from the professionals working in the CJS and MHS with Black men. This would not be with the goal of counterarguing the Black men’s lived experiences, but it would showcase a balanced argument as to what is happening within these systems. It would be important to recruit a variety of professionals from various ethnic backgrounds that have interacted with Black men who have accessed criminal justice and mental health pathways. The findings might highlight explanations for some of the Black men’s experiences, as well as collect robust perspectives on what it is like working within these workforces and whether this could influence their interactions with the Black men.

Self-reflections

I must admit, I was initially intimidated by the idea of needing to complete a research project of this magnitude. My research interests were centred around wanting to understand why mental health disparities were so persistently visible within ethnically diverse communities. I wanted to know if there was anything I could do to change it. Although, I knew I would not have that level of influence at this stage in my career, I was interested in learning how the findings could contribute to change in the long term. Having witnessed these disparities myself, made the process of completing the research more meaningful. However, I encountered multiple challenges along the way, and some have already been highlighted. Whilst I had confirmed the methodology for my empirical research, I remained stuck on what area of the literature I wanted to synthesise for my systematic review. I knew coming up with a question would be a steadfast process, however it took longer than I expected. I think my limited experience of carrying out systematic reviews, played a part in this, but in hindsight I could have made the process easier for myself. One thing I would have done differently is prepared myself more by reading through various examples of systematic reviews to help with research question development.

The conduct of the systematic review would also have been stronger if I practiced piloting smaller scale systematic reviews to familiarise myself with the process. Nonetheless, I do believe the conduct of the review was robust, added knowledge to the field and helped answer a few of my personal queries prior to carrying out the research.

For my empirical research, data collection was the most enthralling aspect of the research process. Engaging in discourse with the Black men about their experiences was an interesting process, however it highlighted to me the nuances in my role as a Trainee Clinical Psychologist. In this scenario, I was acting as a researcher and whilst their stories at times were saddening, I really had to think about my boundaries regarding how I offered emotional support. This was not always easy, however signposting the Black men to services that could offer further emotional support was reassuring. I think I would have spoken more about this in supervision, so that the weight of their stories did not feel as heavy, and my supervisors could have given other suggestions that may have been helpful. I'd like to believe my ethnic identity of being a Black-Caribbean British female permeated throughout the research process, in the sense that I sought to create an allyship with the Black men, by not concealing their experiences, but by honouring the dissatisfaction they felt towards the systems they entered. For me this was an invigorating, albeit risky experience, since research projects such as this are unlikely to be completed by a Trainee Clinical Psychologist. By completing this research, I've improved my project management skills, broadened my understanding of research methodology, and built a repertoire of knowledge I foresee will benefit me throughout my Clinical Psychology career.

Conclusion

The thesis portfolio presented findings associated with health inequities experienced by ethnic minority people. The systematic review revealed positive personal recovery outcomes are feasible for ethnic minority people with SMI, when they are facilitated by family, faith and opportunities to develop ethnic identity. However, cultural family beliefs about SMI, culturally insensitive care and social disadvantage presented as barriers. The findings highlight the need for services to promote recovery-based interventions primarily focusing on community participation as an effective method. The empirical paper provided a robust narrative for Black men accessing MHS through the CJS. The precursors to the transition between the two systems included instances of adversity and trauma that manifested resulting in police involvement. The interactions with the CJS were regarded as discriminatory related to race. Despite this, being under the surveillance of the CJS provided the gateway to psychological care. Receiving this care provided insight into their mental health and newfound growth. The findings suggest the need for better interagency working between professionals working the CJS and MHS, so they can both recognise the trauma’s associated with Black men, how they may present differently, and responding appropriately using evidence-based tailored treatment such as earlier intervention with mental health resources, to avoid re-traumatisation.

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Appendices

Appendix A

Author guidelines for the Journal of Racial and Ethnic Health Disparities

Instructions for Authors

Types of Papers

Original research, literature reviews, consensus and policy papers, case studies, conference abstracts

It is strongly recommended that submitted articles not exceed 7000 words, excluding abstracts and references.

Perspectives are written only at the invitation of the Editor-in-Chief and Editorial Board.

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Manuscript Submission

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- If available, the 16-digit ORCID of the author(s)

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Abstract

Please provide an abstract of 150 to 250 words. The abstract should not contain any undefined abbreviations or unspecified references.

For life science journals only (when applicable)

- Trial registration number and date of registration for prospectively registered trials
- Trial registration number and date of registration, followed by "retrospectively registered", for retrospectively registered trials

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Please provide 4 to 6 keywords which can be used for indexing purposes.

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MSC

An appropriate number of MSC codes should be provided. The Mathematics Subject Classification (MSC) is used to categorize items covered by the two reviewing databases, Mathematical Reviews and Zentralblatt MATH, see

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Text

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- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or MathType for equations.
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Always use footnotes instead of endnotes.

Acknowledgments

Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.

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Scientific style

- Please always use internationally accepted signs and symbols for units (SI units).
- Nomenclature: Insofar as possible, authors should use systematic names similar to those used by IUPAC.
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References

Citation

Reference citations in the text should be identified by numbers in square brackets. Some examples:

1. Negotiation research spans many disciplines [3].

2. This result was later contradicted by Becker and Seligman [5].

3. This effect has been widely studied [1-3, 7].

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- Journal article

  Smith JJ. The world of science. Am J Sci. 1999;36:234–5.

- Article by DOI

  Slifka MK, Whitton JL. Clinical implications of dysregulated cytokine production. J Mol Med. 2000; https://doi.org/10.1007/s001090000086

- Book

  Blenkinsopp A, Paxton P. Symptoms in the pharmacy: a guide to the management of common illness. 3rd ed. Oxford: Blackwell Science; 1998.

- Book chapter

  Wyllie AH, Kerr JFR, Currie AR. Cell death: the significance of apoptosis. In: Bourne GH, Danielli JF, Jeon KW, editors. International review of cytology. London: Academic; 1980. pp. 251–306.

- Online document

  Doe J. Title of subordinate document. In: The dictionary of substances and their effects. Royal Society of Chemistry. 1999. http://www.rsc.org/dose/title of subordinate document. Accessed 15 Jan 1999.

