A Critical Race Study of Non-Statutory Mental Healthcare for Young People Racialised as Black

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Abstract

This was a study of the experiences of young Black people, their pathway to, and experience of, non-statutory mental healthcare. Non-statutory support is that offered by voluntary and community-sector organisations, including churches, community-interest companies and small-scale private providers.

The following main research question was asked: what is the lived experience of young Black people when accessing and receiving non-statutory mental healthcare?

A descriptive phenomenological research approach was used for data collection and analysis. Between October 2017 and May 2018, qualitative interviews were conducted with 25 young Black people from several English cities who had received non-statutory support, drawing out the complex dynamics of their care pathway.

A narrative literature review was carried out. Black people's relationship with mental health services has typically been understood through quantitative data, from the experiences of adults receiving statutory provision or care provided for persons with serious mental health problems. These studies point to longstanding racialised inequalities in the way they access and receive such care.

In this study, critical race theory, studies of racialisation and literature on the sociology of medicine were used in

the research design, practice, analysis and theorisation. Concepts from these fields of scholarship that were used for critical analysis included a critique of liberalism, intersectionality, racism as ordinary, anti-anti essentialism and illness behaviour.

This thesis documents a number of key findings. It shows the importance of fear, and the development of racialised thinking due to societal racism and unsatisfactory service contacts on the pathway to care. This thesis evidences how the antecedents of the difficult relationship between Black people and mental health services can manifest themselves early in the life course. Findings also shed light on the way barriers to help-seeking can be overcome, and service experiences improved, when non-statutory care is contextualised to young Black service-users. In this way, the findings offer a distinct contribution to knowledge. In novel ways, they expand the literature looking at the pathway to care and service-related experiences. This includes opportunistic engagement practices and tailored interventions that are attuned to the racialised realities of young Black people.

Key words: Racialised, racialisation, critical race theory, young Black people, mental health, mental ill-health, non-statutory care, phenomenological research, pathway to care.

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Glossary

A&E	Accident and emergency
Black church	Churches ministered predominantly to Black congregations
BME	Black and minority ethnic people
BVS	Black voluntary sector
CAMHS	Child and adolescent mental health services
CBT	Cognitive behavioural therapy
CIC	Community interest company
Faith-based care	Mental healthcare delivered with a religious component.
GP	General practitioner
IAPT	Improving access to psychological therapies
NHS	National Health Service
YOT	Youth offending teams
Young people	People age 16-25

Chapter 1 Introduction

> Very little research has been carried out on cultural determinants of illness recognition and attribution, users' … service preferences and the role of community-based strategies in improving satisfaction, reducing detention rates and enhancing outcomes. The paucity of such evidence has hindered the development of service-level interventions with the potential to improve mental health care for BME communities. It is also unclear whether generic early intervention services meet the specific demands and challenges of providing care for BME patients (Singh *et al*., 2013: 2).

No research looks specifically at the thoughts, feelings and emotions of young Black people when accessing and receiving non-statutory mental healthcare. This study aimed to fill this void and offers new ways of understanding the pathway to care and the value of mental health interventions that are contextualised to the realities of young Black people.

Racialised inequality in mental health has been described as one of the greatest of all health inequalities (Nazroo and Iley, 2011). Long-established trends reveal a difficult relationship between Black groups and mental healthcare

(Ndegwa and Oladije, 2003). The then UK Prime Minister, Theresa May, referred to the disproportionate number of Black people compulsorily detained under the Mental Health Act as a 'burning injustice' (Gov.UK, 2017, para. 7). Motivations driving this study included a desire to critically examine and better understand some of the factors leading to this intractable and entrenched problem. The researcher had worked for a long time challenging central and local government and statutory healthcare providers about mental healthcare provision for racialised minority people. This involved sitting on advisory bodies, attending ministerial meetings and using the law to influence change. This experience, and his time managing a range of non-statutory community-based mental health services for racialised minority adults, led him to question the significance of young Black people's help-seeking behaviours and experiences in relation to racialised inequality, and the role of non-statutory providers in addressing this. To examine these areas, this thesis researched the lived experiences of young Black people when accessing and receiving non-statutory mental healthcare. The theoretical frameworks embrace these concepts, encompassing the literature on racialisation and illness behaviour. To summarise, the novel contribution of this thesis to policy, practice, and theory is that it extends knowledge about the pathway to care, and receipt of non-statutory support for young Black people.

This introductory chapter offers some context to the study, first providing an overview of racialised inequality in mental health and why it is vital that we start to understand young people's experiences within this broader picture. Gaps in knowledge are identified and an explanation offered for why the pathway to care for young Black people, and the delivery of care to this group, should be viewed as matters of contemporary interest and importance. The chapter then looks at the central theoretical frameworks for the study: the concept of racialisation and critical race theory or CRT. An overview of the research design and methods are briefly described. Before detailing the thesis outline, the contributions made by this study are illuminated, thus making clear its advancing of knowledge.

When it comes to accessing care, Black groups are less likely to seek help for common forms of mental ill-health compared to other racialised groups (McManus *et al.,* 2016), yet they are more likely to be involuntarily detained (Barnett *et al.,* 2019). The literature also suggests their routes to care are typically more coercive and more likely to involve criminal justice agencies (Morgan *et al.,* 2005b). This has led to them being characterised in terms such as hard-to-reach (Flanagan and Hancock, 2010). Further, their contact with mental health services is typified by dissatisfaction and negative encounters (Rogers and Pilgrim, 2014). Thus, Black groups have a well-defined

disadvantageous relationship in the way they access and receive care.

Various explanations have been used to explain the coercive pathways Black groups tend to take in accessing services and to justify why their experiences of care are more negative. These include reports that show a higher prevalence of mental ill-health among Black groups and increased exposure to socioeconomic deprivation (Kirkbridge, 2018). These arguments are important, but they do not go far enough in explaining higher rates of mental ill-health found among Black groups (Qassem *et al.,* 2015) or their different pathways to care (Ghali, et *al.,* 2013; Lawlor, 2010; Morgan *et al.,* 2005b). A perspective that dominates this area is one that suggests mental health services are institutionally racist (Fernando, 2017). Following this argument, Singh and Burns (2006) have suggested that because services are portrayed as being institutionally racist, Black people delay their help-seeking. However, whilst Black groups may delay help-seeking there is no evidence their delay is any longer than for other racialised groups (Kirkbridge, 2018; Anderson, 2014). From this, delayed help-seeking alone is unlikely to be the only factor. Another perspective in this area of scholarship is offered by Keating (2012). When looking at the adult population, he suggested there was a spiral of oppression, which made the journey to care more challenging for Black people as they fear being treated differently because of their racialised identity, compounded

with the effects of mental health stigma. This position aligns with a broader perspective—and a growing body of evidence—that point towards the significance of societal racism and its association with higher rates of mental ill-health (Wallace *et al.,* 2016). This study provided an opportunity to look at the salience of racialisation and to explore Keating's hypothesis in relation to young Black people accessing and receiving non-statutory care.

The experiences of young Black people in relation to help-seeking and their experiences of care has received little scholarly attention. Singh *et al.* (2013: 2) have suggested that minimal research looks at racialised differences in relation to illness recognition and the role of non-statutory organisations in improving service experience. The pathway to care is an area that has received increased attention (Burnet *et al*., 2019). However, there is minimal literature looking at the subjective experience of Black people due to an over-reliance on quantitative data (Utsey *et al.,* 2005). A further problem with this area of scholarship is that it has been dominated by research into adults. Dogra (2012) pointed out that too often this results in assumptions about the mental health needs of young people being based on experiences of the adult population. Thus, research looking into the experiences of young Black people is underdeveloped. This is peculiar as it is possible that the antecedents of the poor relationship between Black groups and mental healthcare providers can be found earlier in the life course. Another issue of concern is

the overdependence on the opinions of mental health professionals rather than that of service-users (Chang *et al.,* 2009), which is problematic given that it is the service-user's experience and perception that is most closely related to a therapeutic outcome (Horvath and Bedi, 2002). Existing research also focuses on the provision of statutory services and more serious forms of mental ill-health. Thus, this study fills an important gap in the literature by giving a voice to young Black people who have experienced a range of mental health problems, and provides a better understanding of their pathway to care and experience of receiving non-statutory mental healthcare.

This thesis engages a range of scholarly literature. Keating (2012) and Fernando (2017) have argued that Black people's experiences of accessing and receiving care is more negative because of their racialised identity. The fields of scholarship on racialisation and critical race theory (CRT) are therefore relevant. First, they acknowledge the social construction of racialised groups. Also, CRT contends that racism is not an aberration, but a normal part of everyday life. This position aligns with ideas about the salience of societal racism that Keating and Fernando put forward. Further, CRT and racialisation provide conceptual perspectives through which the findings can be contested, debated and analysed. CRT critiques liberalism, in particular ideas around formal equality. It also has tools to explore intersectionality and to contest essentialist notions

of race. Studies on racialisation provide a framework for exploring participants' stories in relation to their experiences. Therefore, CRT and racialisation were used theoretically, methodologically and analytically at each stage of the thesis. Literature from the field of medical sociology was also engaged to appreciate the social construction of categories of mental health and mental ill-health. It was also embraced to draw on important sociological theories regarding a service-users' help-seeking journey. The work of Suchman (1965) and Mechanic (1995) is covered as they offer important views and frameworks to conceptualise factors, such as illness recognition, the reception of service-users into care and the service-user and care-provider relationship.

Following a review of the literature, the following main research question was asked:

> What is the lived experience of young Black people when accessing and experiencing non-statutory mental healthcare?

To answer this question, qualitative interviews were used. Fieldwork took place between October 2017 and May 2018. Giorgi's (2009) phenomenological descriptive methods were adapted; they involve staying close to participants' lived experience while attempting to reduce the influence of the researcher. This approach was suited to CRT, which

argues that people who have been racially oppressed are best positioned to describe their experience.

Whilst a range of findings are discussed throughout the thesis, knowledge was expanded in key areas. The findings indicate that many of the precursors to the tense and fractious relationship between Black adults and mental health services can manifest themselves early in the life course. They show the development of racialised thinking among young Black people as a result of challenging social circumstances, the need to overcome a range of fears and a failure of mental health support organisations to provide comforting and effective care during the early stages of their pathway to care. These findings highlight the relevance of, and expand on, Keating's hypothesis about the spiral of oppression. They add granularity to our understanding about the pathway to care, which is typically understood through quantitative data and statutory care provision for adults.

This study shows how significant it is for care to be contextualised to the experiences of young Black people. The findings point to the importance of the social environment for facilitating access to care. They show how support organisations can use opportunistic practices by designing their approach to engage young Black people in places where they would normally associate, creating safe points of entry into care. Also, when young Black help-seekers had the opportunity to be with other service-users

or mental health professionals of the same racialised identity and the same intersectional identities, including age and gender, this operated as an enabler. These approaches and features, which make help-seeking more accessible, normalising and less fearful, have key implications for practice and policy as they help to overcome barriers to help-seeking.

The findings provide further evidence that when care is delivered in a way that is sensitive to the context of young Black people's lives it can be more affirming. Group therapy (often gender-specific) that was tailored to young racialised people and involved professionals of the same racialised identity, was particularly important. These factors created a deep sense of shared understanding they had not experienced previously. Nevertheless, these elements of provision operated in parallel with other important service features. It was vital that mental health professionals understood and acknowledged the pressures of societal racism and designed their intervention in a way that helped to build resilience and empower young Black service-users in relation to these damaging social structures. Again, these findings are critical to policy, as they show how care needs to be in tune with the realities and challenges of young Black people's lives.

Chapter Outline

Chapter 2 briefly defines the construct, young person. The chapter focuses on covering the literature on racialisation and CRT. Racialisation is introduced as a conceptual tool, acknowledging the socially constructed nature of racialised categories. An overview of key historical phases, which contributed to humankind being considered in racialised terms, is presented before the chapter looks more specifically at processes that have racialised people as Black. The first part of the chapter ends by drawing on theories of racialisation and making it clear how the term Black is used in this thesis to define the research participants. The second half of the chapter analyses CRT's framework and illustrates how it has shaped this thesis. CRT's principles provide different viewpoints to conceptualise the presence of race and racism within everyday life. The relevance of these tenets is debated. The chapter concludes by illuminating how CRT is well positioned to academically explore mental ill-health, whilst providing an instrument to explore the salience of race.

Chapter 3 offers a narrative review of the literature. It is concerned with defining key terms pertaining to mental health and mental ill-health. The chapter starts out by looking at the socially constructed nature of these terms, with particular emphasis on the influence of social processes in determining our understanding of mental ill-health. A brief history of mental healthcare is then provided to help contextualise non-statutory care within

the broader picture of healthcare provision. The chapter then turns to look at the literature on racialised inequality in mental health. This helps to identify where scholars have focused their attention when attempting to understand why racialised inequality exists. Gaps are identified, showing the limited attention focused on young Black people and their pathway to, and experience of, care.

Chapter 4 explains the research design and methodology, justifying a qualitative approach and the use of descriptive phenomenological methods. In particular, the study follows an adapted version of Giorgi's (2012) research methods, based on the philosophical work of Husserl. These aspects, and their relevance to the undertaking of the research, are discussed and debated. The chapter also illustrates the tensions and ties between CRT and Giorgi's (1985) version of phenomenological methods. A step-by-step breakdown of Giorgi's methods is provided, relating to data collection and analysis, utilising his ideas around phenomenological reduction, which places the onus on the researcher to suspend their knowledge to embrace fresh understandings. Further sections of the chapter look at the recruitment procedures and participant profile, describing in detail the ethical dilemmas that emerged during these stages of fieldwork. The chapter ends with a personal reflection on the research methods and the researcher's positionality.

Chapter 5 is the first of four chapters of research findings. It looks at social pressures and symptom experience on the pathway to care. The nature, extent and importance of social pressures experienced by young Black people are presented and debated alongside the literature that looks at the impact of structural conditions, stressful life events and societal racism. This chapter also looks at the early stages of symptom experience. It provides insight into participants' early interpretations of mental ill-health—their ability to recognise changes in their normal functioning, the challenges they face in explaining them, and their inability to see the significance of these symptoms—and how these operate as a barrier to help-seeking. Literature, looking at illness behaviour, is drawn on to contextualise the research findings. Throughout the chapter the findings, which show how processes of racialisation, interrelated with social pressures and symptom experience, are presented and discussed.

Chapter 6 focuses on participants' pathways to care and their experiences of receiving support at organisations that were part of their early help-seeking. The first part looks at decision-making on the pathway to care. This follows on naturally from the point where participants identified they were experiencing mental ill-health, discussed in the previous chapter. When focusing on the area of decision-making, the role of social networks, the use of alternative methods of coping, and the thoughts and feelings of participants when help-seeking or involuntarily accessing

support, are examined. The second part of the chapter then moves on to present and debate the experience of young Black people when receiving care in the early stages of their pathway to care. This looks at the dilemmas participants faced and the implications of their experience for future help-seeking.

Chapter 7 is concerned with the experiences of young Black people when accessing and experiencing non-statutory mental healthcare. A range of participants' experiences are covered in the first part of the chapter, showing the various dilemmas they encountered, and had to overcome, on their help-seeking journey. The social environment in which care was provided is presented, showing how safe points of entry to care can be established. The second part of the chapter looks at participants' experiences of receiving care in the non-statutory sector. Factors that made care more successful, including the professional's interpersonal skills, identity and ability to offer meaningful support, are presented and debated. The challenges of receiving non-statutory care are also presented. Group therapy emerged as a key theme for young Black people receiving care.

Chapter 8 discusses the development of racialised thinking among participants. It shows how their stories point towards the existence of institutional racism within care and illustrates the way their perceptions of mental health and mental healthcare evolved over the course of their

help-seeking journey. The chapter starts by showing the way processes of racialisation became an increasingly salient part of participants' thinking about their interactions with mental health providers. This links to the next part of the chapter, which draws on participants' accounts and the lack of fit between young Black people and mainstream mental health interventions. The final third of the chapter draws on the changing views of participants in the way they conceptualise their mental health, their need for mental healthcare, and whether mental health organisations can improve their mental health.

Chapter 9 concludes the study's overall findings. It reflects on the initial research intentions and shows how this was carried out by reporting on the research process. The main findings are presented to show how the study has answered the research questions. This illustrates how the research embraces and expands on Keating's (2012) spiral of oppression concept, by assessing its relevance to young Black people and their pathway to care. The chapter then draws on the findings as a whole to report on the contribution to knowledge this study has made by uncovering the development of racialised thinking on the pathway to care, and the significance of care being contextualised to the lives of young Black people.

Chapter 2 Young people racialised as Black

Defining young people

This study uses the age range 16-25 to define a young person. However, it is accepted that this is a term influenced by context. Guidelines from the National Children's Bureau (Shaw *et al*., 2011) and the UN Convention on the Rights of the Child (Lundy and McEvoy, 2012) categorise children and young people as 18 years and under. UK-based children and young people's mental health services have traditionally provided care up to age 18 years, but policy is now in place for this to be extended to age 25 (NHS, 2019). Meanwhile, researchers use other categories, including 18–20 (Young *et al.,* 2007) and 10–25 (Kuntsche *et al*., 2006). As such, it can be seen that there are fluid understandings about what constitutes a young person that shift between legal and service-related definitions, and those based around evolving competencies.

Multiple reasons underlie the decision to select the age range used in this thesis. Whilst childhood legally ends at age 18, there is evidence that brain development continues until people are in their 30s (Cambridge University, 2019). The World Health Organisation (2014) also refer to the way maturity takes place at a different pace for different people. Therefore, this thesis recognises

that the transition to adulthood is broader than is conventionally understood in legal terms.

Further grounds for focusing on this age range relate particularly to the vulnerabilities people face at certain times in the life course and the limited amount of research looking at this area for young Black people. The age range 16–25 denotes a time when adequate support is vitally needed. Estimates suggest that for 75% of adults the onset of mental ill-health will have occurred by age 24 (Kessler *et al.,* 2005; McGorry *et al.,* 2007). It has also been suggested that, despite extreme levels of complexity in their lives, young people have the lowest access to services amongst any age group (Centre for Mental Health, 2014). For these reasons, meeting mental health needs and designing better services at an earlier stage is crucial to improving life outcomes. Chapter three documents the scarce literature looking at the mental health needs of young Black people. This is concerning, as it is a point in the life course when racialised inequalities in mental health become entrenched. By focusing on people age 16–25, more is revealed about some of the precipitating factors that lead Black groups to have a differential experience within mental healthcare.

The racialisation of young black people

Throughout this thesis frequent reference is made to people in racial terms (*e.g.* Black, White or mixed race).

Serrant-Green (2002) has argued that any reference to such terms is contentious and should be placed within a given context. The position taken in this thesis states that these identities are the subject of ongoing negotiation and contestation, and they are formed as a result of social and political circumstances. For this reason, whenever the terms Black or White are used it is with a view to seeing them as socially constructed.

In this chapter, racialisation and critical race theory (CRT) are introduced. Racialisation is used to discuss and debate human differences that alludes to the notion of race. As a concept, it is fundamental to acknowledging the social construction of race, whilst placing emphasis on the processes that generate and maintain the use of racial categories. These processes are explicated to illustrate how people have been constructed as Black, as this is pertinent to understanding the experiences of the study's participants.

The second part of the chapter presents CRT as a versatile framework that has shaped this study and provided an anchorage to conceptualise the significance of societal racism. After covering the literature, a context is created to explain the use of the term Black and the processes that racialise people as Black, alongside an appraisal of CRT's conceptual tools, which emphasise the salience of race.

Racialisation

Racialisation recognises the power embedded within social, economic and political processes, which have resulted in the fabrication of racial types. In this thesis, racialisation is adopted as a concept that argues against the use of race and ethnicity as signifiers of biological and social difference. These constructs have been shown to be unsound categories, which have been reified by historical, political and social events (Back and Solomos, 2009). As Dalal (2002: 19) asserts, it is 'an uncontroversial fact in genetic theory' that any racial, ethnic or cultural group 'will be found to share approximately 15 per cent of their genes,' the other '85 per cent of the genetic material is unremarkable and similar to that of the rest of humanity.' Thus, it is well established that race is of limited worth for classification purposes (Rex, 1973). Banton (2015) also critiques the use of the term ethnicity as he suggests that many ethnic groups are routinely identified based on idioms of race. This has led Graig *et al*. (2012) to argue that ethnic differences have simply become a coded way of speaking about race. Certainly, all attempts to measure, define and separate humankind into groups using notions of race have proven to be deficient and imprecise. Although racialisation rejects these forms of categorisation, it accepts their social significance. Whilst acknowledging that people have been defined based on idioms of race (often using phenotypical differences), racialisation offers a framework for understanding and

uncovering the means through which humankind continues to be characterised in racial terms without plausible justification. As Miles (1982: 157) explains, racialisation is

> … a process of delineation of group boundaries and of allocation of person within those boundaries by primary reference to (supposedly) inherent and/or biological (usual phenotypical) characteristics.