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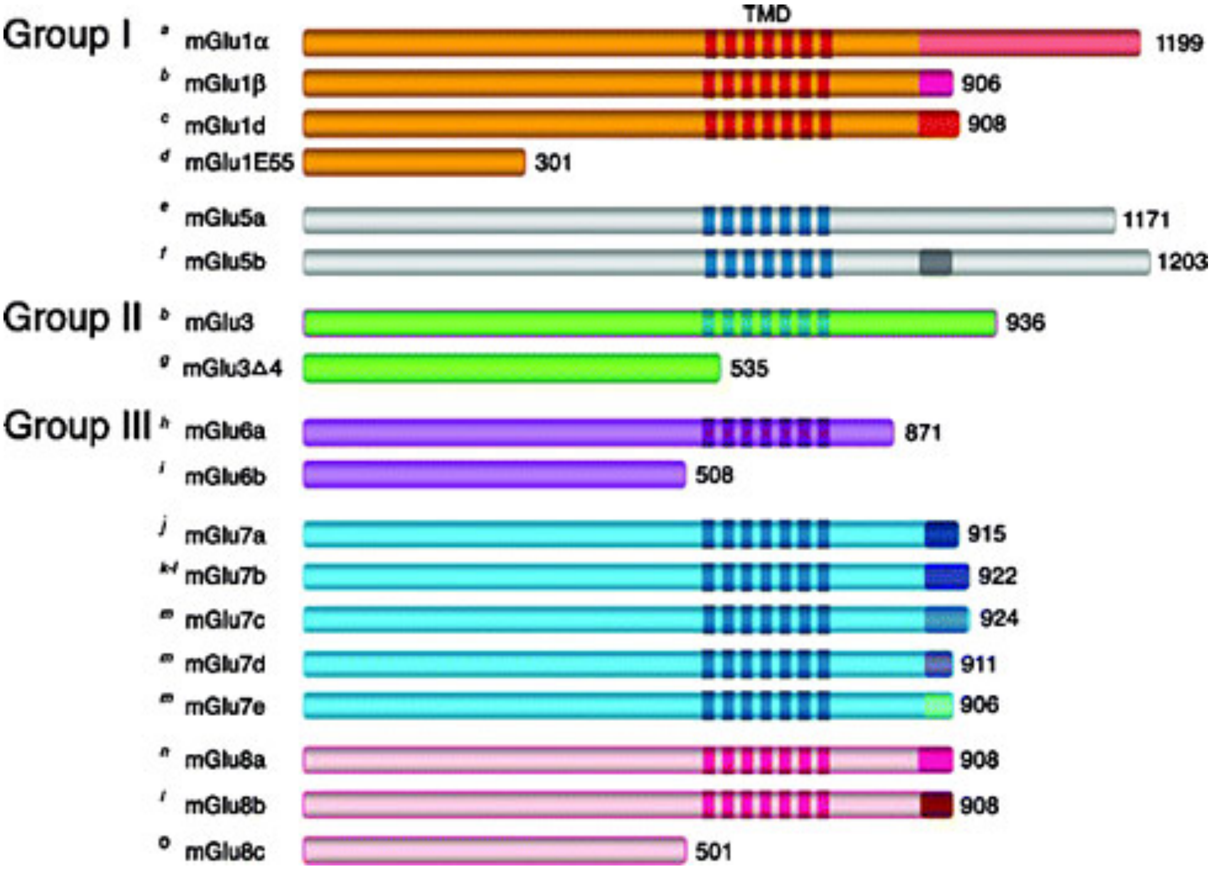

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- If the article has already been published online, depending on the nature and severity of the infraction:

  - an erratum/correction may be placed with the article

  - an expression of concern may be placed with the article

  - or in severe cases retraction of the article may occur.

The reason will be given in the published erratum/correction, expression of concern or retraction note. Please note that retraction means that the article is **maintained on the platform**, watermarked "retracted" and the explanation for the retraction is provided in a note linked to the watermarked article.

- The author's institution may be informed
- A notice of suspected transgression of ethical standards in the peer review system may be included as part of the author's and article's bibliographic record.

Fundamental errors

Authors have an obligation to correct mistakes once they discover a significant error or inaccuracy in their published article. The author(s) is/are requested to contact the journal and explain in what sense the error is impacting the article. A decision on how to correct the literature will depend on the nature of the error. This may be a correction or retraction. The retraction note should provide transparency which parts of the article are impacted by the error.

Suggesting / excluding reviewers

Authors are welcome to suggest suitable reviewers and/or request the exclusion of certain individuals when they submit their manuscripts. When suggesting reviewers, authors should make sure they are totally independent and not connected to the work in any way. It is strongly recommended to suggest a mix of reviewers from different countries and different institutions. When suggesting reviewers, the Corresponding Author must provide an institutional email address for each suggested reviewer, or, if this is not possible to include other means of verifying the identity such as a link to a personal homepage, a link to the publication record or a researcher or author ID in the submission letter. Please note that the Journal may not use the suggestions, but suggestions are appreciated and may help facilitate the peer review process.

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Authorship principles

These guidelines describe authorship principles and good authorship practices to which prospective authors should adhere to.

Authorship clarified

The Journal and Publisher assume all authors agreed with the content and that all gave explicit consent to submit and that they obtained consent from the responsible authorities at the institute/organization where the work has been carried out, **before** the work is submitted.

The Publisher does not prescribe the kinds of contributions that warrant authorship. It is recommended that authors adhere to the guidelines for authorship that are applicable in their specific research field. In absence of specific guidelines it is recommended to adhere to the following guidelines*:

All authors whose names appear on the submission

1) made substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data; or the creation of new software used in the work;

2) drafted the work or revised it critically for important intellectual content;

3) approved the version to be published; and

4) agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

* Based on/adapted from:

ICMJE, Defining the Role of Authors and Contributors,

Transparency in authors' contributions and responsibilities to promote integrity in scientific publication, McNutt at all, PNAS February 27, 2018

Disclosures and declarations

All authors are requested to include information regarding sources of funding, financial or non-financial interests, study-specific approval by the appropriate ethics committee for research involving humans and/or animals, informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals (as appropriate).

The decision whether such information should be included is not only dependent on the scope of the journal, but also the scope of the article. Work submitted for publication may have implications for public health or general welfare and in those cases it is the responsibility of all authors to include the appropriate disclosures and declarations.

Data transparency

All authors are requested to make sure that all data and materials as well as software application or custom code support their published claims and comply with field standards. Please note that journals may have individual policies on (sharing) research data in concordance with disciplinary norms and expectations.

Role of the Corresponding Author

One author is assigned as Corresponding Author and acts on behalf of all co-authors and ensures that questions related to the accuracy or integrity of any part of the work are appropriately addressed.

The Corresponding Author is responsible for the following requirements:

- ensuring that all listed authors have approved the manuscript before submission, including the names and order of authors;
- managing all communication between the Journal and all co-authors, before and after publication;*
- providing transparency on re-use of material and mention any unpublished material (for example manuscripts in press) included in the manuscript in a cover letter to the Editor;

- making sure disclosures, declarations and transparency on data statements from all authors are included in the manuscript as appropriate (see above).

* The requirement of managing all communication between the journal and all co-authors during submission and proofing may be delegated to a Contact or Submitting Author. In this case please make sure the Corresponding Author is clearly indicated in the manuscript.

Author contributions

In absence of specific instructions and in research fields where it is possible to describe discrete efforts, the Publisher recommends authors to include contribution statements in the work that specifies the contribution of every author in order to promote transparency. These contributions should be listed at the separate title page.

Examples of such statement(s) are shown below:

• Free text:

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by [full name], [full name] and [full name]. The first draft of the manuscript was written by [full name] and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Example: CRediT taxonomy:

• Conceptualization: [full name], …; Methodology: [full name], …; Formal analysis and investigation: [full name], …; Writing - original draft preparation: [full name, …]; Writing - review and editing: [full name], …; Funding acquisition: [full name], …; Resources: [full name], …; Supervision: [full name],….

For **review articles** where discrete statements are less applicable a statement should be included who had the idea for the article, who performed the literature search and data analysis, and who drafted and/or critically revised the work.

For articles that are based primarily on the **student's dissertation or thesis**, it is recommended that the student is usually listed as principal author:

A Graduate Student's Guide to Determining Authorship Credit and Authorship Order, APA Science Student Council 2006

Affiliation

The primary affiliation for each author should be the institution where the majority of their work was done. If an author has subsequently moved, the current address may additionally be stated. Addresses will not be updated or changed after publication of the article.

Changes to authorship

Authors are strongly advised to ensure the correct author group, the Corresponding Author, and the order of authors at submission. Changes of authorship by adding or deleting authors, and/or changes in Corresponding Author, and/or changes in the sequence of authors are **not** accepted **after acceptance** of a manuscript.

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Adding and/or deleting authors at revision stage are generally not permitted, but in some cases it may be warranted. Reasons for these changes in authorship should be explained. Approval of the change during revision is at the discretion of the Editor-in-Chief. Please note that journals may have individual policies on adding and/or deleting authors during revision stage.

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For cases in which a co-author dies or is incapacitated during the writing, submission, or peer-review process, and the co-authors feel it is appropriate to include the author, co-authors should obtain approval from a (legal) representative which could be a direct relative.

Authorship issues or disputes

In the case of an authorship dispute during peer review or after acceptance and publication, the Journal will not be in a position to investigate or adjudicate. Authors will be asked to resolve the dispute themselves. If they are unable the Journal reserves the right to withdraw a manuscript from the editorial process or in case of a published paper raise the issue with the authors' institution(s) and abide by its guidelines.

Confidentiality

Authors should treat all communication with the Journal as confidential which includes correspondence with direct representatives from the Journal such as Editors-in-Chief and/or Handling Editors and reviewers' reports unless explicit consent has been received to share information.

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Compliance with Ethical Standards

To ensure objectivity and transparency in research and to ensure that accepted principles of ethical and professional conduct have been followed, authors should include information regarding sources of funding, potential conflicts of interest (financial or non-financial), informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals.

Authors should include the following statements (if applicable) in a separate section entitled “Compliance with Ethical Standards” when submitting a paper:

- Disclosure of potential conflicts of interest
- Research involving Human Participants and/or Animals
- Informed consent

Please note that standards could vary slightly per journal dependent on their peer review policies (i.e. single or double blind peer review) as well as per journal subject discipline. Before submitting your article check the instructions following this section carefully.

The corresponding author should be prepared to collect documentation of compliance with ethical standards and send if requested during peer review or after publication.

The Editors reserve the right to reject manuscripts that do not comply with the above-mentioned guidelines. The author will be held responsible for false statements or failure to fulfill the above-mentioned guidelines.

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Competing Interests

Authors are requested to disclose interests that are directly or indirectly related to the work submitted for publication. Interests within the last 3 years of beginning the work (conducting the research and preparing the work for submission) should be reported. Interests outside the 3-year time frame must be disclosed if they could reasonably be perceived as influencing the submitted work. Disclosure of interests provides a complete and transparent process and helps readers form their own judgments of potential bias. This is not meant to imply that a financial relationship with an organization that sponsored the research or compensation received for consultancy work is inappropriate.

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Interests that should be considered and disclosed but are not limited to the following:

Funding: Research grants from funding agencies (please give the research funder and the grant number) and/or research support (including salaries, equipment, supplies, reimbursement for attending symposia, and other expenses) by organizations that may gain or lose financially through publication of this manuscript.

Employment: Recent (while engaged in the research project), present or anticipated employment by any organization that may gain or lose financially through publication of this manuscript. This includes multiple affiliations (if applicable).

Financial interests: Stocks or shares in companies (including holdings of spouse and/or children) that may gain or lose financially through publication of this manuscript; consultation fees or other forms of remuneration from organizations that may gain or lose financially; patents or patent applications whose value may be affected by publication of this manuscript.

It is difficult to specify a threshold at which a financial interest becomes significant, any such figure is necessarily arbitrary, so one possible practical guideline is the following: "Any undeclared financial interest that could embarrass the author were it to become publicly known after the work was published."

Non-financial interests: In addition, authors are requested to disclose interests that go beyond financial interests that could impart bias on the work submitted for publication such as professional interests, personal relationships or personal beliefs (amongst others). Examples include, but are not limited to: position on editorial board, advisory board or board of directors or other type of management relationships; writing and/or consulting for educational purposes; expert witness; mentoring relations; and so forth.

Primary research articles require a disclosure statement. Review articles present an expert synthesis of evidence and may be treated as an authoritative work on a subject. Review articles therefore require a disclosure statement. Other article types such as editorials, book reviews, comments (amongst others) may, dependent on their content, require a disclosure statement. If you are unclear whether your article type requires a disclosure statement, please contact the Editor-in-Chief.

Please note that, in addition to the above requirements, funding information (given that funding is a potential competing interest (as mentioned above)) needs to be disclosed upon submission of the manuscript in the peer review system. This information will automatically be added to the Record of CrossMark, however it is **not added** to the manuscript itself. Under ‘summary of requirements’ (see below) funding information should be included in the ‘**Declarations**’ section.

Summary of requirements

The above should be summarized in a statement and placed in a 'Declarations' section before the reference list under a heading of 'Funding' and/or 'Competing interests'. Other declarations include Ethics approval, Consent, Data, Material and/or Code availability and Authors' contribution statements.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

When all authors have the same (or no) conflicts and/or funding it is sufficient to use one blanket statement.

Examples of statements to be used when funding has been received:

- Partial financial support was received from [...]
- The research leading to these results received funding from […] under Grant Agreement No[…].
- This study was funded by […]
- This work was supported by […] (Grant numbers […] and […]

Examples of statements to be used when there is no funding:

- The authors did not receive support from any organization for the submitted work.
- No funding was received to assist with the preparation of this manuscript.
- No funding was received for conducting this study.
- No funds, grants, or other support was received.