According to Murji and Solomos (2003) there is general agreement amongst scholars that racialisation implies that racial groups are socially engineered. From this, racialisation is a way of understanding how people continue to be organised with reference to race. Racialisation also recognises the role of power. For Garner (2010: 20) 'racialisation is an exercise of power in its own right, as opposed to a commentary that enables or facilitates a prior exercise of power.' He goes on to suggest that there is broad understanding that racialisation occurs as part of an unequal power relationship, involving the negative characterisation of racialised minority people. Therefore, given the emphasis on power and group allocation, racialisation offers a conceptual frame to situate participants' feelings of being disempowered as a result of the way they are represented.

Racialisation must also be understood as a process. Barot and Bird (2001) argue that this is one of the main

advantages of the notion of racialisation. Miles (1982) sees this as a benefit because social relations are not static, as factors that contribute to groups being racialised are continuously being transformed, shaped and understood in different ways. Small (1994: 33) concurs with this position, stressing that racialisation is 'a process of attribution which has been unfolding over time, and which continues to unfold.' Its emphasis on process is critical to understanding how groups are currently objectified in racial terms, the manner in which this corresponds with historical representations of Black groups, and the way this interacts with participants' experiences of accessing and receiving care.

Processes that racialise people as Black

Racialisation is the term used in this thesis to explain the way notions of race are initiated and reproduced. It acknowledges how idioms of race are invoked and thought to be intrinsic within a given set of social relations. As Gilroy (1993) and LaoMontes (2007) have argued, ideas about race are enmeshed within politics, culture, identity and memory. This is a point also made by Asante *et al.* (2016: 678) who assert that racialised thinking takes place in a

> … space of transnational cultural construction, an ongoing formation with multiple

> axes/intersection in which historical narratives, local politics, and self-identifications are enunciated and debated.

This thesis is principally concerned with processes that have racialised people as Black. Although the term Black can be taken for granted, it is a slippery concept that is loaded with complexity and uncertainty. On the one hand, to use it as a form of human classification makes little sense, as encountering somebody who is as black as the ink on this paper is highly unlikely. However, this is a term that was attributed to people on the African continent during colonial expansion, which has persisted to the present day. Nevertheless, there have been changing constructions about what it means to be Black. Terminology has altered over time, as what is now considered to be outdated and derogatory language (*e.g.* Negro and coloureds) has declined in use (Turner and Collinson, 2003). These inconsistencies and similarities over space and time have formed ideas about what it means to be racialised as Black. Rowe (1998) has argued that it is not possible to understand concepts of being Black contemporarily and locally without considering the historical processes of racialisation and those that operate at national and international level. This section takes account of these dynamics to highlight the processes that have racialised people as Black.

Various scholars have elaborated how ideas about race originated, were developed and acquired social significance. According to Garner (2010: 13) three separate eras each made distinctive contributions that produced a 'set of ideas about the native/indigenous people [of the Americas, Africa, Asia and Australasia] that placed them in a position of moral and cultural inferiority.' These were European expansion and colonisation (15th–19th century), the European Enlightenment (c.1720–1820) and racial science (19th century) (Harvey, 2016). Jordan (2009) notes how during European expansion, African people were defined by Englishmen based on their skin colour, and their darker skin was juxtaposed with notions of being dirty, soiled, deeply stained and symbolically evil. Back and Solomos (2009: 34) suggest that during this phase 'corporeal properties such as skin colour, hair and other phenotypical differences' were a way of 'anchoring difference.' At the same time positive connotations, such as purity, were attributed to White people. These colour-based binaries have been viewed as a reflection of Christian symbolism of the time, were blackness denoted inferiority, which provided justification for punishment that was meted out through servitude (Garner, 2010). Therefore, whilst European expansion stretched across several continents it was people of darker skin complexion in Africa who were constructed as Black, and characterised in a particularly negative light, contributing to the beginnings of people being grouped.

The European Enlightenment strengthened negative ideas about non-White people, as thinkers from varied disciplines attempted to develop an elaborate typology of humans (Harvey, 2016). As a result, non-Europeans were characterised as being uncivilised, savage, barbarian and intellectually inferior (Eze, 1997). Thus, this was a period of time when there was a circulation of ideas that framed darker-skinned people in disparaging terms. In particular, 'Whites' were constructed as 'lively' and 'inventive', the 'Asians' were 'stern' and 'haughty,' whilst the 'African was 'cunning, slow, phlegmatic' and 'careless' (Turner and Collinson, 2003: 6). These ideas were given a greater sense of legitimacy during the period of scientific racism. As noted by Banton (2009), Enlightenment thinkers may have created the ideas and developed the foundations, but science gave these ideas authority. For Banton (2009) scientific racism brought about the specious categorisation of humankind by physically observable differences. He (2009: 56) viewed this as the deception of science, which people found appealing, as it relied upon science and the 'growing European acceptance of an association between differences in physical appearance and ability to build a progressive civilisation.' Whilst these eras each uniquely contributed to the way people were racialised, taken together they were crucial in consolidating particularly negative ideas about Black people.

Idioms of race have also been evoked in relation to the mental health or mental capacity of Black people. Early

evidence of this during the European Enlightenment is presented by Eze (1997: 33-5) when remarking how Kant reasoned that the 'difference between these two races [White and Black] … appears to be as great in regard to mental capacities as in color.' Historically the over-representation of people racialised as Black in mental health statistics has been linked to genetic differences that conjure images of permanency. As Nazroo and Iley (2011: 86) put it:

> In much of the research on ethnicity and health, ethnicity is equated with genetically defined races, and genetic difference is mobilized as a potential explanation for observed differences in health … there has been some discussion of the possibility that differences in risk of psychotic illness between Black and White people may be a consequence of genetic factors that correlate with ethnic/racial background.

Indeed, this is a deficit approach that racialises mental ill-health as an essential characteristic of Black people rather than a factor that has an alternative explanation. Further, more recent examples of the way Black people have been racialised in mental health can be seen in the way psychiatrists have viewed Black groups as being more dangerous (Nazroo and Iley, 2011; Lewis *et al.,* 1990). Keating (2007: 7) also identified that Black men

experiencing mental ill-health were perceived by professionals as 'big, Black and dangerous.' Fernando (2003) has stressed that it is these kinds of racial stereotypes that can influence mental health assessments and decisions about care. Of equal concern is how Black people feel they are perceived as a result of stereotypes. For instance, Keating and Robertson (2004: 440) identified how Black men are fearful and reluctant to access services because they are, 'normally cast as the Other' and viewed with 'suspicion, hostility and anger.' How a person who is racialised as Black is perceived, or thinks that they are perceived, is likely to have disadvantageous outcomes. This is a critical dimension that emerges in this study in the way service expectations can be influenced as a result of racialising factors.

Various other factors and circumstances have been, and continue to be, instrumental in activating notions of race. The media and role of criminal justice agencies are but two. Hall (1982) has noted how the media is a powerful source of ideas about race. According to Rowe (1998: 65) this can be seen in the way public disturbances have been referred to as 'race riots' involving 'Black mobs.' Meanwhile, Williams (2015) has described the way gangs are frequently portrayed as a Black man's problem. He argued that the operationalisation of the term gang by the criminal justice system has resulted in more Black men being defined as gang-associated. Thus, gang has become a signifier for Black men. Consequently, for Williams

(2015: 23), this has resulted in Black men being viewed as the 'Black folk devil', as the term gang contributes to images that are held of them. In such ways notions of race are upheld and ideas about Black people are formed, which presents them in unfavourable terms.

Numerous other processes contribute to people being racialised as Black. Banton (2015) argues that racial groups are perpetuated by government agencies. This is a point also made by Ratcliffe (2004) who notes how race remains a term of common parlance as a result of equality legislation. According to Ahmad and Sheldon (1993) this is because UK public services carry out ethnic monitoring, which use categories like Black British, Black other and Black African. Banton (2005: 63) goes as far as saying that government measures to tackle racial prejudice and discrimination and to promote equality through the collection of data are more likely to be 'race-making processes' more so than 'racist attitudes within government.' Whilst this may be the situation, racialised classification systems homogenise groups; they also give a sense of ordinariness and permanency that sustain and contribute to the racialisation of people as Black.

Experiences of harassment and discrimination, or social situations that draw attention specifically to skin colour have been fundamental to the way young people construct themselves as becoming racialised. This is an area covered by Phoenix (2003) when looking at the first moment young

people became aware of their racialised identity. She found that out of 248 young people (age 14-18) interviewed, only eight had never been conscious of their colour (7 White, 1 Black). Her research documented how myriad relational positions, including having parents of mixed racial heritage or being the victim of racial abuse, were pivotal moments for the majority of interviewees that were in essence their first remembered consciousness of colour. These examples expand the breadth of processes through which young people can be racialised as Black. This thesis further develops understanding in this area by illustrating how different forms of relationality within the sphere of help-seeking and receiving care results in remembered experiences of being racialised.

Racialisation of the mind

Fanon (1967) was one of the earliest and most notable scholars to use the term racialisation. His approach highlighted the way racialised thinking became part of the psyche among the colonised in North Africa. He argued that the colonisers used racialised binaries of Black and bad, White and good, and how this racialised discourse depicted the colonised as being incapable of self-government. This bears resemblance to the negative constructions of Black people already discussed. However, Fanon goes further to expose the way these binaries became embedded in the minds of the colonised. He

argued that the colonised viewed themselves based on the perspectives held about them by the coloniser. According to Fanon (1982: 149) the colonised internalised the negative perceptions held about them in addition to discarding their own racialised identity to be able to progress:

> The Antillean has therefore to choose between his family and European society; in other words, the individual who climbs up into society—White and civilised—tends to reject his family—Black and savage.

Fanon also discussed the relevance of racialised thinking to colonised young people; they first realise they are racialised as Black, then they learn how they have been stereotyped, subsequently these ideas are internalised in their thinking (Fanon, 2008). Ultimately, what emanates from Fanon's work is the need to appreciate that racialised and unequal power relations inflict a sense of inferiority on the psyche of the colonised. These ideas about feeling degraded and less human as a result of internalised racial thinking is an area of knowledge that is developed in this study in the way participants assess whether they are worthy of care.

The foregoing discussions are critical to understanding the different processes that racialise people as Black, providing a reference point to contextualise participants'

experiences. It assists in asking questions about the salience of race when accessing and receiving support. They offer a framework to understand how the dominant White group have constructed and assigned specific expectations, behaviours or meanings to young Black people, which contribute to the experience of mental ill-health that impacts their journeys to and within care.

Young people racialised as Black

Drawing on the literature covered so far it is evident that multiple factors have contributed to the construction of people as Black. There have been shifting definitions about what it means to be Black, which have been influenced by processes of racialisation. The use of pejorative terms has altered with time, yet a great deal of ambivalence remains about how best to conceptualise and refer to human differences couched in racial terms. This point is further highlighted by Ndegwa and Oladije (2003: x) when they refer to the inconsistent terminology used by scholars which includes 'African, Afro-Caribbean or African Caribbean, West Indian, Afro-American or African American.' As they note, these definitions reflect the prevailing context of a given time. Therefore, such terminology should be viewed as a form and product of racialisation, restating the importance of seeing any term as socially constructed.

This thesis refers to people as being Black. Specifically, these are people who self-define as Black African, Black British, Black Caribbean, Black other and mixed race (White and Black Caribbean, and White and Black African). In this sense, the term Black refers to Africans in the diaspora, living in England, and not in the political Black meaning, non-White (Ndegwa and Oladije, 2003). Employing such categories is itself a form of racialisation as already described by Ratcliffe (2004) and Banton (2005). These categories are also conceptualised within the English-speaking language, which represents a further power dynamic (Stephens, 2009). Added to this are concerns that the term Black should be faded out as it is unhelpful due to the heterogeneity it captures and that it is too simplistic a notion to explain health disparities (Agyemang *et al.,* 2005). Whilst these concerns are taken on board, wherever the term Black is used it is done whilst recognising that these categories are not conceptually valid. Rather, they have been constructed by the various processes already identified in this chapter. In this way, processes of racialisation construct the category Black, which is then applied to certain groups and individuals, not least by themselves. Furthermore, what the literature demonstrates is that these categories do have social meaning. Chapter three documents racialised inequalities for young people and adults. Those typically categorised as Black experience the greatest inequality and poorest outcomes. Whenever this thesis refers to the term Black it relates specifically to these identities, focusing on the

groups who are most likely to experience the greatest inequality. As such, this study is being driven by a need to understand and find ways that may help to address racialised inequality. Thus, the aim of this study is to understand more about the social meaning attached to being racialised as Black in relation to non-statutory care.

Critical race theory

It is the aim of this section to analyse the perspective that CRT offers and illustrate how it has shaped this thesis. CRT has proven to be a versatile framework that has now been applied outside the field of legal scholarship where it was initially established. Since its emergence, CRT has confronted orthodox approaches to tackling racialised inequality, as they were perceived as ineffectual in responding to racism, which is deeply embedded within the fabric of society. Principles that underpin CRT, and which are uniquely brought together within one framework, have influenced this study in various ways. This section will draw on the literature to demonstrate how CRT offers a framework to academically explore mental ill-health.

From the US to the UK: the emergence of CRT

> [CRT is] the work of progressive legal scholars of color who are attempting to develop

> jurisprudence that accounts for the role of racism in American law and that works toward the elimination of racism as part of a larger goal of eliminating all forms of subordination (Matsuda, 1991: 1331).

CRT emerged from critical legal studies (CLS) in the USA in the 1970s. During that time, it was felt that CLS did not go far enough to recognise and remedy the ubiquity of racism, which permeated American law. For this reason, it was decided that an approach was needed that would recognise and address the more obvious and overt forms of racism, but also acknowledge and seek to combat its more mundane and deeply embedded manifestations. Thus, from its inception, CRT has sought to shake the foundations of orthodoxy by challenging the legal academy and liberal values.

CRT's first significant introduction to the UK was in the field of education through the work of Gillborn (2006; 2008). It has since been applied to a wide range of areas, including sport (Hylton, 2005), health and social care (Campbell, 2014), and civil defence and terrorism (Chakrabarty *et al.*, 2013). This reinforces the view that CRT is transdisciplinary (Yosso *et al.*, 2004). Therefore, CRT can be seen as an adaptable framework that offers a contemporary perspective on race and racism. The decision to use CRT has been partly driven by its inherent

flexibility, providing sufficient scope to embrace the wider social science literature.

Debates within critical race theory

Parker and Lyn (2002: 10) contend that CRT has three main goals:

> (a) to present storytelling and narratives as valid approaches through which to examine race and racism in the law and in society; (b) to argue for the eradication of racial subjugation while simultaneously recognizing that race is a social construct; and (c) to draw important relationships between race and other axes of domination.

These goals are supported through a set of principles, developed in response to the evolving challenges associated with race and racism (Delgado and Stefancic, 2013; Gillborn, 2006; Brown, 2003). It embraces the notion of racialisation and the social construction of racial groups and brings new ideas as a process of development and learning (Delgado and Stefancic, 2012). Thus, in agreement with Tate (1997: 235), CRT is 'an iterative project of scholarship and social justice', that is flexible to spatial and temporal circumstances. This chapter focuses

specifically on those principles that are directly related to this thesis.

Racism is not an aberration

CRT holds that racism manifests itself ordinarily, which reinforces the ascendency of White people over Black. Various surveys suggest we now live in a post-racial society, where, in essence, race is no longer significant (Dawson and Bobo, 2009). At the same time, Brown (2004) has argued that racism remains a societal problem, albeit much more subtle than in the 1970s and 80s. CRT's position encompasses that of Brown, but goes beyond this to suggest that it is subtle, but it is routinely part of the multiple interactions that comprise daily life. Hence, racism is omnipresent and organically part of everyday financial, professional and personal exchanges. Delgado and Stefancic (2012: 7) assert that racism infuses life and is 'the usual way society does business.' CRT's perspective is that racism is not subtle; rather it is so pervasive and entrenched that it has become ordinary and resultingly it has become unrecognisable. Bell (1995) asserts that the everydayness of racism results in material benefits as, for instance, White people are less likely to be refused employment because of their skin colour. Therefore, CRT views racism as being a central feature of life resulting in inferior outcomes for people racialised as Black.

Another of these outcomes is the relationship between everyday racism and mental health. This is evidenced in the work of Masko (2005) who looked at the internal crisis a 12-year-old encountered with racism. She illustrated how racism was so significant — 'as ordinary as breathing' (Masko, 2005: 329) — that it brought about strong emotions of sadness and anger for a young schoolgirl. This connection between the presence of societal racism and the psyche is connected to an idea that was put forward by Du Bois (1968: 3) over a century ago when he suggested that

> … a world which yields no true self-consciousness, but only lets him see himself through the revelation of the other world. It is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity.

Although Du Bois was elaborating on the way Black people are defined through the gaze of White eyes, his work highlights a fundamental dilemma faced by Black people. It helps to build a picture of the dual psychological and social dynamic within which race and racism is present. This is further articulated by Fanon (1967: 201) who more directly draws attention to its psychological consequences:

> In the period of colonisation when it is not contested by armed resistance, when the sum total of harmful nervous stimuli overstep a certain threshold, the defensive attitudes of the natives give way and they then find themselves crowding the mental hospitals. There is thus during the calm period of successful colonization a regular and important mental pathology which is the direct product of oppression.

Fanon draws a connection between oppression and the mindset of racialised people, which he and Du Bois contend is a consequence of the normality of racism. For CRT it is not necessarily direct colonial oppression but rather the continuation of racialised social, economic and cultural structures that operate to the detriment of Black people. The principle that race and racism are normal resulted in the focus of this study, which examines their salience within the context of mental healthcare. This study has examined whether racialisation is a normal feature of the lived-experience, providing insight into the way this engenders feelings of inferiority, fear and anxiety.

Racialised voices of authority

Racialised voices of authority is a perspective in CRT which entails placing centre stage the experiential knowledge of

those who have encountered racial oppression (Campbell, 2014). It is based on the premise that people who are oppressed will have a lens of privilege to genuinely know what it is like to endure the challenge of living in a racist society.

Another reason that CRT advocates for racialised minority people to be given a voice is to counter the majoritarian story (Chakrabarty *et al.,* 2013). The foregoing sections of this chapter documented how Black people have been portrayed pejoratively. This is a point made by Solorzano and Yosso (2002) who argue that too frequently mainstream views present a negative image of Black people. CRT aims to challenge the way racialised minority people have been represented. Its theorists use methods such as storytelling and counter-narratives to 'cast doubt on the validity of accepted premises or myths, especially ones held by the majority' (Delgado and Stefancic, 2012: 144). CRT's approach, that views racialised minority voices as having authority, informed the chosen research methods of this thesis. In particular, methods that minimise the role of the researcher were selected to offer greater attention to the participants' stories.

Intersectionality

Hill-Collins (2015: 2) refers to intersectionality as a theory that provides the

> … critical insight that race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities.

Intersectionality acknowledges that nobody is just racialised as Black, rather they also have other social identities. The origins of intersectionality can be found over a century ago when Sojourner Truth lamented the multidimensional challenges of not only being Black or a woman but of being Black and being a woman (Bowleg, 2012). However, it was Crenshaw (1991) who coined the term and brought it within the framework of CRT. The main thrust of Crenshaw's position is that Black women will sometimes experience discrimination similar to that of Black men and at other times similar to that of White women. Additionally, they will also experience dual discrimination based on being Black and a woman at the same time.

Various examples of intersectionality have been examined. Crenshaw (1989) discussed how Black women lost their jobs at General Motors during the 1970s recession but Black men and White women retained their positions. For Crenshaw, this case highlights how separate categories of race and gender cannot account for Black women's experiences. In her later work, Crenshaw (1991) looked at

the interlocking aspects of race, class and gender in the lives of Black women who were forced to go to a battered women's shelter as a result of violence and abuse. Her work shows how all women can be situated in positions that are burdened by gender and class oppression, and disproportionately disadvantaged due to poverty, parenting responsibilities and minimal job skills. However, she demonstrated how this disadvantage was compounded for Black women because of racially discriminatory practices in employment and housing. Wing (2015) and Brah and Phoenix (2004) suggest it is this kind of analysis that provides scholarship with insight into different aspects of identity, and the need to recognise that a combination of a person's characteristics can significantly influence their experience.