Examples of statements to be used when there are interests to declare:

- **Financial interests:** Author A has received research support from Company A. Author B has received a speaker honorarium from Company W and owns stock in Company X. Author C is consultant to company Y.

  Non-financial interests: Author C is an unpaid member of committee Z.

- **Financial interests:** The authors declare they have no financial interests.

  Non-financial interests: Author A is on the board of directors of Y and receives no compensation as member of the board of directors.

- **Financial interests:** Author A received a speaking fee from Y for Z. Author B receives a salary from association X. X where s/he is the Executive Director.

  Non-financial interests: none.

- **Financial interests:** Author A and B declare they have no financial interests. Author C has received speaker and consultant honoraria from Company M and Company N. Dr. C has received speaker honorarium and research funding from Company M and Company O. Author D has received travel support from Company O.

Non-financial interests: Author D has served on advisory boards for Company M, Company N and Company O.

Examples of statements to be used when authors have nothing to declare:

- The authors have no relevant financial or non-financial interests to disclose.
- The authors have no competing interests to declare that are relevant to the content of this article.
- All authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.
- The authors have no financial or proprietary interests in any material discussed in this article.

Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.

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Research involving human participants, their data or biological material

Ethics approval

When reporting a study that involved human participants, their data or biological material, authors should include a statement that confirms that the study was approved (or granted exemption) by the appropriate institutional and/or national research ethics committee (including the name of the ethics committee) and certify that the study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that an independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study. If a study was granted exemption from requiring ethics approval, this should also be detailed in the manuscript (including the reasons for the exemption).

Retrospective ethics approval

If a study has not been granted ethics committee approval prior to commencing, retrospective ethics approval usually cannot be obtained and it may not be possible to consider the manuscript for peer review. The decision on whether to proceed to peer review in such cases is at the Editor's discretion.

Ethics approval for retrospective studies

Although retrospective studies are conducted on already available data or biological material (for which formal consent may not be needed or is difficult to obtain) ethics approval may be required dependent on the law and the national ethical guidelines of a country. Authors should check with their institution to make sure they are complying with the specific requirements of their country.

Ethics approval for case studies

Case reports require ethics approval. Most institutions will have specific policies on this subject. Authors should check with their institution to make sure they are complying with the specific requirements of their institution and seek ethics approval where needed. Authors should be aware to secure informed consent from the individual (or parent or guardian if the participant is a minor or incapable) See also section on **Informed Consent**.

Cell lines

If human cells are used, authors must declare in the manuscript: what cell lines were used by describing the source of the cell line, including when and from where it was obtained, whether the cell line has recently been authenticated and by what method. If cells were bought from a life science company the following need to be given in the manuscript: name of company (that provided the cells), cell type, number of cell line, and batch of cells.

It is recommended that authors check the NCBI database for misidentification and contamination of human cell lines. This step will alert authors to possible problems with the cell line and may save considerable time and effort.

Further information is available from the International Cell Line Authentication Committee (ICLAC).

Authors should include a statement that confirms that an institutional or independent ethics committee (including the name of the ethics committee) approved the study and that informed consent was obtained from the donor or next of kin.

Research Resource Identifiers (RRID)

Research Resource Identifiers (RRID) are persistent unique identifiers (effectively similar to a DOI) for research resources. This journal encourages authors to adopt RRIDs when reporting key biological resources (antibodies, cell lines, model organisms and tools) in their manuscripts.

Examples:

Organism: $\textit{Filip1}^{tm1a(KOMP)Wtsi}$ **RRID:MMRRC_055641-UCD**

Cell Line: RST307 cell line **RRID:CVCL_C321**

Antibody: Luciferase antibody DSHB Cat# LUC-3, **RRID:AB_2722109**

Plasmid: mRuby3 plasmid **RRID:Addgene_104005**

Software: ImageJ Version 1.2.4 **RRID:SCR_003070**

RRIDs are provided by the Resource Identification Portal. Many commonly used research resources already have designated RRIDs. The portal also provides authors links so that they can quickly register a new resource and obtain an RRID.

Clinical Trial Registration

The World Health Organization (WHO) definition of a clinical trial is "any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes". The WHO defines health interventions as “A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions” and a health-related outcome is generally defined as a change in the health of a person or population as a result of an intervention.

To ensure the integrity of the reporting of patient-centered trials, authors must register prospective clinical trials (phase II to IV trials) in suitable publicly available repositories. For example www.clinicaltrials.gov or any of the primary registries that participate in the WHO International Clinical Trials Registry Platform.

The trial registration number (TRN) and date of registration should be included as the last line of the manuscript abstract.

For clinical trials that have not been registered prospectively, authors are encouraged to register retrospectively to ensure the complete publication of all results. The trial registration number (TRN), date of registration and the words 'retrospectively registered’ should be included as the last line of the manuscript abstract.

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Springer Nature advocates complete and transparent reporting of biomedical and biological research and research with biological applications. Authors are recommended to adhere to the minimum reporting guidelines hosted by the EQUATOR Network when preparing their manuscript.

Exact requirements may vary depending on the journal; please refer to the journal’s Instructions for Authors.

Checklists are available for a number of study designs, including:

Randomised trials (CONSORT) and Study protocols (SPIRIT)

Observational studies (STROBE)

Systematic reviews and meta-analyses (PRISMA) and protocols (Prisma-P)

Diagnostic/prognostic studies (STARD) and (TRIPOD)

Case reports (CARE)

Clinical practice guidelines (AGREE) and (RIGHT)

Qualitative research (SRQR) and (COREQ)

Animal pre-clinical studies (ARRIVE)

Quality improvement studies (SQUIRE)

Economic evaluations (CHEERS)

Summary of requirements

The above should be summarized in a statement and placed in a ‘Declarations’ section before the reference list under a heading of ‘Ethics approval’.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Examples of statements to be used when ethics approval has been obtained:

- All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Bioethics Committee of the Medical University of A (No. ...).

- This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date.../No. ...).

- Approval was obtained from the ethics committee of University C. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

- The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of D (Ethics approval number: ...).

Examples of statements to be used for a retrospective study:

- Ethical approval was waived by the local Ethics Committee of University A in view of the retrospective nature of the study and all the procedures being performed were part of the routine care.

- This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.

- This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of University B approved this study.

Examples of statements to be used when no ethical approval is required/exemption granted:

- This is an observational study. The XYZ Research Ethics Committee has confirmed that no ethical approval is required.

- The data reproduced from Article X utilized human tissue that was procured via our Biobank AB, which provides de-identified samples. This study was reviewed and deemed exempt by our XYZ Institutional Review Board. The BioBank protocols are in accordance with the ethical standards of our institution and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.

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Informed consent

All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. This is especially true concerning images of vulnerable people (e.g. minors, patients, refugees, etc) or the use of images in sensitive contexts. In many instances authors will need to secure written consent before including images.

Identifying details (names, dates of birth, identity numbers, biometrical characteristics (such as facial features, fingerprint, writing style, voice pattern, DNA or other distinguishing characteristic) and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scholarly purposes and the participant (or parent/guardian if the participant is a minor or incapable or legal representative) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases. Detailed descriptions of individual participants, whether of their whole bodies or of body sections, may lead to disclosure of their identity. Under certain circumstances consent is not required as long as information is anonymized and the submission does not include images that may identify the person.

Informed consent for publication should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort meaning.

Exceptions where it is not necessary to obtain consent:

- Images such as x rays, laparoscopic images, ultrasound images, brain scans, pathology slides unless there is a concern about identifying information in which case, authors should ensure that consent is obtained.

- Reuse of images: If images are being reused from prior publications, the Publisher will assume that the prior publication obtained the relevant information regarding consent. Authors should provide the appropriate attribution for republished images.

Consent and already available data and/or biologic material

Regardless of whether material is collected from living or dead patients, they (family or guardian if the deceased has not made a pre-mortem decision) must have given prior written consent. The aspect of confidentiality as well as any wishes from the deceased should be respected.

Data protection, confidentiality and privacy

When biological material is donated for or data is generated as part of a research project authors should ensure, as part of the informed consent procedure, that the participants are made aware what kind of (personal) data will be processed, how it will be used and for what purpose. In case of data acquired via a biobank/biorepository, it is possible they apply a broad consent which allows research participants to consent to a broad range of uses of their data and samples which is regarded by research ethics committees as specific enough to be considered “informed”. However, authors should always check the specific biobank/biorepository policies or any other type of data provider policies (in case of non-bio research) to be sure that this is the case.

Consent to Participate

For all research involving human subjects, freely-given, informed consent to participate in the study must be obtained from participants (or their parent or legal guardian in the case of children under 16) and a statement to this effect should appear in the manuscript. In the case of articles describing human transplantation studies, authors must include a statement declaring that no organs/tissues were obtained from prisoners and must also name the institution(s)/clinic(s)/department(s) via which organs/tissues were obtained. For manuscripts reporting studies involving vulnerable groups where there is the potential for coercion or where consent may not have been fully informed, extra care will be taken by the editor and may be referred to the Springer Nature Research Integrity Group.

Consent to Publish

Individuals may consent to participate in a study, but object to having their data published in a journal article. Authors should make sure to also seek consent from individuals to publish their data prior to submitting their paper to a journal. This is in particular applicable to case studies. A consent to publish form can be found

here. (Download docx, 36 kB)

Summary of requirements

The above should be summarized in a statement and placed in a 'Declarations' section before the reference list under a heading of 'Consent to participate' and/or 'Consent to publish'. Other declarations include Funding, Competing interests, Ethics approval, Consent, Data and/or Code availability and Authors' contribution statements.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Sample statements for **"Consent to participate"**:

Informed consent was obtained from all individual participants included in the study.

Informed consent was obtained from legal guardians.

Written informed consent was obtained from the parents.

Verbal informed consent was obtained prior to the interview.

Sample statements for **"Consent to publish"**:

The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.

The participant has consented to the submission of the case report to the journal.

Patients signed informed consent regarding publishing their data and photographs.

Sample statements if identifying information about participants is available in the article:

Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.

Images will be removed from publication if authors have not obtained informed consent or the paper may be removed and replaced with a notice explaining the reason for removal.

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Research Data Policy

This journal operates a type 1 research data policy. The journal encourages authors, where possible and applicable, to deposit data that support the findings of their research in a public repository. Authors and editors who do not have a preferred repository should consult Springer Nature’s list of repositories and research data policy.

List of Repositories

Research Data Policy

General repositories - for all types of research data - such as figshare and Dryad may also be used.

Datasets that are assigned digital object identifiers (DOIs) by a data repository may be cited in the reference list. Data citations should include the minimum information recommended by DataCite: authors, title, publisher (repository name), identifier.

DataCite

If the journal that you’re submitting to uses double-blind peer review and you are providing reviewers with access to your data (for example via a repository link, supplementary information or data on request), it is strongly suggested that the authorship in the data is also blinded. There are data repositories that can assist with this and/or will create a link to mask the authorship of your data.

Authors who need help understanding our data sharing policies, help finding a suitable data repository, or help organising and sharing research data can access our Author Support portal for additional guidance.

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The article will be published online after receipt of the corrected proofs. This is the official first publication citable with the DOI. After release of the printed version, the paper can also be cited by issue and page numbers.

Appendix B

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p. 24
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p. 25-26
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p. 29
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p. 29
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p. 30
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p. 30
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p. 30
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p. 31
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p. 32
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	n/a
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p. 32
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p. 32

Section and Topic	Item #	Checklist item	Location where item is reported
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	n/a
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p. 32-34
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	p. 32-34
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p. 32-34
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p. 32-34
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	p. 32-34
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	n/a
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p. 33
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	n/a
Study characteristics	17	Cite each included study and present its characteristics.	p. 35-40
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p. 197-198
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	n/a
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p. 32
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	p. 32-44
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	p. 32-44
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis	n/a

Section and Topic	Item #	Checklist item	Location where item is reported
		assessed.	
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p. 49-52
	23b	Discuss any limitations of the evidence included in the review.	p. 54
	23c	Discuss any limitations of the review processes used.	p. 54
	23d	Discuss implications of the results for practice, policy, and future research.	p. 53
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p. 29
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p. 29
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	n/a
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	n/a
Competing interests	26	Declare any competing interests of review authors.	n/a
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	n/a

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/bmj.n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

Appendix C

Search Terms used in Research Databases

Search Terms			
Perceptions OR Perspectives OR Experiences OR Beliefs OR Attitudes OR "Lived Experience" OR Views OR Interview* OR "Focus Group"	Recovery OR "Personal Recovery" OR "Mental Health Recovery" OR Rehabilitation	Ethnic minorit*" OR "Ethnic* diverse" OR Ethnic OR Black OR Caribbean OR Africa* OR Afro-Caribbean OR Asian OR BME OR BAME OR Pakistani OR Bangladeshi OR Arab OR Indian OR Chinese OR "East Asian" OR "Middle East" OR Multiracial OR Biracial OR "Mixed-race" OR Hispanic OR "People of Colo?r" OR "African-American" OR Indigenous OR Maori OR Latin* OR "Roman Gypsy" OR "Other Ethnic"	"Severe Mental Illness" OR "Serious Mental Illness" OR "Psychiatric Disorder" OR "Mental Disorder" OR Schizo* OR "Bipolar Disorder" OR "Severe Mood Disorder" OR Psycho* OR "Personality Disorder" OR "Complex Emotional Needs" OR "Complex Needs" OR "Major Depressive Disorder" OR "Eating Disorder" OR "Emotionally Unstable Personality Disorder"