Moreover, Sumi *et al.* (2013) make it clear that it is not just about considering the different aspects of a person's life or identity individually. It is about considering how different forms of oppression can impact a person simultaneously. This is well encapsulated by Anthias and Yuval-Davis (1993: 63–66) who state that

> … race, class, and gender are not independent variables that can be tacked onto each other or separated at will … they are concrete social relations … enmeshed in each other.

In spite of these positions, intersectionality has been critiqued as being conceptually ambiguous. Hancock (2016) has stressed that too often intersectional research simply discusses how, for instance, race, gender or class individually impact a person. This contributes to concerns that it has shifted from its roots in Black feminism. Moreover, Salem asserts how intersectionality has been subsumed within liberal feminist theory, which has been historically averse to 'articulating race, gender and other social categories that divide women's experiences' (2018: 407). Although these concerns are acknowledged, and as with other CRT principles this is an ongoing and unresolved debate, intersectionality offers a framework used in this thesis. It provides an inclusive approach whilst giving impetus to consider more fully the multi-dimensional areas of oppression. According to Sumi *et al.* (2015: 795) this involves adopting 'an intersectional way of thinking about the problem of sameness and difference and its relation to power.' Therefore, intersectionality has resulted in an approach which is sensitive to participants' descriptions where they may feel they have been oppressed due to multiple aspects of their social identity, including the experience of being racialised, criminalised, classed and mentally unwell.

Essentialism, anti-essentialism and anti-anti-essentialism

Essentialism and anti-essentialism are two perspectives that attract ongoing attention within the broader CRT movement. The crux of the debate questions whether a Black community exists that is united by aspects such as feelings, attitudes, behaviour or political opinion, or, contrastingly, whether the exercise of racial idioms is just a convenient grouping of humankind, when in reality nothing bonds Black people together. These are questions posed by Delgado and Stefancic (2013: 387) who ask, 'what is the black community, or community of colour? Does it exist? Or are there in reality many partially overlapping, partially competing subcommunities?' Essentialism's position is one that sees a common Black experience. From this, essentialism is a

> … notion that there is a monolithic 'women's experience' that can be described independent of other facets of experience like race, class, and sexual orientation' [and a] 'corollary to gender essentialism is racial essentialism—the belief that there's a monolithic black experience (Harris, 2013: 349)

Essentialism takes various forms. For Ikemoto (1993), racialised essentialism is evident in media coverage. She describes how those involved in the Los Angeles riots were only reported as being Korean American or African

Americans, and thus the intersectional identities of those involved was disregarded in favour of conflated racialised boundaries, which essentialises the idea of race. Austin (1992: 396) provides another dimension to understanding essentialism when explaining how the 'ubiquitous experience of racism provides the basis for group solidarity.' This, of course, begs the question of whether racial oppression should be seen as a monolithic Black experience or whether areas such as politics, class, gender and geography do more to divide. As a concept, essentialism is valuable to this study as it helps to demonstrate commonalities in the way participants feel racialised irrespective of other aspects of their identity.

At the same time, anti-essentialism provides a conceptual frame to explore how differences in a person's identity or life experiences may result in race not being a salient component that unites Black people. Anti-essentialism is therefore a rejection of essentialist notions of race. Although the assumption can be made that all Black people share the experience of being oppressed it is quite possible that this is not the situation. As Celious and Oyserman (2001) observe, a large degree of homogeneity exists amongst African-Americans, but race is not always experienced in the same way. They point out how a middle-class Black person may not identify with the accounts of oppression shared by a single Black mother. Similar accounts of anti-essentialism have been found in relation to physical features and economic position (Masko,

2005). Indeed, Celious and Oyserman (2001: 150) contend that differences between light and dark skinned African-Americans and between poor and wealthy are so significant that the 'experience of being Black in America can be better thought of as multiple experiences rather than one experiential state.' The anti-essentialist position questions the idea of a unified Black experience.

Of relevance to this tenet is the anti-anti-essentialist position offered by Gilroy (1993). Although he may not refer to himself as a critical race theorist he is recognised as a theorist on matters of race and racism in the critical tradition (Essed and Goldberg, 2002). Indeed, Gilroy takes something of a middle ground in how he approaches this matter. He accepts that Blackness is neither innate nor just an absolute fabrication, but he proposes there is a level of connectivity that is passed on through time and space, and through traditions and behaviours. He suggests that those racialised as Black maintain a vivid memory of being mistreated, from slavery through to institutional racism. Winant (2009: 678) also lends support to this position when suggesting that

> … racial identities also seem to be less solid and ineffable than they did in previous ages. While racial identity remains a major component of individuality and group recognition, it partakes of a certain flexibility and fungibility that was formerly rare.

How relevant the essentialism, anti-essentialism and even anti-anti-essentialism debate is for young Black people in relation to mental healthcare is an area open to enquiry. This thesis has advanced knowledge in this area that lends evidence to each of the positions, but in particular it aligns most with Gilroy's anti-anti-essentialism as it shows how participants felt connected in some shape or form to racialised oppression and that the experience of being racialised as Black is not a complete fabrication, but yet each encounter is experienced and processed uniquely.

Critique of liberalism

CRT has a strong dislike for liberalism in the form of mainstream civil rights legislation. In particular, Bell (2014: 686) argues that CRT sees liberal ideals 'such as liberty … and equality' as being problematic and ineffective. West (1995: xi) asserts that these ideals 'seldom address the role of deep-seated racism.' CRT's main concern is that civil rights litigation takes a formal approach to achieving equality, which is based on treating everyone the same. This encompasses principles like neutrality, objectivity and meritocracy. As Gillborn (2008) argues, on the surface, these ideals can appear progress-oriented, but they do not take into account the diverse ways that discrimination can influence outcomes. A formal approach to equality does not recognise the barriers that oppressed people face, which means they do not have

equal access to opportunities. This dilemma has been recognised in the field of mental health and has led Singh (2013: vi) to conclude:

> Statutory health-care organisations need to work closely with community groups to improve pathways to care for BME service users. Rather than universal public education campaigns, researchers need to develop and evaluate public awareness programmes that are specifically focused on BME groups.

As CRT scholars disfavour liberal principles, they also dislike the idea of colour-blindness, which is based on the idea of non-recognition. Colour-blindness advocates that skin colour should be ignored to minimise opportunities for racism. CRT vehemently critiques this approach. Gotanda (2013: 35) questions the adequacy of colour-blindness, arguing that there are three main elements to non-recognition. First, is the need for an element

> … that is cognizable as a racial characteristic or classification. Second, the characteristic must be recognised. Third, the characteristic must not be considered in a decision

He therefore points out that:

> … non-recognition is self-contradictory [as it] fosters the systemic denial of racial subordination and the psychological repression of an individual's recognition of that subordination, thereby allowing it to continue.

Indeed, the problem with a colour-blind approach is that by attempting to treat everyone the same it fails to account for the injustices that racialised people experience. This is the crux of liberalism. Hence, Matsuda (2013) argues that a realistic understanding of people's lives cannot be understood when using a colour-blind approach.

The debate within CRT that critiques liberalism has offered a space for different elements pertinent to this thesis to be examined. CRT's rejection of formal equality has been intrinsic to conceptualising the way participants feel in the care they receive and whether they feel their social identity as a Black person was a factor taken into consideration.

Critical race theory and mental health

CRT provides a framework for examining racism at an individual and group level (McGee and Stovall, 2005). Although some attempts have been made by scholars (Brown, 2003; 2008) to expand the application of CRT to the area of mental health, its use in the US and UK has

been largely confined to legal, educational, economic and women's studies.

Research by Brown (2003; 2008) and Masko (2005) has highlighted how CRT can be applied theoretically, methodologically and analytically to mental health research. The work by Masko (2005) also shows how CRT can assist in analysing data, whilst Brown (2008) has argued for more studies to adopt CRT when investigating mental health problems. In spite of its usefulness, McGee and Stovall (2015: 491) suggest that

> … critical race theorists have unmasked and attached the racial trauma experienced at all levels of the educational system, the connection of CRT to mental health and wellness research is in its embryonic stages.

It can therefore be seen that CRT is relatively unused in mental health studies internationally. Additionally, the relatively recent introduction of CRT to the UK highlights how this thesis offers a fresh and alternative approach to researching, theorising and analysing mental ill-health.

When reflecting on its value to the UK literature, Gillborn (2006: 17) remarks how CRT provides a critical edge, as within education, most research is 'concerned with mapping the scale of inequalities and attempting to generate school-level approaches.' Gillborn (2006: 18)

goes on to suggest that this is insufficient, and CRT offers a more radical approach, as, when paying attention to small-scale change:

> … we lose sight of the most powerful forces operating at the societal level to sustain and extend these inequalities. Essentially, we risk tinkering with the system to make its outputs slightly less awful but leaving untouched the fundamental shape, scale, and purpose of the system itself.

CRT provides the means to challenge the dominant model of mental health service provision. This is important in light of the lack of improvement in addressing racialised inequality, which is discussed in chapter three. Of relevance is how Black groups are underrepresented at primary care level (Boneham *et al.*, 1997) and are less likely to access care via a general practitioner (Morgan *et al.*, 2005b). It is also the situation that they are more likely to disengage from mainstream mental health support (McKenzie, 2012). Against this background of problems, and with the possibility that non-statutory support offers a viable alternative, CRT provides an apparatus to question the entire structure of mental health support.

In Defence of CRT

Whilst many of its positions and strengths have already been discussed, CRT is not without its critics. Indeed, questions have been asked about what makes CRT critical (Essed and Goldberg (2002), whether CRT is critical enough (Trevino, Harris and Wallace, 2008: 8), and a concern that CRT prioritises race, over others axes of oppression, in particular class (Cole, 2009a). However, in response to these points, it is argued here that it is CRT's ongoing and evolving development as a field of study, its existing tenets, and its willingness to draw in other fields of literature, that help it to overcome these concerns.

Trevino, Harris and Wallace (2008: 8) have argued that CRT has been too wedded to addressing racism through the rule of law, thus failing to question the ontological superiority of law itself. They go on to suggest that the answer to this 'rests in phenomenological investigations of the lifeworlds of people of colour,' as this approach may help to bracket – suspend the idea of – law's rule, so the subjective accounts of racialised minority people can be heard. Whilst it is accepted that more can be done to question the foundations of law's rule, CRT scholars have made efforts in this area. Butler (1995) has presented the idea of racially based jury nullification, with a view to removing or reducing the role of White lawmakers and White enforcers deciding the criminal justice sanctions for racialised minority people. Further, Alexander (2011) has

questioned the very structure of laws that result in the mass incarceration of African Americans. Delgado and Stefancic (2012) also use the terms homeostatic device and structural determinism, to explain how they feel changes in law occur too slowly for positive improvements to be realised in the lives of racialised minorities. Thus, within CRT, it is well recognised that a law based system as it operates is not sufficient. Whilst these scholars do not push for entire change, they do open scholarly debate that pushes for transformation.

Nonetheless, returning to the point made by Trevino and colleagues, that phenomenological investigations provide an alternative approach, this should be viewed as one option within a broad research toolkit. A key focus of CRT entails placing centre stage the voices of racialised minority people through the use of storytelling and narratives accounts. Whilst these approaches do not require any bracketing, they do not depend on legal frameworks, and thus there is a parallel framework that allows for an alternative explanation that does not afford superiority to the rule of law.

A different and significant concern has been raised by Cole (2009a), who offers a Marxist critique, suggesting that CRT is an inadequate theory because it advocates the idea of White supremacy. A retort to this has been offered by Mills (2009), and so this matter is only signposted here. Mills (2003) takes the stance, which is followed by this thesis,

that CRT should be viewed as an overarching movement, within which many positions lie. Hence, it should be seen as a broad field of study that does not close off other views, but it acknowledges and holds steadfast to the reality of White supremacy.

Another concern raised by Cole (2009a) focuses on CRT's prioritisation of race over class. Given the different history of the USA, from which CRT emerged, to that in the UK, where there has been a long established class-based system, this concern is justified. However, it is possible that Cole takes a narrow view that appears to polarise race and class. It is acknowledged that the mode of production, in the Marxist sense, has been integral by contributing to the racialised inequalities that exist. Nevertheless, it is not as clear how Marxism can explain all of the varied and intricate facets of racialised inequality as they manifest themselves in the present day. Therefore, in agreement with Mills (2003) and Gilroy (1987), race has acquired a degree autonomy, and, as Mills (2009: 272) contends, requires 'the rethinking of orthodox White Marxism.' This is not to say Marxism is not relevant. As Mills (2009) notes, for example, there is space to consider a Marxist view of CRT that takes into account race and White supremacy as part of European imperialism. Hence, CRT is, and should remain, open to the conversations that Cole (2009b) has encouraged.

Furthermore, as is the view adopted in this thesis, CRT lends itself well to an exploration of racial and class dynamics. As noted by Gilborn (2015: 278):

> For all of its emphasis on the central role of racism in shaping contemporary society, many CRT scholars are keen to explore how raced inequities are shaped by processes that also reflect, and are influenced by, other dimensions of identity and social structure: This is where the notion of intersectionality is crucial.

Thus, CRT has been adopted, in this thesis, as a framework that makes it possible to draw from various fields of knowledge — making it unnecessary to rule out other axes of domination. It is this interdisciplinary enterprise that is part of the beauty of using CRT.

Chapter conclusion

The overall aim of this chapter was to debate the literature pertinent to race. In the first part of the chapter, racialisation was presented as a tool to overcome the conceptual flaws of standard terminology that is conventionally used to classify humankind based on idioms of race. Racialisation was introduced as a concept to acknowledge the social construction of racial groups more generally, and more specifically in relation to the study

participants. Racialisation was also discussed as a discursive tool to examine myriad racialising processes that create and reify people in racial terms.

The second part of the chapter defined how this thesis has been informed by CRT. The way that CRT views race has been a driving force in the way this thesis has been conceptualised. It is true that different elements of CRT can be found in other areas of scholarship. For instance, racialisation, the social construction of racial categories and intersectionality are not areas unique to CRT. Nonetheless, what is appealing about CRT is that it brings many important theories and concepts together within one framework. Additionally, CRT is unequivocal in how it situates the salience of race and racism. Combined with its staunch critique of civil rights legislation and more broadly the idea of formal equality, these are factors that make CRT distinguishable. Moreover, existing debates within CRT offer immediate starting points for academic exploration and the opportunity to pull in other critical approaches, thus accommodating and fostering transdisciplinarity. Therefore, this study has taken steps to expand the breadth of knowledge about the utility of CRT and how the critical nature of its apparatus can facilitate debate about the value of non-statutory support vis-à-vis statutory provision.

Chapter 3 Mental ill-health, non-statutory care and racialised inequality

This chapter is separated into two main parts. The first looks at the social construction of mental ill-health and mental healthcare. A position is taken that the way mental ill-health and mental health provision are conceptualised are subject to temporal and spatial dynamics – politically, professionally and academically. Therefore, in order to appropriately situate this study, the literature pertinent to these areas will be covered. To meet this end, the first section starts out by providing a brief overview of the challenges of defining mental health. It then looks more specifically at the concept mental ill-health and explains why it should be thought of as a contested and culturally-specific term. This is achieved by looking at the field of psychiatry. As psychiatric terms are commonly used in the way people define mental health problems and it informs key areas of mental health service provision for young people it is of further importance to address this area. Although these arguments have been well rehearsed elsewhere in the literature, they need to be reiterated here to illustrate the socially constructed nature of mental ill-health, whilst they also inform the research methods, and the analysis and presentation of findings.

A broad and secondary aim of this chapter is to illustrate the gaps that exist in the mental health literature and to

justify the need for a study of this nature. In order to do this, a narrative literature review was carried out that involved identifying key scholars and themes of relevance to the study focus. Main health and social case databases were searched for published literature using key terms relating to mental health, young people people and race. Author tracing was also used. Key areas of scholarship relevant to this study are presented here as it is necessary to fully contextualise this study within the realms of knowledge pertinent to the research questions.

Very broadly, the second part of the chapter has been split into three main sections. In the first the overarching problem, that of racialised inequality in mental health, is defined. It covers research looking at children and young people, adults, and gendered inequalities that are delineated by race. This part of the chapter also examines and debates contemporary theories that have been put forward to explain why racialised inequalities exist.

Once the main theories on race and mental health have been addressed, it is possible to see how this study, which looks at the way people access support, offers a different approach to understanding factors that may contribute to inequality. To attend to this subject matter, an exploration of the various factors pertaining to Black people and their pathway to care are examined. In doing so, various positions emerge from the literature that are critiqued,

whilst articulating how this study can add to the existing evidence base.

The final section looks at the way mental health services are experienced by Black people. By looking at satisfaction rates and outcomes it is possible to see the significance of race within the context of mental health support. This part of the chapter provides a contextual overview of the relationship that Black groups have with mental health services. Against this backdrop, the argument is made that the present study fills a void in the literature pertaining to Black service-users' experiences in a non-statutory environment. The chapter then concludes by taking account of what has been presented and debated, and emphasises how this study is well positioned to contribute to this field of knowledge.

Debates surrounding mental health and mental ill-health

Challenges defining mental health

Before looking at the term mental ill-health it is worthwhile recognising that what is often understood by the term mental health is also contested. Various attempts have been made to define mental health. Westerhof and Keyes (2010) state that mental health is often viewed simply as the absence of mental ill-health. However, another view sees mental health and mental ill-health as being located

on a continuum with overlapping elements, thus indicating that there is a blurred boundary between the two concepts (Corey and Keyes, 2002). There are other competing positions: Mirowsky and Ross (2002) argue that mental distress and mental health are concepts that can be situated on a continuum, but mental disorder is something discrete and needs to be considered separately. Contrastingly, Payton (2009) asserts that there is no underlying continuum and each concept needs to be understood and researched in its own right. For Aneshensel (2002: 236) these areas of contestation about the validity of mental health and mental ill-health are 'unresolved epistemological issues that are especially consequential for sociologists.' A viewpoint that is taken here, and further developed throughout this section, is one that stresses the lack of agreement about what constitutes mental health and mental ill-health.

Alternative ways of defining mental health are frequently cited. For the World Health Organisation (2010) mental health is

> A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

At first glance this definition is seemingly straightforward. However, Galderisi *et al*. (2015) voice concern as it incorporates the need to feel and function positively. Additionally, Manwell *et al.* (2015) have observed how it does not go far enough to reflect factors such as spiritual development, intellectual capacity, positive self-image and self-worth, intrapersonal harmony and links to physical health. It is acknowledged that all people may find the WHO definition of mental health problematic (Manwell *et al*., 2015). However, given that ideas about mental health are grounded in Western culture (Summerfield, 2013), Keating (2012: 211) contends that 'little is known about whether BME communities share or subscribe to this [WHO's] understanding of mental health.' Thus, it can be seen that how people interpret what it means to be mentally healthy is disputed, and this is likely to be influenced by spatial and temporal factors and social demographics.

Challenges defining mental ill-health

Finding a concept to describe mental ill-health is equally challenging. Elsewhere in the literature mental ill-health is referred to as mental disorder/illness/distress, mental health problems or being mentally unwell (Westerhof and Keyes, 2010). It is not the intention of this paper to explore in-depth the advantages and disadvantages of different terminology. Rather, what is being pointed out is

that there is no consensus on how to describe human experiences that are not mentally healthy. Bessa (2012) suggests this is because concepts like mental illness have altered throughout history. Bracken and Thomas (2005) agree with this position and stress the significance of social conditions and structures, the prevailing thought and discourse, and how these contribute to diverse interpretations of human behaviour. These issues are now discussed to highlight the factors that contribute to the dilemma of defining mental ill-health.

One of the main challenges is dealing with the mistaken assumption that what constitutes mental ill-health is obvious and self-explanatory. Part of this complexity relates to the way various social groups and actors make sense of mental ill-health in different ways. This is discussed in greater detail later in this chapter in relation to illness behaviour and illness recognition. However, different professions and disciplines have influenced people's thoughts about mental ill-health. Rogers and Pilgrim (2005) suggest that four professional discourses have shaped understandings in this area. These are psychoanalysis, psychology, sociology and psychiatry. Each of these offer contrasting approaches to the study of mental ill-health and they also present different perspectives on its probable causes. Of these fields it is psychiatry which is often thought to have dominated thinking and treatment (Fernando, 2014). Thus, it is apt to discuss this area of practice to draw out how this discipline

has influenced thinking, whilst at the same time showing its limitations. By addressing the material in this way, it is also possible to demonstrate the context-specific nature of this field of study and its implications to understanding the nature of mental ill-health.