Appendix D

Specialist Unit for Review Evidence (SURE) Quality Assessment (2018)

Questions to assist with the critical appraisal of qualitative studies	Armour et al. (2009)	Clark et al. (2024)	Habhab (2016)	Jankowski et al. (2023)	Lawrence et al. (2021)	Lee (2012)	Lee et al. (2015)	Misra et al. (2020)	Mohsin et al. (2024)	Moore et al. (2024)
Does the study address a clearly focused question/hypothesis?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the choice of qualitative method appropriate?	Y	Y	Y	Y	Y	Y	Y*	Y*	Y	Y
Is the sampling strategy clearly described and justified?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the method of data collection well described?	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y
Is the relationship between the researcher(s) and participants explored?	Y	Y*	N	N	Y	N	N	N	N	Y
Are ethical issues explicitly discussed?	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the data analysis/interpretation process described and justified?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Are the findings credible?	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y
Is any sponsorship/conflict of interest reported?	?	N	?	N	?	N	?	N	N	N
Did the authors identify any limitations?	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y*
Are the conclusions the same in the abstract and the full text?	?	Y	Y	Y	Y	Y	Y*	Y	Y	Y

Y= Yes, N= No, ?= Can’t tell, *= reported poorly

Continued…

Questions to assist with the critical appraisal of qualitative studies	Myers et al. (2016)	Pahwa et al. (2018)	Saunders et al. (2023)	Tuffour (2020)	Tuffour et al. (2019)	Virdee et al. (2017)	Wang et al. (2012)	Whitley (2012)	Whitley (2011)	Whitley (2016)
Does the study address a clearly focused question/hypothesis?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the choice of qualitative method appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the sampling strategy clearly described and justified?	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the method of data collection well described?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the relationship between the researcher(s) and participants explored?	Y*	Y	Y	Y	Y	N	N	Y	Y	N
Are ethical issues explicitly discussed?	N	Y	Y	Y	Y	Y*	Y*	Y	Y	Y
Is the data analysis/interpretation process described and justified?	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y
Are the findings credible?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is any sponsorship/conflict of interest reported?	?	N	N	?	N	?	N	?	?	N
Did the authors identify any limitations?	N	Y	Y	Y*	Y	Y	Y	Y	N	Y
Are the conclusions the same in the abstract and the full text?	Y	Y	Y	Y	Y	?	?	Y	Y	Y

Y= Yes, N= No, ?= Can’t tell, *= reported poorly

Appendix E

Author Guidelines for the Journal of Ethnic and Migration Studies

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

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This title utilises format-free submission. Authors may submit their paper in any scholarly format or layout. References can be in any style or format, so long as a consistent scholarly citation format is applied. For more detail see the format-free submission section below.

Contents

- Using Third-Party Material
- Submitting Your Paper
- Data Sharing Policy
- Publication Charges
- Copyright Options
- Complying with Funding Agencies
- My Authored Works

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*Citations received up to 9th June 2021 for articles published in 2018-2022. Data obtained on 23rd August 2023, from Digital Science's Dimensions platform, available at https://app.dimensions.ai**Usage in 2020-2022 for articles published in 2018-2022.

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If your manuscript is based on research with human participants (individuals, samples, or data), please include a statement within your manuscript, which must provide details of the name of the ethics committee and reference/permit numbers where available. Read the full policy on research involving humans.

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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4 **Graphical abstract** (optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .tiff. Please do not embed it in the manuscript file but save it as a separate file, labelled GraphicalAbstract1.

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able to interpret the table without reference to the text. Please supply editable files.

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Appendix F

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	p. 77
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	n/a
Occupation	3	What was their occupation at the time of the study?	p. 77
Gender	4	Was the researcher male or female?	p. 77
Experience and training	5	What experience or training did the researcher have?	p. 77
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	p. 77
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	p.215
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	p. 77
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	p. 72
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	p.73
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	p. 73
Sample size	12	How many participants were in the study?	p. 73
Non-participation	13	How many people refused to participate or dropped out? Reasons?	p. 131
Setting			

Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	p. 73
Presence of nonparticipants	15	Was anyone else present besides the participants and researchers?	n/a
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	p.74
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	p. 74, 214
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	p. 75
Field notes	20	Were field notes made during and/or after the inter view or focus group?	p. 113
Duration	21	What was the duration of the inter views or focus group?	p. 75
Data saturation	22	Was data saturation discussed?	p. 74
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	n/a
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	p. 76
Description of the coding tree	25	Did authors provide a description of the coding tree?	n/a
Derivation of themes	26	Were themes identified in advance or derived from the data?	p. 76
Software	27	What software, if applicable, was used to manage the data?	p. 76
Participant checking	28	Did participants provide feedback on the findings?	n/a
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	p. 79-89
Data and findings consistent	30	Was there consistency between the data presented and the findings?	p. 79-92
Clarity of major themes	31	Were major themes clearly presented in the findings?	p. 79-92
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	p. 79-92

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix G

Recruitment Study Poster

University of East Anglia

Participants Needed!

Are you a Black male aged 18 or older who's accessed Mental Health Services through the Criminal Justice System?

We want to hear about your experience!

What does taking part involve?

- Sharing some demographic information about yourself
- Completing a 60-minute online interview about your experiences of being in the criminal justice system and transitioning to mental health services

Why choose to participate?

- Your voice and experience will be used to improve healthcare services for black men, with similar experiences
- You will receive a £20 Love2shop gift voucher

If you're interested in participating, then please contact Shaquilla Linton
Trainee Clinical Psychologist (Lead Researcher)
Email address: Shaquilla.linton@uea.ac.uk
Work mobile: 07749003281

Recruitment poster Version 4.0, 16/03/2024
IRAS Project ID: 335796

Appendix H

Interview Schedule

1. General perspectives on mental health and wellbeing.

   i.e., What does mental health and wellbeing mean to you?

2. Identifying what the participants wellbeing was like before they accessed MHS.

   i.e., What was your life like, before receiving mental health treatment?

3. Reflections on the period of transition from being in CJS and then MHS.

   i.e., What time during this transition impacted you the most?

4. Making sense of the interpersonal dynamic between black men and staff.

   i.e., How do you think the staff providers perceived you?

5. Reflections on care provision and unfulfilled care needs.

   i.e., How would you describe the care you received from the services? Is there anything you would have preferred or not preferred?

6. What life is like now after being in these systems or if they are still part of the system and how it has impacted their mental health and wellbeing. The researcher will also ask the participants to expand (if they comfortable to) on the wider system(s) that might have been impacted such as family and friends.

   i.e., How do you think your experiences have impacted your mental health and wellbeing? If not your own, do you think it may have impacted any of your family and/or friends?