Kraepelin, regarded as the founding father of psychiatry, viewed mental ill-health as an organic dysfunction of the body (Decker, 2004). His conclusion was that, by observing and subsequently classifying behavioural symptoms it would be possible to determine the aetiology of mental ill-health. Kraeplin's position was that, if symptoms occurred with sufficient frequency they could then be referred to as a disease. The model of psychiatry was based within the illness framework, meaning that diagnosis, prognosis, aetiology and treatment are fundamental components of its process. Consequently, it was perceived to be a specialist field of medicine (Pilgrim and Rogers, 2005). Whilst it may be possible to assume that this would bring logic, objectivity and ultimately a way of determining and defining what mental ill-health is, this has not been the case. Therefore, although psychiatry is the profession that has dominated the field of mental health, this should not be equated with any degree of conceptual superiority.

Having raised these concerns there is an obligation to state the reasons for this. Whilst covering these matters the evolving position that is developed throughout this chapter

is one that views mental ill-health as being socially constructed.

Various aspects associated with the development of psychiatry have been influenced by social processes. As Busfield (2000: 544) argues:

> … social processes shape the very concepts of mental health and disorder, thereby setting the boundaries of what constitutes mental disorder and the categories that are used to distinguish one disorder from another. Second, social processes play an important part in the aetiology of mental disorders and mental disorder is always a product of genetics and environment.

The way that social processes are seen to influence the categorisation of mental ill-health draws attention to the temporally-specific nature of psychiatry. Bendelow (2004) highlights this point by documenting how homosexuality was once a classified disorder, whilst this is no longer the case. This, for Drescher (2015), draws attention to the impact social activists played in lobbying for homosexuality to be removed from the DSM, whilst for Scull (2015) it is indicative of the power that allows social groups to be pathologised as abnormal. Similarly, drapetomania was a diagnosis given by psychiatrists to describe slaves who attempted to run away from their holders, as this was,

surprisingly, viewed as peculiar behaviour (Bynum, 2000). Similarly, terms including moral insanity, hysteria, amentia and melancholia are no longer used (Cockerham, 2017). Each of these changes highlight that psychiatry is not a value-free profession. Rather it is one that is subject to the caprices of societal changes and human interpretations about what constitutes normalcy.

This raises a specific dilemma for this thesis, as what is considered to be a mental health problem can vary dependent on how it is assessed. If a threshold is set high for a person to be diagnosed as mentally ill then it is likely that fewer people will receive a diagnosis. Setting high thresholds for diagnosis is a point debated by Kecmanovic (2013). He argues that definitions of mental disorder that stress the need for clinical significance have no empirical support and have been of limited success in eliminating 'false positives' (Kecmanovic, 2013: 394). At the same time, some mental health professionals prefer a broad definition of mental disorder, such as any deviation from a positive standard mental health (Cockerham, 2017). As Szasz (1970) has noted, this leads to many human experiences being diagnosable. For Horwitz and Wakefield (2007) this approach can blur the boundaries between normal psychological feelings and psychopathology. Indeed, Stein *et al.* (2010) comment how this can mean that being slightly shy in social situations or sad after a traumatic event could be constructed as mental ill-health. Thyer (2015) suggests that this is a problem with the most

recent definition of mental disorder as it includes states which are temporary, such as alcohol intoxication or fever-induced delirium. These examples illustrate the challenges of demarcating the difference between what is normal behaviour and something that could be considered mental ill-health. They also expound the importance of social influences in the decision-making process.

In its strictest form, psychiatry pays little attention to the influence of social factors when considering aetiology. Traditionally, it is implied within psychiatry that the cause of mental ill-health can be found within the biological functioning of the individual. As noted already, social and environmental factors are intrinsic to understanding the aetiology of mental ill-health. Coppock and Hopton (2000) suggest that there is ample evidence demonstrating the strength of this relationship. There is therefore a tension, as psychiatry acknowledges the existence and importance of symptoms. However, whilst these symptoms are heavily associated with social and environmental conditions, psychiatry offers minimal scope to consider these aspects in the diagnostic process. Thus, social factors are important in the aetiology of mental ill-health, but this is not fully embraced within diagnosis or prognosis.

Many further concerns have been levelled at psychiatry that point towards its imperfections. Szasz (1970) was one of the earlier commentators to voice his disapproval. He argued that mental ill-health should not be seen as an

illness because it is the body that is ill whereas the mind is an activity of the body. Another concern of Szasz (1970) was the over-reliance in psychiatry on categorising symptoms without tangible evidence from bodily signs. Connected concerns have been raised by Timini (2011; 2016) who asserts that no robust evidence shows a physical (genetic or neuro-chemical) dysfunction for most forms of mental ill-health. Meanwhile, Burstow (2015) suggests that too many psychiatric interventions have limited success. This is a line of argument followed by Aboraya *et al*. (2006) who show that the accuracy of psychiatric diagnosis has improved very little over a thirty-year period. Similar studies demonstrate that diagnostic processes are less accurate when applied cross-culturally (Watters, 2010; Eshun and Gurung, 2009). Taking these critiques as a whole, it is possible to see that this is a contested terrain that is ever-evolving.

Mental ill-health as a socially constructed phenomenon

This section has so far illustrated the significance of social processes to the way mental health problems are categorised. Having covered this literature, an approach to viewing mental ill-health as being socially constructed has been justified. Concerns have also been raised about the validity of psychiatric concepts and why defining mental ill-health is problematic. As Thyer (2015) comments, many insufficient definitions have been offered over the years.

Nevertheless, whilst these challenges exist, it is recognised that people face real-life difficulties that are linked to their mental health.

This thesis aims to take a broad and pragmatic approach to the way mental ill-health is defined, thus recognising the temporal and spatial considerations by which mental ill-health is constructed. Cockerham (2017: 5) has argued that the DSM-5 offers a more simplified approach, as it determines mental ill-health as being a 'significant deviation from a person's past behaviors, thought processes, and emotions that results from an abnormal disturbance in his or her mental state.' Whilst this study may seem broad, and the DSM is itself a socially contructed phenomenon, it is nevertheless based on a medical model of illness.

Beresford (20002) has argued that the medical model is based on a deficit approach that locates pathology and inadequacy within the individual—defining their behaviours, thoughts and perceptions as unacceptable and defective. As already discussed, the DSM is based on an illness model that is associated with Western psychiatry. Marrington-Mir and Rimmer (2007) have challenged the medically dominated orthodoxy in Britain's mental health services, suggesting it is not holistic and does not draw on African-centred models which emphasis collective support, alongside participant and empowerment. This position chimes with the work of Sewell (2009), who discusses how

there are alternative ways of understanding mental ill-health, which do not depend on medical understandings that are conceptualised within the language of psychiatry. Also, the medical model pays no attention to the association between mental ill-health and broader societal oppression and discrimination. Thus, the medical model is an approach that has been viewed as failing to take account of cultural and racialised differences (Fernando, 2014). Whilst it does not acknowledge social issues more generally, research by Beresford *et al.* (2016) has indicated that mental health service-users believe the medical model contributes to the stigma they experience. These factors undermine the applicability of the concept of illness as it is conceived by psychiatry.

It is for these reasons that this thesis advocates a social model approach to understanding mental ill-health. Such an approach builds on the social model of disability, which draws a distinction between an individual's impairment and a disabling society (Beresford, 2002). In this sense, disability is understood to mean the barriers that society creates, through discrimination and oppression, and it thus explicates the societal response to impairment and their negative effects.

A social approach acknowledges the social constructed nature of mental health problems, whilst also providing a space to celebrate intersectional differences (Timander, 2017). It is an approach which has been welcomed by

mental health service-users, particularly as it recognises that mental health challenges are influenced by numerous factors (Beresford, Nettle and Perring, 2010); therefore bringing into the consideration the importance of social and environmental factors. Hence, whilst the social model of mental health should be recognised as an evolving concept, it is one that is more holistic, accounting for social circumstances important to each person.

This study followed a social model approach to conceptualising mental ill-health that would be based on the interpretations of participants, rather than one pertaining to a medical model. It views mental ill-health as any deviation in a person's mental health, which is seen by the participants as being significant to compel them to access care and receive a mental health intervention. This approach sees mental ill-health as being socially constructed based on the terms defined by service-users and non-statutory organisations.

Therefore, this thesis adopts the position that encompasses a wide range of experiences that participants and care providers construct as a form of mental ill-health. This means care is obtained for varying reasons including depression, anxiety, self-harming, experiencing a social phobia or a conduct-related problem.

The changing landscape of mental healthcare and the role of the non-statutory mental healthcare sector

The objective of this section is to make it clear what non-statutory mental healthcare means in relation to this thesis. To achieve this, it is important to contextualise mental healthcare more generally. The literature that looks at the history of provision will be covered. This helps to highlight the way care has evolved and how services have responded to people's mental health needs. It will also illustrate the main types of organisations that have been involved in providing these services. By covering these areas this will identify some of the factors that make non-statutory care distinct.

A brief history of mental healthcare

Historically the treatment of people experiencing mental ill-health has varied. Benevolent forms of care have been sprinkled throughout time, whilst cruelty has also been observed since the Middle Ages (Burstow, 2015). Foucault's (1988: 7) reference to 'ships of fools' and his depiction of the great confinement are indicative of emerging attitudes and treatment from the 17th century. During this timeframe there have also been changes in the professional affiliations of people providing care and in the kinds of services available (Busfield, 2000). These matters are now turned to as they relate to the management of people experiencing mental ill-health.

Rogers and Pilgrim (2014) have noted that treatment for mental ill-health dates back to antiquity, whereby service-users could expect to be sprayed with water or have holes drilled in their head to release evil spirits. Various types of providers have also been documented. For example, Reynolds (2017) has argued that care was provided for the insane at a monastic priory in London in the 15th century, whilst Killaspy (2006) states that care in the UK dates back as far as 1247. Thus, there is a long history of different forms of care being provided. According to Arieno (1989) the church played a significant role in supporting people with mental health problems. However, she also notes how there was no formal (statutory) or coordinated national approach until the advent of institutionalised care in asylums. A consideration of the Victorian asylums and post-war mental health provision is crucial as they demarcate key periods in the history of mental health provision.

Asylums were built away from the main population centres in England. The process of constructing and populating these large institutions was at its peak from 1840–1950 (Killaspy, 2006). Rogers and Pilgrim (2014) have summarised three of the main reasons that have been used to explain the inception of asylums. One considers the housing of insane people as medical progress and a humane form of treatment. Another sees it as an example of capitalist enterprise encompassing the need for social deviance to be contained. The third view draws on

Foucault (1988) and sees the creation of asylums as the result of the separation of reason and unreason. Those who lacked reason were seen as animal-like, irrational and undisciplined, and in need of being contained. Although there are different perspectives as to the creation of asylums there is greater clarity about the treatment people received within them.

Psychiatry was the dominant profession of the day (Kilaspy, 2006). Once detained, service-users were isolated from public life for significant periods of time, leading Goffman (1961) to refer to these establishments as total institutions. Rogers and Pilgrim Rogers (2014) argue that it may have been the initial intention for people to be provided with moral treatment within asylums, however this was soon discarded as they became overburdened with people suffering from chronic conditions. As such, asylums have been typified as unhappy environments that were not conducive to healing and places within which service-users lost their autonomy.

The post-war period saw a big shift from hospital to community-based care. Johnson *et al.* (2001) have suggested that government policy since the early 1960s has been towards the closure of asylums. Nettleton (2013) has referred to a post-war consensus that viewed community care as the preferable option. She notes how changes in legislation in 1959 had an explicit focus on increasing community-based services.

Various explanations have been put forward to explain the decline in asylums. These include the significance of legal reform (Goodwin, 1997), the introduction of psychotropic drugs, making it easier to manage people in the community (Jones, 1993), and the financial burden of running large institutions (Chow and Priebe, 2013). Alternative explanations focus on the realisation that institutions were not an appropriate environment for helping people to learn how to live in society (Nettleton, 2013), whilst it is also important to acknowledge the social climate at the time within which high profile scholars questioned the profession of psychiatry (Foucault, 1988; Szasz, 1961; 1970; Goffman, 1961). Thus, Chow and Priebe (2013) suggest that the prevailing socio-political climate was one that indicated people should be treated in the least restrictive setting. Hence, from the mid-twentieth century, the number of people housed in asylums fell. In the UK, in-patient beds decreased from 140,000 in 1950, to approximately 36,000 in 2000, whilst there has been a marked increase in community mental health teams (McCulloch *et al.,* 2000). Also, in the UK, the reduction of people being housed in institutions had a particularly marked decrease from the 1980s (Nettleton, 2013). Rogers and Pilgrim (2005: 182) describe some of these shifts:

> Community care is constituted by a variety of activities and services. The main initiatives evident over the past 20 years include

> psychiatric services in primary healthcare settings, the expanded use of community psychiatric nurses, the development of community mental health centres, the provision of domiciliary services, the development of residential and day care facilities, an increased emphasis of voluntary services and informal care by relatives and friends, and the relocation of mental health responsibilities from the secondary care sector to primary care.

Another transformation that has been partly driven by a desire to provide care without confinement has involved the use of liaison and diversion. This entails supporting the mental health needs of people who come into contact with the criminal justice system, particularly in courts and police stations. Part of its purpose is to provide appropriate care to offenders at the earliest point possible and divert away from custodial sanctions in prison (Dyer, 2013). Thus, alongside the changes detailed earlier, there has been a general push to providing more care in the community.

Changes have not only been observed in the way services are delivered but also in the views of those providing care. As Johnson *et al.* (2001) remark, the present consensus among mental health professionals is one that suggests that the majority of in-patients, other than those located

within secure forensic care, can live in the community. Therefore, overall, there have been significant changes in views about whether it is appropriate for people experiencing mental ill-health to live among people who are mentally healthy, which has brought about sweeping changes to the way services are delivered.

Another transformation of equal importance is the shift in the professional affiliations of those providing care. Busfield (2011: 2) acknowledges this shift when drawing attention to the number of mental health nurses, psychologists, social workers and psychoanalysts who are now employed as mental health professionals.

> Some have argued that since the 1950s psychiatrists' dominance over the field of mental health and illness has, in some respects, been weakened, not least by the emergence of new groups of 'psy' professionals – that is, practitioners and academics focusing on the mind or psyche, such as psychoanalysts, psychotherapists, clinical and health psychologists, mental health nurses and psychiatric social workers, with whom psychiatrists are, to some extent, in competition.

McManus *et al.* (2016) also remark on this transformation when discussing the changing rates of adults receiving

psychological therapy. In 2014, 18.4% of mental health services-users were receiving psychological therapy, compared to 12.5% in 2007. This shift in the type of services is matched by a changing pattern in the problems that service-users present. Previously, a person needed to be classified as insane to receive formal support (Killaspy, 2006). However, Brown (2013) points out that nowadays problems such as substance misuse, personality disorder and neurosis, are dealt with by mental health services whilst anxiety and depression are managed within primary care. Moreover, in accordance with the literature already addressed, the vast majority of people receiving care do so in the community. This means that using out-patient facilities in the community or seeing a general medical practitioner have become the norm (Horwitz, 2010). As such, there has been a significant change from dealing with severe mental health problems, like psychosis, which fewer people experience, to providing support for a greater number of people with common forms of mental ill-health such as depression and anxiety.

The role of the non-statutory sector in dealing with mental ill-health

In this thesis the non-statutory sector is used to refer to care that is not delivered within the statutory sector, involving church-based care, and care provided by

voluntary and community-sector organisations, social enterprises and community-interest companies.

The provision of clinical mental health provision in the UK is predominantly government-funded and delivered as a public service; however noticeable changes have seen the increased involvement of the non-statutory sector (Rogers and Pilgrim, 2014). In particular, there was a noticeable increase in the number of non-statutory organisations delivering public services from 1997 (Rees *et al*., 2012). This pattern became further entrenched as a result of the increased marketisation of public health services (Milbourne and Cushman, 2013).

The non-statutory sector is now recognised as a normal feature of mental healthcare delivery (Gilbert and Peck, 2014), whilst they are also referred to in government policy (NHS England, 2016; DH 2007). Estimates suggest there are approximately 171,000 non-statutory organisations in England, and 39,340 of these operate with a health and social care remit (Clark *et al*., 2010). Furthermore, almost a quarter of National Health Service (NHS) investment seeking to improve access to psychological therapies was directed to the non-statutory sector (Mental Health Strategies, 2012).

Non-statutory provision varies from community-based organisations focused on niche issues, such as peer support for a specific racailised group, to national

organisations providing intensive interventions (Mohan, 2011). From this it can be seen that the non-statutory sector makes a broad contribution to the delivery of mental healthcare.

Defining the non-statutory sector

The voluntary and community sector (*i.e.* non-profit organisations) have often been viewed as the third sector, that is, they are situated between the public and private sector. In 2005, in an effort to accelerate the growth of social entrepreneurship, the UK government introduced Community Interest Companies (CIC) (Nicholls, 2010). Chew (2010) describes how the enabling legislation for the creation of CICs allowed many charities to convert to or set up a subsidiary CIC, many of which were established to provide mental healthcare (Chew, 2010). Hence, CICs have an increasing presence in the delivery of mental healthcare. Although CICs are part of the private sector, this thesis refers to third sector organisations (including church-based support) and CICs as the non-statutory sector.

When looking specifically at the functions of the voluntary sector Karlsson and Markstrom (2012) concluded that organisations involved in service delivery operated in a way that was complimentary to state provision. Research has suggested that they fill a gap by offering care that is

more focused on outcomes defined by service-users. This is a point identified by Froggett (2015) and Macmillan (2013), who have remarked how this support has minimal barriers (severity thresholds) and is typically based on informality. These are some of the values that Billis and Glennerster (1998) believe give the voluntary sector a comparative advantage in caring for excluded groups. They also contend that the culture of these organisations is underpinned by ideals based on being non-judgemental and encouraging nurturing relationships. This indicates that the non-statutory sector could be a valuable alternative to state healthcare provision.

The role of the non-statutory sector in specifically supporting racialised minority groups has been documented in the adapted pathway to care model put forward by Bhui and Bhugra (2002). They adapted an earlier model showing various referral pathways to psychiatric services by incorporating the voluntary sector, traditional healers and other specialist services in the early appraisal of a person needing help. These scholars contend that, by including the voluntary sector into the care pathway, their model is a more accurate reflection of the way racialised minority people access support. The model not only illustrates the specific role of non-statutory care provision in the pathway to care but particularly for people who have been discharged from statutory care.

It has been argued by Gray (1999) that the voluntary sector plays a crucial role in supporting groups who are often discriminated against. He suggests that the voluntary sector offers a source of help that is the least stigmatising and the most appropriate. One area of provision that has been identified as being particularly suited to racialised minority people is the black voluntary sector (BVS) (also referred to as ethnocentric support, (Fernando, 2005)). Keating (2012) has posited that the BVS offers the most relevant support to racialised groups because their work is based on different conceptual ideas about what it means to experience mental ill-health than do state services. Further, he argues that the BVS embraces the whole person when combating mental health problems rather than other models that narrowly define mental ill-health within a psychiatric framework. Whilst most research on the BVS focuses on the adult population, the findings from this research demonstrate its value for young Black people and expands knowledge in this area.

Racialised inequality: pathways into care and service experience

When discussing the context of race and mental health, Halvorsrud *et al*. (2018: 2) note how

> … ethnic inequalities in access to and outcomes from mental health services are well known, having been documented for more than four

> decades. The issues that have been investigated include compulsory treatment, criminal justice involvement, police contact and admissions to psychiatric hospitals. All of these are more common in Black patients. The explanations for these adverse pathways include multiple social disadvantages that ethnic minority people face, including living in urban environments, poverty, resource-poor services, unemployment and chronic experiences of exclusion, racism and discrimination, operating at both interpersonal and societal levels.

Whilst Halvorsrud and colleagues (2018) point towards a longstanding pattern of racialised inequality among Black groups in relation to mental health, gaps in knowledge remain. In particular, Singh *et al* (2013) draw attention to a number of gaps in the evidence base in relation to racialised minority people and mental health support. They point specifically to the scarcity of research that looks at their thoughts and feelings when accessing and experiencing care. This study takes a step to fill this void in knowledge by exploring the experiences of young Black people in relation to non-statutory care support.

Racialised inequality in mental health

Over 60 years has passed since early studies in the UK identified that Black people have poorer outcomes with mental health services in comparison to the White British population (Kiev, 1965). Despite this passing of time, Nazroo and Iley (2011) argue that racial inequality in mental health is one of the greatest disparities across all areas of health service provision, whilst government policy states this is an area that should be prioritised for action (NHS England, 2016). There is therefore an established need for ongoing consideration until more is known about how these disparities can be substantially reduced. With this in mind, to help set the scene, and to contextualise this study within the literature that led to this study taking place, an overview of racialised inequality in mental health is now provided.

Racialised inequalities in mental health for children and young people

It is recognised that there is a paucity of reliable and consistent research looking specifically at racialised issues among children and young people with regard to mental health care (Dogra, 2012). It is thus important to look at some key trends. First, they highlight the scale of the problem of racialised inequality. Additionally, when data for children and young people is contrasted with that of the adult population there is a noticeable increase in rates of

mental ill-health in comparison to the White British population. This highlights the significance of focusing on an age range (age 16–25) when experiences of mental ill-health are likely to occur (McGorry *et al*., 2007; Kessler *et al*., 2005). Therefore, this study provides an opportunity to look at dynamics relating to service access and experience at a point in the life-course when mental health need is relatively high and racialised inequality becomes more profound.

There is a mixed pattern when looking at rates of racialised inequality in mental ill-health for children and young people. The common perception is that there is an under-representation of young Black children in mental health services (Lavis, 2014; Malek and Joughlin, 2004). This may be misleading as the Children's Commissioner (2016) found no differences in rates of access, whereas other research has found over-representation in some areas and under-representation elsewhere (Goodman *et al.*, 2008). Looking at age up to 16 years, most community-based research points towards those racialised as Black experiencing better levels of mental health (Astell-Burt Thomas, 2012; Goodman, 2008; Green *et al.,* 2005; Meltzer *et al.,* 2000). Although this may be so, both community-based and clinical data have identified that more often children falling within the Black ethnic group are assessed as meeting the threshold for conduct disorder (Laurens *et al*., 2007; Green *et al.*, 2004; Meltzer *et al*., 2000). Meanwhile, African-Caribbean children have been

found to be between four to six times more likely to be diagnosed with a psychotic-like disorder (Corrigal and Bugra, 2013; Tolmac and Hodes, 2004; Goodman and Richards, 1995). Thus, although young Back people are not thought to be more likely to experience mental ill-health than other ethnic groups, one feature which appears to be consistent is that they are more likely to meet the threshold for externalising disorders (*e.g.* conduct disorder or psychosis).

Racialised inequalities in mental health for adults

One of the main questions to emerge when looking at data for adults relates to higher treatment rates for psychosis than what would be expected from community-based studies. Ngaage and Agius (2016) have documented a well-established picture highlighting the over-representation of Black people using secondary mental health services. Their review, covering a ten-year period concluded that Black groups were three to five times more likely to be diagnosed with psychosis than the White British group. A consistent pattern also highlights that people racialised as Black are over-represented within first episode psychosis services (Kirkbride *et al*., 2008; Morgan *et al*., 2005a; Coid *et al*., 2000; Bhui *et al*., 1998; Van Os *et al.,* 1996; Davies *et al*., 1996). Contrastingly, community-based studies do show elevated rates of psychosis but not to the same extent as those found in

clinical settings (Rees *et al*., 2016; McManus *et al*., 2016; Sproston and Nazroo, 2002; Nazroo, 1997). Hence, the pattern for adults is similar to that for children and young people and indicates that Black groups show an elevated need in the population with regard to psychotic-based disorders, which is even greater when looking at clinical data.

Treatment rates and community-based studies for common forms of mental ill-health present a more complex and diverse picture. What is apparent is that for some reason people racialised as Black are not receiving support when there is evidence of need (Nazroo and Iley, 2011; Bhui *et al*., 2006). Some research suggests this is particularly the situation for Black women, but not for men (McManus *et al.,* 2016; Rees *et al.,* 2016). However, according to McManus *et al.* (2016), the overarching picture suggests that for common forms of mental ill-health, Black groups show a greater need in the population that is not matched by receipt of support.

This section so far has highlighted the scale of racialised inequality and with it the need for continued attention to this field of study. The data also highlights how racialised inequality becomes more profound, especially for common forms of mental ill-health, during adolescent years, thus demonstrating the importance of focusing attention on young people. However, it is not so easy to confirm and comprehend why these inequalities exist and why patterns

of inequality are contradictory. This is the case considering that Black groups are more likely to be diagnosed with psychosis to a greater extent than need in the population would suggest, whilst for common forms of mental ill-health the trend runs in the opposite direction.

Explaining inequality

The research presented thus far raises pertinent questions about why prevalence and treatment rates are not more closely aligned and why racialised inequalities actually exist. Arguments used to describe these differences are now illustrated and discussed in light of their suitability to explain the racial disparities presented. Further, by covering this literature it will then be possible to see how the approach taken by this study contrasts with the main theoretical approaches about race and mental health.

Two theories that are worth addressing very briefly relate to migration and genetics. They are both, however, very limited in explaining the present rates of racial inequality. The experience of migrating has long been associated with increased rates of mental ill-health (Cantor-Graae and Selten, 2005). However, any justification based solely on the idea that international migration results in Black groups experiencing worse mental health outcomes is difficult to sustain. This is largely because racial disparities continue, without improvement, for second and third generation Black groups living in the UK who have not

migrated (Morgan *et al*., 2009). Additionally, many people who migrated from South Asia to the UK have not experienced the same extent of inequality as that experienced by Black groups (Pinto *et al*., 2008). These two reasons alone can be seen to weaken any migration-based position.

Rogers and Pilgrim (2014) do point out that some racial groups can be susceptible to particular health problems as a result of their genetic make-up. For mental ill-health, an argument against this position is that, if genetic predisposition was a causal factor, then one would expect there to be incidence rates of schizophrenia in Caribbean countries that are similar to Black Caribbean people in the UK. However, this is not the case as incidence rates are thought to be no greater, and even slightly less, in the Caribbean than in developed countries (Mahy, 1999; Bhugra, 1996; Hickling and Rodgers-Johnson, 1995). Furthermore, research carried out by Sugarman and Craufurd (1996) and Hutchinson *et al*. (1996) looked at parents and siblings of patients with schizophrenia and found there was no greater genetic vulnerability between different racialised groups, but rather that factors operating in the environment were likely to be of greater significance.

Although the validity of arguments based on genetics or migration have been questioned, there are further noticeable deficiencies in each of these approaches. When

considering that many Black groups potentially have a mental health need, yet they do not access support, there are clearly factors operating at some level, which results in this difference. Neither the argument rooted in genetics or that based on migration provide insight into this dilemma nor do they provide a framework to understand how services—once accessed—are experienced.

Institutional racism

Institutional racism (IR) has been put forward as one of the fundamental drivers of racialised inequality in mental health. The origins of the concept date back to Carmichael and Hamilton (1968) who used it to encapsulate the way in which racialised attitudes are deeply entrenched throughout different institutions and operate to the detriment of racialised people. They used an example of there being malnourished Black people living in neighbourhoods that were typified by inadequate housing. This, they suggested, was the result of an institution that failed to support Black people. What is essential to recognise about IR is that racialised stereotypes that are thought to permeate all levels of decision-making do not always need to be intentional. Rather, decisions can be made that inadvertently have an outcome that can be disadvantageous to racialised people.

IR re-emerged in the UK to describe the inadequate way that the Metropolitan Police Service responded to the racist murder of Stephen Lawrence (Macpherson, 1999). The MacPherson Report (1999: 8) that resulted from the Stephen Lawrence Inquiry defined IR as follows:

> The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racial stereotyping.

The concept of IR is not without its critics. One of the issues with the use of the term is that it lacks clarity in separating out the actions of individuals from something which is institutional, and the relationship between each (Phillips, 2011). IR has also been criticised when used as the sole explanation for racialised inequalities in mental health (Fearon and Murray, 2007; Singh, 2007). Nevertheless, it remains one of the key arguments used to explain the continued racialised inequality in mental health services.

There are a number of ways that IR can be seen as contributing to racialised inequality. Three are most relevant here in light of the study focus and the disparities

and contradictions already discussed. Firstly, IR can be seen as inflating the number of Black groups being deemed to have mental ill-health because psychiatry and psychology are based on Western ideas about what is (ab)normal. As discussed in an earlier chapter, mental ill-health is based on Western definitions about what is not normal. For example, within psychiatry this means that some symptoms of schizophrenia (*e.g*. hallucinations) are pathologised as abnormal. Yet such symptoms are thought to occur to a greater extent in Black populations and are often culturally sanctioned (Littlewood and Lipsedge, 1984). Furthermore, various scholars (Fernando, 2010; McKenzie, 1999; Browne, 1995) contend that psychiatry does not account for social pressures that apply differentially. Consequently, there is no allowance in diagnostic processes to consider the way Black people may have justified anger as a result of societal racism. There is also the possibility of clinical bias as racial stereotypes may influence the diagnostic process through the unwitting prejudice, referred to in the definition of IR (Pinto *et al.*, 2008; Hickling *et al*., 1999; Horwitz, 1983). Each of these factors could contribute to higher rates of Black people being diagnosed with psychotic disorders.

Two further aspects of IR that may also contribute to racial inequality relate to the lack of, or ineffective, engagement with Black groups experiencing mental ill-health. Using the example put forward by Carmichael and Hamilton, which stressed the failure of institutions to address malnourished

Black people, a similar position can be taken here. For example, if Black groups are experiencing greater levels of mental ill-health and are not accessing services then arguably there is a responsibility on public institutions to take effective action. Similarly, if Black groups access mental health services and do not feel content with the support they receive they may be less likely to want to engage in future. Each of these factors can contribute to racial disparities in mental ill-health. Thus, IR offers a way to understand how structural processes may lead to an over-representation of Black groups in mental health statistics. However, even if we take these arguments as being plausible, once again, as a concept, IR does not offer any insight into the interpretations of the people receiving services or the barriers that may exist for people who may need support.

Societal racism

The evidence-base that looks at how societal racism contributes to mental ill-health is one that is slowly developing. Research with young people has highlighted the negative effect that racism can have on mental health (Astell-Burt *et al*., 2012; Malek, 2011; Priest *et al*., 2013). Similar studies with adults have also shown how racism is associated with psychosis and common forms of mental ill-health (Karlson *et al*., 2005) and how the cumulative effects of racism can have a greater and more negative

impact on Black people than most other racialised groups (Wallace *et al.,* 2016). Sophisticated studies also draw attention to the way race-related stressful life events are a significantly more powerful risk factor than other stressful life events (Utsey *et al*., 2008). Thus, it is possible to see that the perception of being racially discriminated against alongside experiencing racism, may have some purchase in explaining higher rates of mental ill-health.

Social and economic influences

Macro-demographic research has been particularly dominant and there is a well-established literature highlighting the strong association between lower socioeconomic status and higher rates of mental ill-health (Tausig *et al.,* 2004). As Black people are more likely to experience socioeconomic deprivation than White groups, the argument can be made that this accounts for the inordinate number of Black people experiencing mental ill-health.

Looking at health more broadly, Nazroo (1998: 712) suggests that, although socioeconomic disadvantage is heavily associated with health differences, there

> ... remains an essential component to ethnicity that could make a contribution to differences in health, that when explaining the relationship

> between ethnicity and health, ethnicity cannot simply be emptied into class disadvantage.

This summary is a result of the findings from the Fourth National Survey of Ethnic Minorities (Nazroo, 1997). In this Nazroo concluded that greater numbers of Black Caribbean people could be found in the lower socio-economic groups (defined by occupation) than the ethnic White population. He therefore goes on to accept that social class does have a relationship with poorer health outcomes for Black groups. At the same time, Nazroo agrees with an early conclusion made by Marmot *et al.* (1984), that the differences in social class distribution do not fully explain racialised differences in health. Nazroo (1998: 719) therefore summarises by asserting that there is an 'unidentified component of ethnicity that increased' some racialised groups' risk of poor health. Although research has highlighted an association between socio-economic variables and psychotic-like experiences among young Black people (Zilanawala *et al.,* 2015; Morgan *et al.,* 2009), the broader trend would appear to run in the opposite direction (Qassem *et al*., 2015; Kirkbride *et al*., 2008). This seems to suggest that socioeconomic factors are certainly important in explaining higher rates of mental ill-health but they do not go far enough in explaining all racialised inequalities in mental health.

Other socioeconomic factors that have been looked at include urbanicity and ethnic density. The former concept

draws attention to the way living in an urban area is associated with higher rates of mental ill-health. As more Black people live in an urban environment this may contribute to their poorer mental health (Pinto *et al.,* 2008). Additionally, ethnic density looks at how the number of people of the same ethnic group living in an area can have a positive association with mental health. Nonetheless, it is thought that very high levels of non-White ethnic density (over 85%) can begin to have a negative effect on mental health (Becares and Nazroo, 2013). Hence these two areas (urbanicity and ethnic density) need much more research before accurate conclusions can be made.

In summarising the chapter so far, research highlights that people racialised as Black are exposed to a number of vulnerabilities, which can put them at greater risk of experiencing mental ill-health. Additionally, most evidence appears to indicate that there is a component to racialised mental health inequalities that cannot be explained by general socioeconomic variables. The evidence also suggests that inequalities become more profound as people enter their adolescent years. This data is helpful to develop an understanding about some of the broader patterns about mental ill-health and how they may be connected to main theories within the literature. However, they do not provide any indication about the intricacies associated with the experiential nature of accessing and

receiving support, which may inform the debate about racialised disparities.

To achieve this, an approach that draws on the views of the individual is needed to understand whether there are barriers to provision that may be experienced differently. Taking such an approach is important as Gilvarry (1999a; 1999b) and Karlson *et al*. (2005) have identified race as being a salient feature in the way Black groups interpret life events and adverse situations. Hence, if Black people are likely to detect racism in their experiences, this may deter them from seeking support, whilst it may also impact on any therapeutic relationship with a mental health service provider. The chapter will now turn to address the first of these points.

Race and the pathway to care

This part of the chapter focuses on the literature that is concerned with young Black people and their pathway to care. The main purpose of this section is to show why there is a need to understand if, and to what extent, race plays a part in the decisions young people make when accessing mental health support. To be able to place this study in a wider context the subject matter of illness behaviour is addressed. Next, the main body of literature on race and the pathway to care is presented. This requires a direct focus onto the significance of race and debating key assumptions of a pivotal theory and

questioning its relevance to young Black people accessing non-statutory healthcare provision.

Illness behaviour

Sociologists have an interest in the social and environmental factors that interact with, and influence, how a person's behaviour alters due to changes in their normal functioning. This is known as illness behaviour. Mechanic (1995: 1208) defines illness behaviour as

> [T]he varying ways individuals respond to bodily symptoms, make attributions, take remedial action and utilise various sources of formal and informal care.

These aspects of illness behaviour are encapsulated within Suchman's (1965) five-stages illness model, that aims to represent the service-user and care-provider relationship. For the purposes of looking at the pathway to care the first three stages will be addressed initially.

Symptom experience stage

According to Suchman (1965), stage one is that of symptom experience. Evidence suggests that factors associated with different racialised populations effect the way symptoms are experienced. Various studies indicate

that Black groups have a higher threshold of pain (Thomas and Rose, 1991), that Black African women are less likely than White British women to recognise symptoms of depression (Mantiovani *et al.,* 2016) or to think it has serious consequences (Brown *et al.,* 2011). Evidence also suggests some Black groups are more likely to experience paranoia (Littlewood and Lipsedge) or hallucinations (Morgan *et al.,* 2009; Johns, 2002). These occurrences are not necessarily harmful, and can often be valued (Ndetei and Vadher, 1984; Chandrasena, 1987). Taking these factors into account, it is possible that some Black groups may not recognise symptoms of mental ill-health. This all interrelates with how people conceptualise mental health and mental ill-health, and how they respond to the latter. Thus, divergent explanatory illness frameworks differ across racial and ethnic groups, which in turn results in varying forms of illness recognition.

Assuming the sick role and seeking help

The second and third stages of Suchman's model puts emphasis on the way people assume the sick role, seek advice from friends and networks, and make the decision to seek professional support to legitimate their illness. The concept of the 'sick role' was coined by Parsons (1951) to describe the varied rights and responsibilities placed upon service-users and health professionals when help is sought. Parsons' work was important as it pointed towards

moral dimensions associated with being ill. The applicability of Parsons' sick role has been brought into question with regards to mental ill-health due to service-users' decreased willingness to conform to the sick role (Lubkin and Larsen, 2012). Suchman's model is nevertheless sufficient for the purpose of understanding the different stages of the service-user and care-provider relationship. The model also builds upon the Parsonian sick role (1951) by adding greater possibilities for self-care and alternative help-seeking. Stage two and three are now discussed concurrently in looking at the pathway to care.

There are a number of factors that can impact the pathway to care from the point that somebody realises—or is told—that they are experiencing mental ill-health up to the point of receiving support. At a very basic level a person must first recognise they are unwell. This, as Freidson, remarks, is not always straightforward (1988: 278):

> This is a difficult problem, for although the individual may be aware that he has some difficulty, he may not believe that it is an illness; or if he does, he may not think it is serious enough for him to seek professional help or that it is so amenable to professional ministrations.

Thus, what Freidson points out is echoed by Nazroo and Iley (2011), who argue that, even if treatment is universal,

whether a person seeks support very much depends on illness behaviour. Mechanic (1995) also acknowledges this when referring to the way different coping strategies and perceptions inform how people respond and select a caregiver.

Racialised people, mental ill-health and the care pathway

Early studies looking at the pathway to care identified divergent findings, however, towards the end of the last century, a more concerning pattern was established from research. One early study found no differences in primary care attendance rates or alternative help-seeking (Kiev, 1965) whilst Pinsent (1963) identified higher rates among Jamaican migrants. Although there is a contrasting picture from these earlier studies a pattern of underrepresentation of Black people within primary care was not observed. Bhui *et al's*. (2003) review of pathways into specialist care concluded that African-Caribbean patients were more likely than all other groups to access support through a criminal justice route and to be compulsory detained, whilst being less likely to access support via a general practitioner (GP) referral. Indeed, a finding that has now been repeated in numerous studies is the different types of service contacts, and how these are often adversarial, for people racialised as Black.

One of the methodological problems with many early studies was that a clear picture of patients' initial help-seeking behaviour was not obtainable, as many patients were readmissions. The Aetiology and Ethnicity in Schizophrenia and Other Psychoses (AESOP) study (Morgan *et al*., 2005b) was an attempt to overcome this issue by focusing specifically on first-episode psychosis. The AESOP study identified notable differences in the pathways to first contact with services. More specifically, the study found that African-Caribbeans and Black Africans experienced higher rates of compulsory admissions, they were more likely to have criminal justice agency involvement in their pathway to care, and they were less likely to have had a GP referral, in comparison to all other racialised groups. Many of the above findings have since been replicated in other studies looking at first episode psychosis (Ghali *et al*., 2013). Hence, the overwhelming pattern is that Black adults access mental health support via routes that are more coercive. This pattern of involuntary routes into support also appears to be replicated for young Black people who are more likely to access child and adolescent mental health services (CAMHS) as a result of referrals from social services or education (Eldbrooke-Childs *et al.*, 2016).

The broader picture is one that shows that people racialised as Black take routes into mental health services that are less favourable and are more likely to have

deleterious outcomes. It is now timely to look at what is known about why these differences exist.

Explaining the illness behaviour of people racialised as Black

One of the aims of this study is to find out whether race is a factor in the way young Black people access mental health support. This involves taking a more person-centred approach to research that draws upon the lived experiences of young people. Therefore, in order to make this study relevant, research that addresses experiential factors relevant to the pathway to care will now be considered.

The role of stigma in illness behaviour

Since Goffman (1963: 3) conceptualised stigma as 'an attribute that is deeply discrediting,' the literature that relates to or is based in some way on stigma has grown significantly. This has led to some suggestions that its conceptual value has been diminished due to the wide range of situations to which it has been applied (Manzo, 2004). It nevertheless remains a vital concept in understanding and examining the negative consequences that can result from a personal or group attribute. It is acknowledged that there is a degree of overlap between

the concepts of racialisation and stigma, each of which is integral to this study. Indeed, it is of primary interest to this study to understand the stigma, which is associated with how people have been racialised. Racialisation is the framework used to discuss the processes by which race becomes meaningful. Race, and its relevance to illness behaviour, is discussed later under the 'role of race'. It is nonetheless important that stigma is addressed here because of the way it can impact illness behaviour in relation to attributes other than race. Weiss *et al*. (2006: 280) define stigma related to health as follows:

> A social process, experienced or anticipated, characterised by exclusion, rejection, blame, or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group.