Appendix I

Participant information sheet

The stories of Black Men Accessing Mental Health Services through Criminal Justice Systems

Researcher: Shaquilla Linton, PhD Student at University of East Anglia

We would like to invite you to take part in our new research study. The study will form part of a PhD Student's research project through Norwich Medical School at the University of East Anglia (UEA). Participating in the research study is completely voluntary and your care will not be impacted if you do decide to participate. If you are interested in taking part in the study, then please continue reading the participant information sheet which will explain details about what the study entails. You will also have the opportunity after reading the participant information sheet, to discuss and/or ask any questions you have regarding your participation with the study.

Background and purpose of the study

Living in the UK as a black man may mean your experiences with Criminal Justice Systems such as the police, and Mental Health Services, (professional help for people in distress) might vary depending on how you make sense of your experience. However, black people only make up 4.2% of the UK population, and young black men in particular, are 40% more likely to access Mental Health Services, when they are under the supervision of staff working in the Criminal Justice System in comparison to white men. From a young age, black people are more likely to have encounters with the police compared with any other ethnicity. Police encounters may be unpleasant and harsh, which can be traumatising for some people. Similarly, black people are 4 times more likely to be sectioned under the Mental Health Act and tend to face hostile and discriminatory mistreatment whilst under the care of Mental Health Services. Currently we don't know if these experiences are the case for everyone within these systems, because most of the background information we have on black men and their encounters with Mental Health Services and Criminal Justice Systems are based on statistics. We are unable to draw any conclusions on how black men interpret their experiences when they are under these systems. Therefore, we would like to learn more about black men's experiences when their route into accessing Mental Health Services have been through encounters with Criminal Justice staff and systems.

What would taking part involve?

After reading this participant information sheet, the researcher will give you at least 24-72 hours to reflect and think about whether you want to participate in the project or not. You will arrange to speak with the researcher at a time that suits you and them to discuss the participant information sheet and make sure that you understand what it means to participate in the study. Once you have asked any questions and discussed any queries/concerns, if you agree to participate, you would then be asked to record your consent either by completing a consent form or providing recorded verbal consent. If you decide to provide verbal consent, then the discussion will need to be recorded and used as evidence of consent. This project would involve attending an interview, where you will be asked questions related to your experience when you were under police custody and the journey from that experience up until having contact with Mental Health Services. It would then involve sharing what your experiences were like when under the Mental Health Service team and/or after your experience if you are no longer under the care of the service(s). The interview will be completed over Microsoft Teams and will roughly be 1 hour long. After the interview the researcher will transcribe the recording into written text; at this point the original recording will be deleted from the research database. Before answering the interview questions, the interviewer will gather demographic information about you. This will involve confirming your age, ethnicity, education level, employment status, and nearest city or town you live in. This information will be non-identifiable, and the demographics will be reported in the final research paper. It will not be used in a way that could identify you to other people.

What are the possible benefits of taking part?

Taking part in the research will help staff working in the Criminal Workforce and Mental Health Services improve the services that they are currently offering to black men. It will allow the researchers to develop training and service development opportunities to the staff, so that black men who are accessing these services have better experiences and enhance their overall quality of life. Your participation will influence changes across local NHS trust policies regarding provision of care for black men. If you do agree to participate you will also receive a £20 love2shop multi-store gift voucher to thank you for taking the time to participate in the study. After the data analysis the outcomes will be written in a report, and you will receive a lay summary copy of the study's findings if you so wish.

What are the possible disadvantages and risks of taking part?

Taking part in the study requires you to talk about your personal experiences during what may have been a difficult period in your life. We understand that this is a sensitive topic to discuss, therefore sharing your experiences may be upsetting for you. If this does happen, the interviewer will pause the interview and offer the opportunity to reflect on how you are feeling. You may at this point not want to continue with the interview, which is completely fine. If you no longer want to continue with the study, then you will be able to withdraw your consent.

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

If during the interview you decide you no longer want to continue participating in the study, you will be able to withdraw your consent. If you decide to get in touch with the researcher **two weeks** after completing the interview and want to withdraw your data from the study, at this point the researcher would have anonymised the data and started data analysis. This will mean that your data would have merged with other participants data, therefore the researcher will be unable access your information. However, if you contact the researcher within two weeks of completing the interview then the researcher will withdraw your data from the study.

How will my information be kept confidential?

The information you share about yourself will be anonymised and be non-identifiable once it is secured in the research database. You will be assigned a Participant study ID number to maintain your anonymity. Your information will be held securely in an online research database that will be password-protected under the UEA server. Only the researchers and University examiners will have access to the database, and it will only be used for the purpose of this research study. Your data will be safely stored on the research database and will only be accessible to the research team until the research study is published in a journal article. The University of East Anglia Records Retention Scheme policy archives anonymised research up to 10 years post study completion. After this period the data will be destroyed. Confidentiality and protection of your data is in accordance with the UK General Data Protection Regulation (The UK GDPR, 2023) and the Data Protection Act (DPA, 2018).

Who is organising and sponsoring this study?

The lead researcher for this study is a Trainee Clinical Psychologist, who is studying at the University of East Anglia (UEA). UEA will be the data handler and sponsor for the research study.

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

The researcher has consulted with Norfolk and Suffolk NHS Foundation Trust (NSFT) Advancing Mental Health Equality (AMHE) group who are staff working with black men and have been involved with the development of the research study design. There are also a few lived experienced advisors in the AMHE group, who the researcher will continue to consult with throughout the research process.

If I have any concerns, who can I contact?

We care about your wellbeing and overall experience during your time participating in the study. Therefore, if there is a point during the study whereby you need to make a complaint and/or express a concern regarding your participation, then you can contact Sian Coker (Course Director) on s.coker@uea.ac.uk.

Under what circumstances will confidentiality be breached by the research team?

We care about your safety, therefore if you disclose anything that causes yourself and/or anyone else you know to be at risk of harm, then we will need to share whatever identifiable information you have provided us with the relevant authorities such as your doctor and/or any other healthcare professional part of your care. This will include any psychological, physical, emotional, and neglectful harm. It can also include disclosures around any criminal activity.

Who has reviewed this study?

This research study has been reviewed by NHS Ethics and the National Health Research Authority (HRA). They have given a favourable opinion, and the study has obtained ethical approval. The study has also been reviewed by the University of East Anglia and they have approved for this study to be conducted by a Trainee Clinical Psychology as part of their Doctoral training in Clinical Psychology.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your name, age, ethnicity, education level, employment status, nearest city or town you live in, and your contact details. The researchers will use this information to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name, contact details or demographic information. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have unless you contact us within **two weeks** of participating in the study.