Livingston and Boyd (2010) propose that there are three interacting levels at which stigma can be conceptualised. These are internalised, social (including interpersonal) and structural. According to Livingston and Boyd (2010), internalised stigma is also known as felt or self stigma and operates at the micro-level and involves the endorsement of stereotypes about people with mental ill-health. What follows from this is that people believe they are not valued in society in the same way as others and live with the anticipation that they will be rejected. As Corrigan *et al*.

(2005) point out, this can result in changes in the way people behave and think because of their experience or a perception about how society will react towards them. Social (or group) stigma operates at the meso-level and incorporates the idea that social groups accept, adopt and act upon prejudicial thoughts about stigmatised groups. Structural stigma is a macro-level process that is thought to permeate the policies, practices and procedures within institutions that consequently restrict opportunities for stigmatised people. As the three levels overlap and interact, it can be difficult to disentangle from where the cause of stigma that informs illness behaviour emanates. Thus, micro-level stigma can be seen to take account of the processes that are taking place at the meso and macro level and how these are internalised.

Stigma is recognised as a key factor that influences the pathway to care. The idea that stigma can operate as a barrier to seeking support is evidenced in a review of over 100 empirical studies (Clement *et al*., 2014). As Corrigan *et al*. (2014: 37) comment the

> … the prejudice and discrimination that comprise the stigma of mental illness is one important reason for the disconnect between effective treatments and care seeking.

Singh *et al*. (2013) also point out that highly stigmatising attitudes have resulted in people seeking religious rather

than psychiatric help. The latter scholars also note how stigma can result in sufferers distancing themselves from friends, family and other social networks. This is of critical importance because of the role such networks can play in facilitating access to mental health support.

It has been hypothesised that differences in help-seeking are the result of attitudes towards mental ill-health being much more stigmatising within Black populations. Research in this area has produced different results. Wolff *et al*. (1996) found that Black groups are more likely to object to people with mental ill-health living near them. At the same time, other research has found that Black groups hold less stigmatised opinions about constructs of mental ill-health (Brown *et al*., 2011; Stone and Finlay, 2008), whilst a meta-analysis found internalised stigma was not influenced by age, gender and ethnicity (Livingston and Boyd, 2010). A small-scale comparative qualitative study looking at depression and the pathway to care did find that Black groups wanted to be with people of their kind but did not find that stigma was a barrier to accessing services (Marwaha and Livingston, 2002). Thus, it is clear that stigma can affect all people with mental ill-health. However, there is limited large-scale evidence to suggest that there are racialised differences in the way mental health stigma operates as a barrier to service access.

Although there is limited quantitative data that racialised differences exist, what is easier to appreciate is that, over

a long period of time, stigma associated with mental ill-health is significant for those racialised as Black (Cooper *et al*., 2012; Weerasinghe, 2012). Kiev (1963) suggested that, among West Indians in Britain, the stigma associated with psychiatric illness is severe. More recent studies have highlighted how some racialised groups will simply not access support due to the imperative to 'save face' and maintain social status and moral reputation (Mereish, 2012: 57). Mantoviano *et al*. (2017) also highlight how cultural identity and stigma combine to create a barrier that results in people not wanting to admit to experiencing mental ill-health because this is something that they should be able to cope with. Research has also identified that help-seeking by young people is impacted by their strong negative emotions towards people experiencing mental ill-health (Rose *et al*., 2007). It is therefore acknowledged here that stigma plays a part in the care pathway. This study helps to find out if mental health stigma is a social factor that is salient in the experience of young Black people on the pathway to care.

Further barriers to mental health support

Some of the reasons used to explain the different pathways to care taken by Black groups have already been addressed. These include how people recognise symptoms, seek alternative support and experience stigma. There are further dynamics that may impact illness behaviour. Low

levels of mental health literacy (Bristow *et al.*, 2011), limited awareness about service provision (Malek, 2011), language difficulties and excessive waiting times (Memon *et al*., 2016; Bristow, 2011), weak social networks (Moffat, 2009), substance misuse (Etheridge *et al*., 2004) and previous experience of coercive treatment (Prospero and Kim, 2009), are all thought to impact whether and how people access services. Young people also suggest that mental health services need to do more to build trust and display how they take confidentiality seriously (Malek, 2011; Young Minds, 2005). The perception that mental health services are not culturally appropriate has also been evidenced as a possible barrier (Cooper *et al*., 2012; Edge and Mackian, 2010). It is apparent that many of these factors could be relevant to all racialised groups. However, what has not been studied in specific detail for young Black people is how race interrelates with these experiences on the pathway to care. It is this point that is now explored.

The role of race

One of the main explanations put forward to describe the unconventional pathways to care taken by people racialised as Black is suggested by Keating (2003; 2007; 2012). He (2012: 216) adapted and expanded a model known as the 'spiral of oppression' to assist in highlighting the cumulative steps that result in racialised people accessing mental health services coercively. The spiral

begins with the negative perceptions racialised people believe society holds about them. This includes the perception that they will be treated differently because of their race, added to the perception they will be treated differently because they are experiencing mental ill-health. Consequently, Black men are thought to be reluctant to seek help whilst services do not effectively engage. The downward spiral continues as levels of distress and symptoms worsen resulting in the increased likelihood of coercive interventions.

Keating *et al.* (2002: 21) go on to contend that fear is a part of the pathway to care for Black people. As they state, 'fear is a phenomenon inextricably linked with both racism and mental illness.' Keating and Robertson (2004) highlight that a real and potent fear exists among Black people that involvement with mental health services could eventually lead to their death. Consequently, Keating (2007) argues that these levels of fear result in Black people being reluctant to seek support. Keating and Robertson (2004: 445) further stress this point when they contend:

> It is clear that these fears impact negatively on the interactions between Black people and mental health services. For service users it led to delays in seeking help, which meant that they presented to mental health services in serious states of crisis

A theme emerges from the literature that suggests Black groups delay seeking support, which contributes to the adversarial pathways they take (Mantoviano *et al*., 2017; Singh and Burns, 2006; Department of Health, 2003; Harrison, 2007). This is the position adopted by Keating. However, this rests on a number of key assumptions, three of which are pertinent to the present study. First, they suggest that Black people delay seeking help. Secondly, they contend that Black people fear accessing support because of how they will be viewed because of their race. Thirdly, it assumes that racialised people know that they are experiencing an episode of mental ill-health, as it is proposed that they do not access services because of the fear of stigma linked to a person with this status.

Taking the first of these points, there is limited evidence to suggest that Black people take longer to get to support than do other racial groups when looking at the duration of untreated psychosis (DUP) (Anderson *et al*., 2014). Hence, if all ethnic groups experience the same period of DUP, then why are White British people not also accessing services when in crisis and via coercive means? Therefore, it is possible that the reasons for the higher rates of compulsory admissions may lie elsewhere. In other words, if DUP is not different this may not explain the pathway to care taken by Black people, so attention should perhaps be focused on the way in which the pathway to care is experienced. This brings the discussion onto the second point and the salience of race.

Keating (2012) and Keating and Robertson (2004) conclude that Black men do not trust mental health services because of a fear about how they will be treated as Black men. This would suggest that race is a prominent factor in the thought processes of Black people needing to access services. However, due to the nature of Keating and Robertson's (2004) study it was not possible to ascertain how relevant this is for young Black people accessing non-statutory healthcare provision. Herein lies the need for this study.

The final assumption that follows from the work of Keating is that people Black would be aware that they are experiencing mental ill-health. In one respect this is problematic as research has suggested that Black people are less likely to recognise that they are experiencing mental ill-health at first point of contact with services (Commander *et al.,* 1999; Perkins and Moodley, 1993; Moodley and Perkins, 1991; Harrison *et al.,* 1989). Kessler *et al*. (2001) refer to there being as many as half of the people diagnosed with schizophrenia and biopolar disorder lacking insight that they are experiencing anything unusual. Against this background, the idea that Black people delay seeking support because of a fear of being stigmatised for doing so is seemingly challenged. It is plausible that the fear of stigma described by Keating related specifically to former service-users and/or those who were aware they were experiencing mental ill-health. Additionally, the studies that have been addressed here by

Keating (2002: 2004) were all carried out with an adult population. The extent to which these arguments are relevant to young Black people accessing non-statutory healthcare provision is an area where this study can add to the evidence-base.

Experiences of mental healthcare for racialised people

Stage four of Suchman's illness model is known as the 'dependent-patient' stage. At this point the service-user is constructed as handing over a degree of decision-making control to the professional who then makes decisions about the provision of care and treatment. There are various ways of judging whether this relationship has met the needs of service-users. Historically this area has been dominated by clinical outcomes. Nevertheless, as a result of shifts in policy, much more focus is now placed on subjective and personal aspects of service delivery, which is vital to understanding the intrinsic aspects of service delivery (Millar *et al*., 2016). The present study is concerned with finding out about the lived experience of young Black people in non-statutory mental health support. It is therefore appropriate to address the literature that looks at the relationship between Black groups and mental health services, and to debate the vulnerabilities and contradictions of the different approaches.

Rogers and Pilgrim (2014) assert that a body of research portrays a pattern that is typified by dissatisfaction and negative racialised encounters between Black people and mental health services. This is regularly evidenced by the high-profile deaths, particularly of Black men, when receiving mental health support (Bracken and Thomas, 2007; Crichton, 1994). Such was the extent of concern in this area that the UK government agreed for the need for a national strategy to improve services for Black people (Department of Health, 2003). This resulted in a five-year programme—Delivering Race Equality—aimed at increasing the satisfaction rates of racialised minority groups (Department of Health, 2005).

Service outcomes for Black people in primary care

When looking at primary care provision the picture starts to point towards different outcomes, different service expectations and different service engagement. Some studies have found few differences in the number of referrals from GPs for non-psychotic disorders (depression and anxiety) (Lloyd and St Louis, 1999; Shaw *et al*., 1999). However, much of the evidence appears to suggest lower levels of GP referrals for Black people to mental health support (Commander *et al*., 1997; Gillam *et al*., 1989). Also, research already presented in this chapter shows that there is limited GP involvement in the pathway to secondary care services. This illustrates the differential levels of service engagement. Furthermore, a study by

Nazroo (1997) documented how Caribbean people, who scored higher on depression scores, were significantly less likely to be receiving treatment than White people even though they were equally likely to have contacted their GP. Meanwhile, a study by Lloyd and St Louis (1999) found that Black women were not as likely as the remaining group to be clear about what they wanted from the doctor. They were also less likely to make multiple requests from their GP, less likely to say they needed a clear explanation about symptoms they were experiencing, and less likely to request a follow up appointment in the 12 months following the initial consultation, even though they were recorded as being the most distressed. Here it can be seen that there are fundamental differences in the way different people interact with services, which results in different service outcomes.

Non-statutory healthcare provision principally operates at the primary care level. In comparison to statutory healthcare provision much less is known about the outcomes and experiences of Black people when using non-statutory services. From the literature reviewed here, service-user experiences within non-statutory care are more positive for Black groups, than is reported in state provision. A study of a community organisation found that ethnicity was not a factor when considering levels of disengagement, or in terms of the success of a psychological intervention for young people (Baruch *et al*., 2009). A further study of a pilot project involving statutory

and non-statutory healthcare delivery partners also highlighted that people continued to engage with their intervention at much higher rates than with statutory healthcare services alone (Lwembe *et al*., 2017). Further, Secker and Harding (2002) researched an African and Caribbean mental health resource centre in West London and found the service proved successful in providing service-users with self-worth and opportunities to address matters relating to their identity. Service-users shared their thoughts about how the service made them feel less isolated because of the stigma and racism they had previously encountered. Similar positive findings have also been documented in other community-based studies involving culturally adapted psychological support for Caribbean people (Edge, 2016; Afuwape *et al*., 2010). Although these studies appear positive, they do not provide a comprehensive picture of outcomes and experiences. Moreover, it is not possible to ascertain whether service-users are comparing their experiences to those within the statutory care sector.

The stigma of being a mental health service-user

Stigma must also be considered as a social factor which may contribute to how a person experiences support, and how they respond to holding a stigmatised position. Research with adults has shown that stigma can affect a person's confidence and result in service disengagement

(Wagstaff *et al.,* 2016; 2017; Corrigan and Watson, 2002a). It must also be recognised that stigma can bring about action as people can feel motivated and compelled to challenge stigmatising attitudes. Meanwhile, a study by Morrison *et al.* (2013) illustrates how self-stigma decreased over the period of a yearlong CBT intervention with young people deemed to be at high risk of psychosis. Thus, the common assumption that being labelled as experiencing mental ill-health results in feeling stigmatised is questionable. This study is appropriately positioned to draw out the negative, positive or indifferent responses young Black people describe in how they experience non-statutory care support.

Service outcomes for Black people in secondary care

A lot of the research looking at the experience of Black people in secondary care paints a saddening picture. The general pattern is one that mirrors that of the pathway to care; one that is typified by coercive interventions. In one respect this can be seen in the way Black people are exposed to harsher and more physical treatments (Chen *et al*., 1991). Shah and Hanna (2003) refer to ten reports between 1982 and 1992, which show the disproportionate use in compulsory forms of treatment for people racialised as Black, including use of electro-convulsive therapy and neuroleptic drugs. Other research has found that Black people are more likely than White British people to receive higher doses of medication (Cole *et al*., 1995), be treated

in intensive care following compulsory admission (Moodley and Thornicroft, 1988), placed in seclusion and stay in inpatient care much longer than other groups (CQC, 2011) including in secure care (NHS England, 2016). Even when Black people are discharged into the community, they are more likely than other racialised groups to be put on an enhanced care programme that involves greater reporting requirements (Raleigh *et al.,* 2007). As a result of these differences in treatment, it has been suggested that many Black people view psychiatric care as an extension of the way they are policed, and that mental health care is another strong arm of the state that enforces social control (Ghali *et al*., 2013; Cochrane and Sashidaran, 1996).

Another approach to looking at the way different racialised groups experience secondary mental health support can be seen in their access to therapy. The picture here is not clear cut. Some evidence suggests that Black people are more likely to receive medication as the primary form of treatment and are less likely to receive evidence-based treatments (Das Munshi, Bhugra and Crawford, 2018; McKenzie and Bhui, 2007; McKenzie, 2001). Nonetheless, Commander (1997) found that psychological interventions in hospitals were infrequent and that there were no significant differences in the rates of access amongst different racialised groups. The picture is further complicated by whether a person decides they want therapy or not. As Fearon and Murray (2007) suggest, the White group receive cognitive behavioural therapy (CBT)

to a greater extent than Black patients, but the majority of White patients accept CBT compared to over 50% of Black patients who refuse it. Therefore, more needs to be known about why certain racialised groups make the decision not to receive psychological interventions. This study offers insight into some of the factors that racialised people consider when contemplating receiving support.

One way of considering service-user outcomes is to look at levels of service engagement. The logic is that, if somebody thinks or finds a service is beneficial, they are more likely to use it. Following this logic, as Black people are over-represented among absconders from inpatient units, this could suggest they are more likely than patients from other groups to be dissatisfied with the care they receive (Fallowski *et al.,* 1990). Similar findings have been evidenced for children dropping out of services that provide treatment for externalising disorders (Kazdin *et al*., 1995). Meanwhile, studies have shown that, when Black patients leave care, they are less likely to re-engage with NHS services through choice and are more likely to obtain support from the non-statutory sector (Singh *et al.,* 2013). Bindman *et al*. (2005), Goater *et al.* (1999) and Takei *et al.* (1998) did find that there were no ethnic differences in the levels of engagement between Black groups in comparison to other ethnic groups. However, the general pattern is one of lower levels of engagement with services for Black groups.

As already noted, perceptions about the way people racialised as Black are treated and experience mental health services have been informed by several high-profile deaths of Black men in psychiatric units (Bracken and Thomas, 2007). Perhaps the most notable incident was the death of David 'Rocky' Bennett in 1998. The Inquiry into the death of Mr Bennett found that he had been held down for 25 minutes by at least four nurses using methods of restraint judged to be unacceptable and unapproved. The Inquiry also concluded that, 'No indication that his racial, cultural or social needs were adequately attended to' (Secretary State for Health, 2003: 12). This Inquiry and the incidents described have fed into accusations that mental health services are institutionally racist. Thus, what emerges is an argument that mental health services have not sufficiently adapted to cater to the needs of everyone. This is emphasised by McKenzie and Bhui (2007: 649):

> [I]nstitutional racism is not simply a statement of the fact that disparities exist between ethnic groups in treatment, but also reflects the priorities that services ascribe to dealing with these disparities, the processes that generate disparities and those that inhibit effective actions to remove disparities.

Approaching the matter from the perspective of institutional racism, Rogers and Pilgrim (2014) agree that it is not those who are racialised as Black who should be

perceived as problematic. Rather, the problem should be seen in the way services do not always respond in a professional and appropriate way to racial differences. This links into the position adopted by Sewell (2012: 13) when he describes the relationship between Black groups and mental health services as being a 'toxic interaction'. In this way, Sewell depicts a system that has policies, processes and people operating within them who do not take full consideration of the needs of Black people. Taking this viewpoint, institutional racism within mental health services results in Black people being exposed to and experiencing continued systems of racial oppression resulting in toxic interactions with the system. It is this perspective that arguably dominates the literature when looking at the relationship between Black people and mental health support.

Rates of satisfaction

Robust data on satisfaction rates with services is scarce, especially that of a comparative nature across different racialised groups. A further problem with this area of study lies in the instruments used for measuring satisfaction. There is not the space here to review the literature that looks at the reliability and validity of satisfaction surveys. However, the uncertainty surrounding this area of study is encapsulated by Thornicroft (1999) who comments:

> [S]atisfaction can be both an outcome and a process measure … as a dependent variable satisfaction has been thought to be influenced by factors such as expectations of services, attitudes to life, self esteem, illness behaviour and previous experience of services. As an independent variable, satisfaction can influence the efficacy of interventions, treatment compliance and service utilisation.

Taking account of these factors, one would assume, based on the extent of racialised disparities, that satisfaction rates of Black groups would be lower than that of the White British population. This picture however is not so clear. Two studies looking at service delivery in primary care settings each suggested that Black mental health service-users report lower levels of satisfaction (Bhugra *et al.*, 2004; Lloyd and St Louis, 1999). Similar findings were repeated in secondary care services (Parkman *et al*., 1997). Other studies, however, have found there to be no difference in the levels of satisfaction (Commander *et al.,* 1999; Callan and Littlewood, 1998; Leavey *et al.,* 1997; McGovern, Hemmings and Cope, 1994). One of the largest studies carried out by Raleigh *et al.* (2007) looked at patients in receipt of community services in 2004 and 2005 (26,625 and 24,143 participants respectively) including recipients of secondary and primary mental health services. Their findings suggest that ethnicity is not a significant predictor of service-user experience. Rather

factors such as age, living alone and having been either in hospital or detention in the previous 12 months were correlated with patient experience. The findings from Raleigh *et al*. (2007) mirror the findings of an earlier study by Sharpley *et al*. (2001) that suggest the number of previous admissions to mental health services was the strongest predictor of patient satisfaction among Black groups. Hence, satisfaction surveys point to mixed findings which are likely to be influenced by a wide range of factors.

Satisfaction with services takes different forms. Various reviews have demonstrated some of the features that positively influence service-user satisfaction. Lambert and Barley (2001) divided these into four areas when looking at psychological support: extra therapeutic factors (fortuitous events, social support), expectancy effects (placebo), specific therapy techniques (hypnosis) and common factors (empathy, warmth, therapeutic alliance). They found that common factors were of particular importance. Their findings are aligned with a later review by Newman *et al.* (2015), which further highlight the relationship between the service-user and mental health professional. Newham *et al.* (2015) conclude that it is the mental health professional's interpersonal skills and experience that provide the main healing component by being able to tailor support to service-user needs. This finding is replicated in the wider literature, showing the significance of the mental health professional to manage

challenging situations (Anderson *et al.*, 2009). Chidarikire (2012) suggest this can include the ability of the professional to incorporate spirituality into treatment plans as this has been shown to aid recovery, improve quality of life, reduce relapse and contribute to general well-being and symptom relief. Racialised identities have also been shown to be crucial. A review by Cabral and Smith (2011) showed that there was no significant effect size in outcomes when ethnic matching service-users and care providers. However, they did find that service-users favoured and perceived matching the racialised identity of the service-user with the professional more beneficial. A further review by Bhui *et al.* (2015) went further to find that culturally adapted care was favoured by service-users, and that it was clinically effective. The significance of racialised identities in the service-user and professional relationship is articulated in a letter from Mr Bennett to the head of nursing at the clinic he was detained shortly before his death:

> As you know, there are over half a dozen black boys in this clinic. I don't know if you have realised that there are no Africans on your staff at the moment. We feel there should be at least two black persons in the medical or social work staff. For the obvious reasons of security and contentment for all concerned please do your best to remedy this appalling situation (NSC NHS, 2003: 9)

Thus, there is clear evidence that the interpersonal skills, experience and identity of the practitioner influence how satisfied a person is with the care they receive. This study builds on this evidence by examining what was beneficial for young Black people.

Race, young people and non-statutory support

Institutional racism has frequently been offered as a key factor in the differential outcomes discussed in this chapter and is seen as epitomising the experience of Black people. However, as already noted, institutional racism can be seen as a process that very much operates at the meso-level (Phillips, 2011). This study is interested in understanding how the experience of receiving non-statutory support is described by young Black people. As a result of the influence of CRT this study is keen to explore whether race is a salient feature of this experience. The 'spirals of oppression' model put forward by Keating (2012) suggests that fear and race remain pertinent features of the relationship between Black people and mental health services. Additionally, Sewell (2012) posits a 'toxic interaction theory' to explain the hostile relations between mental health services and Black service-users. These theories and models, alongside the accusation of institutional racism, all point towards mental health services not providing an affirming environment that is engaging to Black people. One question that follows from

this is whether these experiences are borne out in the experiences of young Black people in a non-statutory care setting.

It has been recognised that engaging the experiences of young Black people is an area which has been overlooked (Gurpinar-Morgan *et al.,* 2014). Most research has focused on the adult population or on statutory care services. In recognition of the absence of literature, looking at the significance of race in the receipt of mental health support for young people, Gurpinar-Morgan *et al.* (2014) conducted a small study to look at this issue. This showed how prominently race featured in the service-user and care provider context, particularly in relation to establishing foundations within the therapeutic relationship. Other research within the grey literature has indicated that racialised minority young people felt mental health services made assumptions about them based on their racialised identity (Kurtz and Street, 2006). Hence there is an indication that issues of race are likely to be important for young people in respect of the care providers and service-user relationship. The above studies did not, however, separate out the experiences of the different racialised groups that took part in the studies nor the services that they accessed. Therefore, the present study has the opportunity to add to the knowledge base by specifically focusing on the experience of young people racialised as Black within a non-statutory care setting.

Chapter conclusion

For mental health, substantial changes have been apparent. This has seen service delivery shift from being predominantly targeted at only severe problems within institutions to support that is now mainly provided in the community for a range of mental health problems. Another change that has been observed over the last half century are the skill-sets of the people, and the type of organisation, providing mental health support. This chapter has also illustrated the context within which non-statutory support can be understood. What can be seen from this is that the non-statutory sector comprises a diverse range of organisations that occupy a growing and varied role in the delivery of care. Research looking at these organisations shows they offer an environment that racialised minority adults, as distinct from young people due to scare literature, find affirming and suitable to their needs. Meanwhile, the varied approaches to delivering mental health support make the role of the non-statutory care sector different compared to support typically provided by general practitioners, psychologists and psychiatrists within the National Health Service (NHS). Therefore, a context has now been set for the organisations that will be involved in this research and the role they play in the delivery of mental health services. Against this background a stance has been taken that views mental health, mental ill-health, and the types of treatment provided as constantly evolving and therefore subject to the caprices of political and social transformation.

This chapter has provided a narrative review of the literature. Policy and research have continued to identify Black people as being particularly vulnerable to mental ill-health. Long-standing research has also illustrated significant inequalities across a broad range of service outcomes. From the literature presented it is possible to see that people racialised as Black have distinctly different journeys to receiving support. They are more likely to access services through intrusive means. As a consequence of this they are at increased risk of being constructed as mentally ill, criminal or both. Theories have been developed about why racialised people access services via coercive means. How useful these theories are when explaining the situation for young Black people and non-statutory support is yet to be seen. Hence much more needs to be known about the subtleties of experiences which are embedded in decision-making. Research demonstrates that very little is actually known about the steps, decisions and experiences racialised people take before they access services. This study takes a step to fill this gap in knowledge.

Most literature looking at service-users' experiences of mental health support looks at statutory healthcare provision and focuses on adults. This study aimed to fill a void in relation to young people and non-statutory healthcare provision. Most research is also of a socio-demographic nature. This study takes a personal approach to draw out the lived experience of young Black people to

help better understand whether race is a significant feature of their experience when receiving mental health support.

Chapter 4 Research, design and practice

After reviewing the literature in chapters two and three the following primary question was formulated:

> What is the lived experience of young people racialised as Black when accessing and experiencing non-statutory mental healthcare?

This chapter justifies why qualitative research in the form of descriptive phenomenological methods was part of the overall research approach. Each section is discussed in the order in which the research process was undertaken. An overview of the philosophical foundations of the thesis is offered, debating the work of Husserl and how this relates to the chosen methods. In brief, this thesis accepted a constructionist ontological position and interpretivism as its epistemological standpoint. From this, qualitative research was seen as an appropriate research method to construct and analyse the data regarding the voices of young Black people. Descriptive phenomenological methods are discussed in detail, linking its philosophical underpinnings to its practical application. The section also looks at the tensions and ties between CRT and Giorgi's (1985) version of phenomenological methods, as the former advocates a race conscious approach to data collection and the latter a more neutral stance.

Remaining sections look at the recruitment procedures, the participant profile, a review of the ethical dilemmas and a personal reflection on the research methods. Fieldwork was carried out across several English cities using purposeful sampling, recruiting 25 participants from various non-statutory organisations. The ethical challenges that arose during this point in the field are discussed in the recruitment sections. The final sections reflect on the use of the method, the role of the researcher and further ethical considerations.

Husserl, phenomenology and the study's philosophical underpinnings

Phenomenology is a school of philosophy and form of qualitative enquiry. The philosophy of social science covers a broad area (Benton and Craib, 2001). Therefore, this section will pay specific attention to the philosophical principles that underpinned this research, which are based on a type of phenomenology developed by Husserl (Merriman, 2009). It will focus on two main areas of philosophical empirical enquiry, being ontology and epistemology. Ontology has been described as questioning the form of nature and reality and what can be revealed about it, whereas epistemology is concerned with the association between the knower and what can be known about it, in essence what is known to be true and constitutes knowledge (Lincoln and Guba, 1985).

This thesis applies a constructionist ontological position and interpretivism as a suitable matching epistemological standpoint. These positions are mutually reinforcing: social constructionism views the social world as being dependent on human existence. This overlaps with interpretivism which accepts that social reality is constructed through interaction and the notion that meaning is embedded within knowledge production (Benton and Craib, 2011).

Husserl's decision to study consciousness came at a point in time when knowledge production was largely confined to the natural sciences (Moustakas, 1994). Husserl challenged this and aimed to develop a human social science approach based on natural science principles, aiming to minimise bias through rigorous procedures. As Moustakas (1994: 45) asserts, phenomenology 'pointed to a new way of looking at things, a return to things as they actually appear.' To be able to focus on subjectivity the rules that applied to the natural sciences would need to be altered and different terms about what constitutes knowledge were needed. A human science would need to be able to analyse subjectivity, considering factors such as imagination, thoughts and hallucinations, thus contrasting the natural sciences (Feest, 2012). Indeed, Husserl wanted to include knowledge that came from not only real objects but also those he considered to be irreal. According to Giorgi (2009: 67), Husserl indicated that:

> … any object is real that is in space, time, and is regulated by causality. An object that would lack any of those characteristics would be irreal. Ideas, for example, are given to individuals in time but not in space, and for phenomenologists they are not causally determined. Meanings are also not spatial and so would not be considered real objects. Dreams, memories, and images are other phenomena that would not be considered real in the strict sense, but they are experiential in the sense that they can only appear in the consciousness of individuals.

Husserl and constructionism

Husserl (2008) wanted to uncover human experience as it was lived and which he felt was lost through empirical scientific explorations. He challenged scientists' claim that there was one way of viewing the world. According to Jones (1975), Husserl argued that there are many ways of viewing the world, and therefore we are one life among many worlds. From this, minds and objects were seen as being part of the same experience, which was a rejection of objectivism. Husserl placed significant emphasis on the study of consciousness as he believed this was the mode through which access to subjective knowledge could be reached. According to Moustakas (1994: 45), he wanted to

obtain knowledge that could be 'discovered through reflection on subjective acts and their objective correlates.' Thus, what makes an object real is not just the existence of the object but how this is inextricably related to a person's consciousness of it, as they are part of the same experience. Indeed, people should not be seen as having consciousness of nothing but rather that their consciousness is being intentionally directed towards an object. This is known as the intentionality of consciousness (Stewart and Mickunas, 1990). Ashworth (2006: 212) further denotes this distinction:

> … we discuss perception continually without any attention given to the two elements of the process of perception; the mentality of the perceiver and the material thing perceived … which leads us to not think about how the different elements of the person, the mental and the physical, are to be considered together.

The inclusion of irreal objects is a fundamental principle of the phenomenological philosophy of science (Moustakas, 1994). Giorgi (1985) does not view this idea as being in opposition to empiricism. Rather, it embraces empiricism whilst considering irreal objects.

Husserl and interpretivism

Husserl's views altered over time. Whilst his early career was in the field of mathematics, which may have influenced his thinking, his later work was dominated by subjectivity (Laverty, 2003). Husserl (1983) was concerned by the way natural science methods were applied to the area of psychology (Jones, 1975). Whilst this approach may appear positivist, he believed in the existence and importance of irreal objects as a form of knowledge. Husserl (2008) acknowledged that the object of study within human science was ontologically different to that in the natural science. Given this, it is necessary to analyse social meaning to be able to produce a scientific summary of social reality, which is why Husserl adopts an interpretivist epistemology. This point is built upon by Ashworth (2006: 214) who suggests that Husserl is clear that both the 'mode of consciousness' (for example, judging) and the 'object of this consciousness' (the judgement and the thing judged, etc.) are within personal experience. As Ashworth (2006: 214) summarises: the 'thing judged or the thing perceived is judged or perceived within the whole web of meanings that it has for us in lived experience.' Various scholars (Creswell, 2007: van Manen, 1997) comment that Husserl focused on the idea that people's minds are constantly capturing information that informs what an object means to them, and consequently this contributes to the lived experience when interacting with that object. Therefore, within the context of this

study, a participant's interaction with a stimulus (*e.g.* the receipt of care) is likely to be informed by the meaning and perceptions they attribute to that stimulus (*e.g*. one potentially infused by previous experiences of being racialised), which combine to provide the lived experience.

Qualitative enquiry

Silverman (2000: 93) has argued that no one research method is better than another, as 'everything will depend on one's research objective.' This study was descriptive and exploratory, allowing detailed accounts to emerge from participants based on their experience. This was crucial as there has been little attention to this field from the perspective of a young Black person. Utsey *et al*. (2005) assert that an over-reliance on quantitative methods provides an impoverished view of processes of racialisation in the context of mental healthcare. Meanwhile, Quraishi and Philburn (2015) have suggested that an understanding of subjectivity and lived experience is central to a more nuanced exploration of racialisation. Therefore, an approach that would be flexible to grasping the rich and detailed stories of everyday life was pursued.

Moustakas (1994: 105) states that a human science research question has the following characteristics:

1) it seeks to reveal more fully the essences and meanings of human experience;

2) it seeks to uncover the qualitative rather than quantitative factors in behaviour and experience;

3) it engages the total self of the research participant, and sustains personal and passionate involvement;

4) it seeks to predict or to determine causal relationships; and

5) it is illuminated through careful, comprehensive descriptions, vivid and accurate renderings of the experience, rather than measurements, ratings, and scores.

These components are encapsulated in the study's overarching research question and sub-questions. These are:

- What are the lived experiences of young people racialised as Black in accessing and receiving non-statutory mental health care?
    - How and why do young Black people access non-statutory care?
    - What obstacles do young Black people experience in their pathway to care and how do they overcome them?

- How do young Black people experience non-statutory early intervention support?

- What challenges do young Black people encounter when using non-statutory care, and how do they overcome them?

The decision to ask these questions was taken for two interrelated reasons. These are the existence of racialised inequalities in pathways to care and the possible significance of processes of racialisation in explaining them. More specifically, the literature review highlighted that Black people are more likely to access support via a coercive pathway, often attributed to delayed help-seeking. However, as discussed in a previous chapter, other studies have shown that there are no differences between racial groups in the length of time from when they first experience a psychotic symptom to the point of accessing mental health support (known as duration of untreated psychosis (DUP)). If the length of time to access care is not different for racialised groups when measured by DUP, but the pathways to care and outcomes are different, what factors may explain this, and how relevant is this for mental health problems more broadly? Although the literature review helped to identify such inequalities, CRT directed attention to the salience of racialisation. The literature review also drew attention to the way Black people have less favourable experiences in relation to the

care they receive. Thus, the thesis sought to understand whether, how and under what circumstances the racialised identity of young Black people contributes to their journey into and within non-statutory care.

Qualitative enquiry was selected as an appropriate method to explore these experiences. Glynn (2014; 2019) has argued that power relations too often render racialised minority voices invisible. In order to address this imbalance, there was a desire to reach out to examine whether the racialised identity of participants resulted in common thoughts, feelings or emotions of any type. Freire (1970) highlighted that those who are oppressed are best placed to know that oppression and that their voices must speak and be heard. Denzin (2010) also argued that steps need to be taken to overcome the silences imposed on the oppressed. According to hooks (1990), narratives offer a conduit through which resistance can be realised. Similarly, Hill-Collins (1986) has suggested that stories can be liberating, and provide an opportunity to challenge racialised stereotypes. Thus, a qualitative approach is deemed appropriate as it draws on the nuanced aspects of experience and appreciates the lens of privilege afforded to Black groups (Williams, 1987). This overlaps with the epistemological stance advocated by CRT that assumes knowledge is held, understood, created and best articulated by people who have direct experience of being racialised.

Research methods and practice

Phenomenological research

This thesis employed descriptive methods of qualitative enquiry. Creswell (2007: 57) remarks, 'a phenomenological study describes the meaning for several individuals of their lived experiences of a concept or a phenomenon.' Thus, phenomenological researchers aim to depict the 'essence or basic structure of experience' (Merriman, 2009: 25). Hughes and Sharrock (2007) assert that phenomenological enquiry is about obtaining the meaning(s) people attach to any ongoing set of relationships through analysis and description of everyday experience. Hence, there is an emphasis within phenomenological research on understanding an experience as it was when lived. In particular, this study followed methods used by Giorgi (2009). Giorgi is credited with bringing Husserl's phenomenological methods from the discipline of philosophy and systematically applying them to qualitative research practice (Gill, 2014: Finlay, 2009).

There are numerous approaches to phenomenological research (Moran, 2000). Despite this diversity, Finlay (2012: 174) explains that five 'mutually dependent and dynamically iterative processes' unite this form of enquiry. These are: entering the lifeworld through descriptions, embracing the phenomenological attitude, dwelling with horizons of implicit meanings, explicating the phenomenon

holistically and integrating frames of reference. In the next sections of this chapter these parts of the phenomenological research process are explicated in the order that the research unfolded. Whilst elaborating on the different stages of the research process reference will be made to the relationship between CRT and the chosen methods and the ethical challenges that arose.

Entering the lifeworld through descriptions of experience

The lifeworld is comprised of features of everyday life and the meaning social actors attribute to them. As Finlay (2012: 179) puts it, the lifeworld 'is our embodied sense of self, which is always in relation to others given through shared language, discourse, culture, and history.' The aim of the qualitative researcher, is to enter participants' lifeworld, seeking out 'embodied consciousness, aware that person and world are intentionally and intersubjectively intertwined' (Finlay, 2012: 180). In this study the lifeworld is the experience of young Black people on their pathway to care and the receipt of care.

Phenomenologists go about entering the lifeworld based on participants' descriptions of their lived experience (van Manen, 1997). Giorgi (1985) contends the aim should be to obtain fresh, complex and rich descriptions of a phenomenon as it is concretely lived, rather than an idea about what happened. Therefore, the aim is to obtain the

experience in its raw form as it unfolds in daily life. For Finlay (2012: 173), this involves probing questions which ask, 'What is this kind of experience like?' She (2012) states that phenomenologists should seek down-to-earth descriptions. Giorgi (2012: 124) provides the following example of an opening question: 'Please describe for me a situation in which you experienced learning.' Based on this guidance an interview guide was developed for this study (appendix 1). The following two main questions were used to elicit the lived experience:

- Can you talk me through your experience of accessing [insert organisation name]?

- Can you talk me through your experience of receiving support at [insert organisation name]?

The interview guide included further prompts to explicate the lifeworld experience and help document the barriers and facilitators to accessing and receiving care. For example, Finlay (2012: 173) describes how phenomenological researchers use probing to help participants return to the scene when the experience took place by asking: 'put yourself in that place, and look around. What do you see/hear/smell?' By asking these questions the objective is to aid the participant to return to the experience as it happened, assisting the researcher to focus on discovering dynamic processes rather than seeing

the phenomenon as fixed. The interview guide included various probes, including:

- Can you take a moment to put yourself back in that place when it happened and describe to me how it felt?

- Can you recall any of your thoughts or feelings at that time?

The interview questions did not specifically focus participants' attention to the area of racialisation. As a result, it is acknowledged that a tension exists between this approach and methods informed by CRT. Within CRT, questions about race are situated centrally, as it is implicit that racism is ever present (Yosso *et al*., 2004). This would typically lead to more direct questions that ask about the significance of race and racism on the pathway to care. It was decided that a neutral approach would allow participants to draw upon racialised elements they see as salient. The approach that was followed offered the scope for a nuanced understanding of the embodied experience of being racialised in relation to the pathway to and receipt of care.

Embracing the phenomenological attitude

According to Husserl (1977), to fully comprehend the essence of a phenomenon it is necessary to withhold all

judgement about it; suspending any theory and knowledge that is held about the world. He referred to this suspension as the epoché. Within social research the epoché is a process that encourages researchers to embrace the phenomenological attitude by putting to one side what they would normally take for granted. Ashworth (1996) points to areas where epoché can occur. These are scientific theories, knowledge, and explanations, and the personal views and experiences of the researcher. Therefore, epoché entails the researcher suspending their natural everyday attitude of knowing, so that emphasis can be placed on understanding the world of the researched.

Giorgi (2012) argues that great emphasis should be placed on the epoché throughout the research process. He highlights that it is not for the researcher to forget all they know; rather they should neither reject nor accept it, but ignore it. As Giorgi notes (2012:4), 'she treats it as something that is present to her consciousness and she refrains from saying that it actually is the way it presents itself to her.' Therefore, for Giorgi (2000), the epoché requires the researcher to try to not allow their past understandings and theoretical frameworks to be engaged. Whilst assuming the epoché it is then the role of the researcher to fully embrace the experience of the participants and be open to new knowledge about the subject under study.

Descriptive phenomenological methods were selected to keep attention focused on the stories of participants, whilst simultaneously limiting the researcher's influence. Giorgi and Giorgi (2003) argue that descriptive research keeps the voice of the participant at its centre throughout the analysis. The point of selecting methods that encourage the researcher to suspend their worldview, was to gain a more accurate reflection of participants' lives, and thus adhering to CRT's tenet, which focuses on racialised voices of authority.

There is no standard guidance about how the researcher can engage the phenomenological attitude (Willig, 2014). After reviewing the literature (Willig, 2014: Finlay, 2009: Giorgi, 1985: Moustakas, 1994) it is apparent that this is a mental exercise that involves a meaningful attempt to focus on what is being described without external influence. Prior to commencing participant recruitment, a pilot interview, using the interview guide whilst adopting the phenomenological attitude, was conducted. In this instance the method seemed appropriate. When in the field the phenomenological attitude was adopted, which meant the researcher attempted to hold in suspense 'whatever object or state of affairs' were present (Giorgi 2012: 4).

Participant recruitment

Purposeful sampling

Purposeful sampling is a well-established approach that aims to recruit individuals based on clearly defined selection criteria (Bryman, 2004). Purposeful sampling was used to recruit participants who were aged 16–25, who had been racialised as Black, and had received care from a non-statutory organisation that aimed to improve their mental health.