We need to manage your records in specific ways for the research to be reliable. This means that we won’t be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team

Lead researcher: Shaquilla Linton
Contact: aqr22thu@uea.ac.uk

Primary Project Supervisor: Bonnie Teague
Contact: B.Teague@uea.ac.uk

Appendix J:

Centre Number:

Study Number:

Participant Identification Number for this trial:

University of East Anglia

CONSENT FORM

Title of Project: **A Qualitative Study Exploring the Narratives of Black Men Accessing Mental Health Services through Criminal Justice Systems**

Name of Researcher: Shaquilla Linton

Supervised by: Dr Bonnie Teague, Dr Sheri Odoula

Please put your initials in each box

1. I confirm that I have read the information sheet dated.................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the University of East Anglia, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
5. I agree to for my interview to be audio and video recorded for the purpose of data collection. I understand that my recordings will be destroyed after transcription securely at the end of the study. ☐
6. I am aware that I can withdraw from the study up until 2 weeks after data collection otherwise my data will be merged with other data and withdrawal from the study will no longer be possible. ☐
7. I agree to take part in the above study. ☐

8. I would like to receive a summary copy of the study’s findings after the study has ended. *(Please circle one option)* YES NO

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix K

Socio-Demographics Questionnaire

University of East Anglia

Demographic Information

The stories of Black Men Accessing Mental Health Services through Criminal Justice Systems

Thank you for agreeing to participate in the study. Before we complete the interview, we would like to ask if you could provide the following details about yourself.

Age ……………….

Ethnicity *(please tick only one)*

Black Caribbean ☐

Black African ☐

Black Other ☐

Highest level of education *(please tick only one)*

No formal qualifications at GCSE or higher ☐

GCSE (or equivalent) ☐

A-Levels (or equivalent) ☐

Undergraduate degree ☐

Postgraduate degree ☐

Current employment status *(please tick only one)*

Unemployed ☐

Part-time employment ☐

Full-time employment ☐

☐

Student

Retired ☐

Nearest town or city you live in ……………………………………………….

Thank you for completing this information. If you could please inform the lead researcher Shaquilla Linton on Shaquilla.linton@uea.ac.uk and you will be able to continue onto the next stage of the study.

Appendix L

Debrief Sheet

The stories of Black Men Accessing Mental Health Services through Criminal Justice Systems

Thank you for participating in the study. You were asked to share your experiences of what it was like being under the Criminal Justice System and Mental Health Services. The aim of asking you to share your story, was to understand more about the lived experience of black men having encounters with these services. Previous research has found that black men accessing Criminal Justice Systems through Mental Health Services are overrepresented and the circumstances being within these services are unjust. However, we do not know the details of what makes their experiences unjust and the long-term consequences of those experiences. I hope by participating in the study you feel that your voice has been listened to and that you have found the experience overall positive.

The recorded interview will remain anonymous, and your information will be given an ID number. The information provided will only be used for the purpose of analysis. After analysing the data, any conclusions drawn from the interviews will be written in a report and will be made publicly available for you to read if you wish to. If you would like to know where the published report will be available to read, then you can contact the lead researcher Shaquilla Linton on Shaquilla.linton@uea.ac.uk. You can withdraw your data from the study up to **two weeks** after participating in the research. After this point, you will be unable to withdraw from the study because your ID number will be non-identifiable by the researcher.

If you would like to make a complaint about you experience of participating in the study, then you can contact Sian Coker (Course Director) on s.coker@uea.ac.uk.

Mental Wellbeing Resources

We understand that talking about difficult experiences can be emotionally distressing. Below are some resources that can offer you additional support:

Samaritans: 116 123

Mind: https://www.mind.org.uk/

Black Minds Matter UK: https://www.blackmindsmatteruk.com/

Rethink Mental Illness: https://www.rethink.org/

First Response Services: 999 or 111 (non-emergency)

Appendix M

Consent to Contact Form

Research Project Title: The stories of Black Men Accessing Mental Health Services through Criminal Justice Systems

Chief Investigator: Shaquilla Linton of the Norwich Medical School, University of East Anglia

Please complete this form if you are happy for a member of the research team at the University of East Anglia to contact you to discuss your participation in the above research project.

I give permission for the research team for the above study to contact me to discuss taking part in the above named study.

I understand that my personal contact details below will be stored securely, in line with the Data Protection Act and General Data Protection Regulations and shall not be used by the research team for any purpose other than to discuss my participation in the study.

Participation is voluntary, and I can withdraw my interest at any time. If I withdraw my interest, and decide not to take part, the research team will destroy any copies of my personal details and my clinical care will not be affected in any way.

Full Name of Participant:

Signature:

Date:

Telephone/Mobile:

Email:

Preferred Method of Contact (please circle):

Telephone Email

Preferred Time to be contacted (please circle):

Morning Afternoon Evening

Appendix N

Ethical 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

Miss Shaquilla Linton
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Foundation
Trust/ University of East Anglia
Elizabeth House, Fulbourn Hospital
Fulbourn, Cambridge
CB21 5EF

11 April 2024

Dear Miss Linton

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

Study title: **A Qualitative Study Exploring the Narratives of Black Men Accessing Mental Health Services through Criminal Justice Systems**
IRAS project ID: **335796**
Protocol number: **1.0**
REC reference: **24/WA/0064**
Sponsor **Research & Innovation Services**

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 **335796**. Please quote this on all correspondence.

Yours sincerely,
Tracy Biggs

Approvals Specialist
Email: HCRW.approvals@wales.nhs.uk

Copy to: *Ms Sarah Ruthven*

Appendix O

Amendment Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Ariennir gan Llywodraeth Cymru
Funded by Welsh Government

Wales Research Ethics Committee 4
Wrexham

Mailing address:
Health and Care Research Wales
Castlebridge 5
15-19 Cowbridge Road East

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/ Wales until the outcome of the HRA/ HCRW assessment has been confirmed.

2nd October 2024

Dear Miss Linton

Study title:	**A Qualitative Study Exploring the Narratives of Black Men Accessing Mental Health Services through Criminal Justice Systems**
REC reference:	**24/WA/0064**
Protocol number:	**1.0**
Amendment number:	**SA_01**
Amendment date:	**07 September 2024**
IRAS project ID:	**335796**

The above amendment was reviewed in correspondence by a Sub-Committee of Wales REC 4 on 25th September 2024.

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]	2.0	07 September 2024
Research protocol or project proposal [Research Protocol]	3.0	29 August 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 - 335796:	**Please quote this number on all correspondence**

Yours sincerely

MJR

pp Mr Martin Rawson- Approvals Administrator
Dr Julie Latchem-Hastings
Chair

E-mail: Wales.REC4@wales.nhs.uk

Enclosures:	*List of names and professions of members who took part in the review*
Copy to:	*Miss Shaquilla Linton*