Recruitment

Non-statutory organisations were identified through a range of means. The researcher had worked in the non-statutory sector for approximately ten years and was able to contact several organisations and individuals with which he was familiar. Contact with other organisations was established via networking events, and cold-calling organisations that were found on the internet and appeared to meet the research criteria. Over 40 organisations were contacted between June 2017 and April 2018, and participants from 17 organisations participated. Organisations that did not identify any young people provided various explanations. A Somali-led organisation in a northern city said they don't provide support within the specified age range, even though they were funded to do so. Other mainstream organisations, operating in areas

with sizeable Black populations, and with a remit to provide support to young people age 16–25, advised they had no young Black people attending their services. Three organisations did not respond.

Where it was established that an organisation had service-users who potentially met the inclusion criteria, and the organisation was willing to assist with the research, the process of publicising the research opportunity detailed in the ethics application was followed. Generally, the CEO of each organisation nominated one employee as the point of contact for the researcher, and recruitment was usually carried out by a mental health professional (*e.g.* counsellor or psychologist). The professional was provided with an organisational information sheet and participant information sheet. Some of the challenges and concerns relating to participant recruitment are detailed in this section. The professional placed the participant information sheet in waiting areas. Where there was no waiting room a participant information sheet was provided to potential participants and the professional was asked to ensure young people were not put under any pressure to participate. Participants who were interested could contact either the researcher directly or make contact via the mental health professional for further information. In all situations, participants were provided with a minimum of two weeks to consider their involvement and make contact with the researcher if they had any questions.

To be able to identify participants there was a need for key parts of the inclusion criteria to have working definitions. As noted in chapter two, a broad and pragmatic approach based on a social model, was assumed to the way mental ill-health was defined. This was: any significant deviation from past behaviours—thought processes or emotions—and the receipt of a mental health intervention. Therefore, this thesis adopted the position that mental ill-health encompasses a wide range of experiences that participants and care providers constructed as a form of mental ill-health. Participating organisations were those carrying out a specific mental health intervention and were not part of the statutory sector. This included the third sector (*i.e.* voluntary and community-sector bodies), faith-based organisations and community interest companies.

On one occasion there was uncertainty regarding the definition of non-statutory organisation. This was because service-users were accessing a charity that was delivering an NHS contract for people with first episode psychosis. The researcher made contact with the organisation through a colleague he had at NHS England. Consequently, the manager at the charity assumed that ethical clearance had been obtained through NHS England. This was despite the researcher sending University of Nottingham's ethical clearance documents. It was only at the point of arranging interviews that this matter came to light. The manager was uncertain about whether interviews could proceed because the organisation was delivering an NHS service,

even though the organisation was a non-statutory body. No further time was spent pursuing this option as it was possible that relevant NHS ethical clearance may be needed.

Revisions and clarifications were also required with regards to inclusion criteria that stated young people could only participate if they had not previously accessed statutory care. At the outset, one of the objectives of the research was to interview participants who were only accessing care for the first time. It was thought that if participants had accessed care previously this would influence later help-seeking and would not provide an accurate picture of emotions and feelings. However, this is a criterion that had to be reviewed. It came to light that for several organisations the main route to receiving non-statutory care was via GP referral. Also, many participants only recalled they had accessed previous support during their interview. Winkielman and Schwarz (2001) have identified how many factors can affect memory recall including negative events. Further, Bhandari and Wagner (2006) have reviewed the challenges associated with self-reporting and healthcare utilisation and how memory can be influenced by factors such timeframe, type of services and frequency of attendance. What became apparent was that many of the participants had attended care previously but had disengaged, mainly after only one session. This, of itself, became an interesting finding that is discussed in chapter six. Therefore, a decision was made to include

participants who had only had light-touch contact with services (no more than two sessions with one organisation) and for these service contacts to be explored using the same interview guide. Despite these clarifications the researcher attended three interviews where the potential participants had been sectioned under the Mental Health Act and had spent considerable time in a mental health hospital. These individuals received an explanation about why the interviews could not take place and thanked for their interest and involvement.

A range of barriers to engaging racialised minority people in research have been identified in the literature (Brown *et al*., 2014). The approach to participant recruitment was well received by most organisations. However, whilst efforts were made to ensure different professionals had an understanding of the inclusion criteria, a number of challenges relating to terminology emerged during recruitment. These are now discussed.

What it meant to be Black needed clarification on two occasions. In one example, the researcher made a trip to an organisation on the premise that he would simply introduce the research. Not long after he arrived it was brought to his attention that a number of young people were there to be interviewed. This raised an ethical issue as the young people had not had sufficient time to consider their participation in line with agreed protocols. Interviews did not take place. After meeting and talking to

the young people it was apparent that they all self-defined as being British Pakistani as they acknowledged such to the resident professional. It turned out this was a misunderstanding on the practitioner's behalf as he thought the research was for all racialised minorities.

At another organisation, the practitioner sought clarification following his discussion with potential participants, as they were predominantly of Egyptian or Moroccan heritage and would not see themselves as Black, but rather Brown. This supports wider research which suggests 'people from northern African, the Horn of Africa, and some parts of the eastern coastline and islands of Africa may not identify themselves as Black African' (Aspinall and Chinouya, 2008: 186). This part of the fieldwork required clarification with the practitioners to ascertain how the young people would typically self-define using standard ethnic monitoring. As one of the factors driving the research was the over-representation of those who self-define as Black, this became instructive in making decisions. Having a conversation about how society racialises young people as Black through other means, and expecting the practitioner to relay this to potential participants, did not seem practical. Therefore, explaining to practitioners that it would be young people who would typically self-define as belonging to a Black group as defined by ethnic monitoring became the guide whenever there was ambiguity.

Stigma associated with the term mental health was also thought to be a barrier. Within the recruitment material young people were encouraged to participate if they had accessed mental health support. Some professionals remarked that, although the services they provide are aimed at improving a person's mental health, these terms are not used. This is highlighted in the following email response:

> The feedback I had back was that most of the work that the partnerships have been doing with young men has not been 'branded' as overtly mental health focused. This was because early guidance was that there was significant fear around the use of this language and these concepts – quite understandably given many families' experiences of such services. So, they have usually been early intervention projects branded as focusing on supporting men's goals, interests and resilience. They would not be seen as 'mental health services or support'. So, this created a problem and a silence – with few getting back to me. One partner did get back to say that this description of what you might be dealing with during interviews might make it very difficult indeed to recruit young men – as mental illness remains such a sticky and fearful concept (personal email, 18 February 2018).

A similar response was received from another organisation working in London. They felt that young men did not want to talk about mental health because of the fear of stigma after hearing stories of over-medication and hospitalisation. The practitioner from this organisation also shared that he felt young Black people just try to manage and tolerate their experience of mental ill-health due to the fear of being stigmatised. Therefore, in two instances, gatekeepers felt that the use of language relating to mental health/illness created a barrier to recruitment.

Participant profile

Interviews were carried out with 25 young people. This falls within the range of five to 25 interviews recommended by Polkinghorne (1989) for phenomenological research. Table 1 (page 154) provides a breakdown of the study participants. The table shows socio-demographic data for each participant in the first column. Twelve females and 13 males were interviewed. Fifteen were aged 16-19 and ten in the age range 20-25. Column one also shows the region in England in which they accessed care. Each subsequent column identifies the different services contacts for each participant. For example, a female age 25 (row two) initially sought support from her GP. She was referred to improving access to psychological therapies (IAPT) and disengaged after one session, then accessed care privately.

Key:

	Education-based: school (sch), college (coll), university(uni)
	Statutory provision: IAPT, GP, A&E, YOT, CAMHS
	Non statutory: Third sector or CIC
	Non statutory: faith-based (fb), private (pv) or private & faith-based (Pv-fb)
	Social: seeking out social opportunities

Table 1 Participant service contacts

	Service contacts					
Social demographic	**1st**	**2nd**	**3rd**	**4th**	**5th**	**6th**
Male, 25, London	VCS*	GP	IAPT	IAPT	VCS	
Female, 25, Northwest	GP	IAPT	Pv			
Male, 19, Southwest	Sch	LA	Coll			
Female, 17, Southwest	Sch	Fb	VCS			
Female, 17, London	Sch	PRU	VCS			
Male, 17, London	CAMHS	LA	VCS			
Male, 16, London	YOT	VCS	YOT	YOT	VCS	
Male, 16, London	YOT	VCS				
Female, 22, London	VCS	VCS				
Female, 25, London	Uni	IAPT	Pb	VCS		
Female, 24, London	VCS	GP	Coll	VCS	VCS	VCS
Female, 25, London	LA/IAP	VCS				
Female, 16, West Midlands	GP	IAPT	GP	VCS		
Female 17, West Midlands	Sch	Sch	CAMHS	Sch	GP	VCS
Male 17, West Midlands	GP	IAPT	Coll	VCS		
Male, 17, West Midlands	CAMHS	CAMHS	IAPT	VCS		
Female, 18, West Midlands	GP	CAMHS	IAPT	VCS		
Male, 20, West Midlands	A&E	VCS				
Male, 17, West Midlands	A&E	GP	Sch	VCS		
Female, 22, London	Fb	Fb				
Male, 23, London	Pv-fb	Fb				
Male, 22, London	Fb					
Male, 22, London	GP	Sch	GP	IAPT	GP	Pv-
Female, 19, London	GP	IAPT	Social	VCS		
Male, 24, London	CAMHS	A&E	VCS	VCS		

*Participant stayed with this organisation whilst continuing to access further care.

Interviews

Interviews were carried out at the premises of the organisation where the participant was receiving care, and took place between October 2017 and May 2018. Interview length varied from 15-75 minutes. Prior to commencing every interview the researcher discussed the information sheet and consent form with every participant. This process reminded participants of their right to stop the interview should they wish. They were also advised they could take a break at any time. Prior to the interview a two-stage process was applied allowing participants to state their racialised identity. They were initially asked to identify how they self-defined in an open field. This allowed participants to state, without being influenced, what they believed to be their racialised identity. Participants were subsequently asked to complete a box on a standardised ethnic monitoring form (responses in Table 1). In each of the open field responses participants self-identified with reference to skin colour, highlighting the importance of this as a racialising factor. Although responses on both forms were similar for most participants a few dissimilarities were observed. One participant put 'British/Darkskin, human being' on the open field form and, 'Black - British African' on the standardised ethnic monitoring form. Another participant wrote 'Black' (open field) and 'Black African' (standard form). These examples show the ambiguities associated with racialised identification. A potential participant's interview was terminated (and the participant

thanked for their time, thus far), as it emerged he had been detained under the Mental Health Act. He put 'Nigerian, Black British, don't know' in the open field, and 'Black African' in the standard form. Whilst this example further demonstrates the flexibility of racialised concepts (Winnant, 2006), it also shows the importance attached to country of origin rather than being defined in pan-African terms, such as Black African.

A voice recorder was used to record each interview and questions followed the prepared guide (appendix 1). Two amendments were made to the guide due to complications.

In the first four interviews participants were asked this opening question:

- In as much detail as possible, tell me what it was like for you on your journey to accessing support at [insert organisation name]?

Two of the participants showed puzzled faces, and one mentioned the word journey in a confused way. The question was revised and replaced with the following:

- Can you talk me through your experience of accessing [insert organisation name]?

Another question that participants frequently requested clarification on was:

- Can you tell me if you think there was anything about you in particular that may have made your experience different?

This question was included so that participants could be encouraged to describe any factors that were pertinent to their racialised identity. In most instances, participants were perplexed by the question. It was difficult to remain neutral yet clarify the question without drawing attention to race. The question also felt inappropriate as some participants were attending a service that was delivered by and for people racialised as Black. Given this context it was felt that it would be less likely for racialised issues to emerge than if the participant was in group therapy with only White people. As a result of the confusion the question engendered it was removed from the interview guide after several interviews. Removing this question appeared to have no apparent negative impact as it did not glean any information when it was used.

During interviews, if a pertinent matter was discussed by the participant and they spontaneously diverted to another point, a mental note was made or jotted down, as described by Merriam (2002). Once the participant had naturally finished speaking this was used as an opportunity to probe for further information on the pertinent point with a view to getting a more complete picture and create novel data to further represent the experiences of participants.

Data analysis

All interviews were transcribed by the researcher using the NVivo software package. For most parts of the data analysis process Giorgi's (2009) procedures were followed. A modification based on the application of descriptive methods by Koivisto *et al.* (2002) was used in a later stage of analysis to give greater detail to the findings. This section will document the overall approach.

Husserl's ambition was for there to be a rigorous approach to philosophy that was based on the principles of natural science. Giorgi (2009) based his methods of qualitative analysis on these principles, following an approach akin to the natural science but applicable to the field of human and social science. This involves being transparent about each stage of the analytic process. It also entails remaining true to what the data says and therefore keeping a focus on the descriptions of the participants with minimal interpretation. Each of the steps are aimed at reducing bias. Despite these positivist tendencies this was an approach that stayed true to description and the qualitative features of human life. As such, Giorgi (2000) states that this is a scientific approach to analysing data that uses description as part of a larger interpretive project.

Stages of analysis

Getting a sense of the whole

Within phenomenological research the first four stages of data analysis involve working with the same transcript until a specific statement for that participant has been written. Initially, this entails reading through a transcript attempting to comprehend the whole experience of that participant. According to Finlay (2012), phenomenological researchers spend a significant amount of time examining data so a deeper understanding of the participant's lifeworld can be realised. From this, the researcher should stretch their thought process so that they begin to re-experience the situation as it was lived by the participant (Finlay, 2014). In this way the exercise should be one that seeks to provide an embodied and empathetic experience for the researcher and not simply an intellectual endeavour. By dwelling on the data, the goal is to discover any hidden meaning that may otherwise be overlooked as general themes or categories take precedence. Giorgi (2009) reiterates that it is important for the researcher to stay in the phenomenological attitude by not attaching any explanation or theoretical framework to the data.

There is no guidance on the number of times a researcher should read each transcript (Finlay 2012: Giorgi, 2009). Rather, the focus is on reading until there is a strong sense of what the experience was like. The first two transcripts were each read five times. For the remaining transcripts

the number of times they were read varied depending on the length of the transcript and the complexity of the narrative. For instance, it felt necessary to read the longer transcripts three to four times and the shorter interviews only twice.

Dividing the text into meaning units

Still working with one participant's full transcript the next step is to compartmentalise the data. This stage is focused on establishing units of meaning that lie within the transcript.

Giorgi (2012: 129) stresses that 'most descriptions are too long to be retained and so the constitution of parts helps in the analysis.' Giorgi (2009) also notes that the process of marking the text is arbitrary as each part has no theoretical weight. Giorgi (2012:130) suggests that

> … as one begins to reread the description, one makes an appropriate mark in the data every time one experiences a shift in meaning. The end step is that the script is broken down into a series of meaning units.

At this stage of data analysis, no explanation of the meaning units is provided. De Castro (2003) adds that, while the researcher is dividing the text into meaning

units, they need to keep in mind the whole description of the participant to ensure that any external framework of meaning is not imposed.

Table 2 demonstrates how this process was conducted. When carrying out this stage of analysis it was often the situation that the participant's response to a question simply formed the meaning unit. This can be seen in Table 2: point 4 of transcribed data (*i.e*. column one) comprise one meaning unit (*i.e.* point 5 column two). This meaning unit only provides information about the importance of social contacts in help-seeking. In other instances, if a participant provided a more detailed response that covered various areas of meaning this would be divided into multiple meaning units. A short example of this can be seen where point 2 in the transcribed data column in Table 2 has been separated into two meaning units in column two. This is because it provides information on how the participant was feeling (point 2 meaning unit) and the reasons they believed they felt that way (point 3 meaning unit).

Table 2 Transcribed data into meaning units

Transcribed data	Text put into meaning units
1. How did that feel when making the decision to go and see the GP, what	**1. How did that feel when making the decision to go and see the GP, what**

was that like? 2. Mmmh, I just, I just couldn't describe it was just like, I just kinda looked like, look around what going on, what's wrong with me. Like what's going on. And, er, from the … it was realising the connect, erm, the bad relationship played a part, but it was also my grandad's death what caused it, it was grief. Cos I didn't deal with it properly, it kinda, it just spun into anxiety as well as depression. 3. **And when the decision was made, sorry, was it you who made the decision to go to the GP or your mum?**	**was that like?** 2. Mmmh, I just, I just couldn't describe it was just like, I just kinda looked like, look around what going on, what's wrong with me. Like what's going on. 3. And er, from the, it was realising the connect, erm, the bad relationship played a part but it was also my grandads' death what caused it, it was grief. Cos I didn't deal with it properly it kinda, it just spun into anxiety as well as depression 4. **And when the decision was made, sorry, was it you who made the decision to go to the**

4. It was my mum cos she was worried. She booked an appointment	**GP or your mum?** 5. It was my mum cos she was worried. She booked an appointment

Transformation of meaning units

The next stage is to transform the data from natural attitude expressions into phenomenological expressions. This involves taking the everyday expressions of participants and making them relevant to the discipline of the researcher. For Giorgi (1985; 2009), this means using terminology to make the expressions relevant to the discipline within which the study is taking place and, since he is a psychologist, this entails illuminating the psychological dimension of the experience. This thesis is located within the field of sociology and therefore any transformed expressions should be appropriate to that field. This is the first stage within the data analysis process when the researcher is expected to change the data without altering its meaning. Put simply it involves re-expressing the data using disciplinary language whilst being dedicated to what each participant actually said. This involves retaining the context within which the experience occurred. De Castro (2003: 53) contends:

> This stage is not completed through abstract thinking, but by going through the concrete expressions and language that the [research participant] is describing in order to re-describe the meaning.

The transformation of meaning units also involves imaginative variation. This is a process of mental experimentation that is used to help reveal what is essential about a phenomenon. Moustakas (1994: 97–98) explained:

> The task of Imaginative Variation is to seek possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions [...] Describing the essential structures of a phenomenon […] In this there is a free play of fancy; any perspective is a possibility and is permitted to enter into consciousness.

Practically this is about removing and/or rephrasing the meaning unit whilst making sure that the underlying message of the description is maintained. This is a process that is thought to be helpful in defining what is meaningful and essential about a phenomenon. It involves taking a

phenomenon and mentally removing different features of it to see whether this alters its essential character. If the phenomenon appears to be radically different after a feature is removed then the feature is deemed to be essential. If the removal of a feature results in the phenomena still being recognisable it is likely that the feature is a contingent part. Turley *et al.* (2016) argue that Husserl used free imaginative variation to reveal the essences of an experience, as only features that are invariant to the experience should be viewed as part of the phenomenon.

Giorgi (2009) explains that, by the end of this stage, each meaning unit should be systematically interrogated for whatever it exposes about the study focus pertaining to a concrete situation for each participant. Giorgi also suggests that, by using imaginative variation, the data becomes more general. This is because similar terms are used and this helps at a later stage when the data from other participants needs to be integrated. The example provided in Table 3 shows how the text has been reduced but the core message related to the pathway to care maintained. The illustration shows how the opportunity for P10 to participate in a social activity based on a friend's recommendation became the catalyst for her to receive care which she had not anticipated.

Table 3 Transformed meaning units

Meaning unit	Transformed meaning unit
AS: Two themes, one is helping seeking which is looking at the journey into services and the other is receipt of support, so looking at whilst you are in support. In terms of the first area, can you talk me through how you come to access support at [support organisation]? P10: Erm, I was [studying] at the time. A friend told me that, her friend needed dancers. So this is just before, this [was a few years ago]. Yeah, and I thought oh yeah, I'd like to dance. I haven't danced in a long time, and then, er, her friend got in contact with me, and then I came to one of the sessions, which was	P10 states that she accessed [organisation] for social activity based on a friend's recommendation. P10 was unaware that in addition to dancing the organisation focused on improving a person's mental health.

[ORG NAME]. I didn't know what it was about then. Erm yeah, so I came to the first session, erm, and at the time they were looking for people to do a dance in a play called Broken. Erm and, they kind of explained what we had to do so, we were gonna dance. I just thought we were gonna come and dance, but I didn't know the other side of it which was dealing with your whole issues. So, erm, for me it, it was quite interesting because obviously it wasn't what I expected, and then once I had, I arrived I was look 'Ok, I'm here now so let's just see how this turns out in the end'. Erm so yeah that's how I accessed it. it's not really a great explanation, but literally a friend invited me to come and dance. I thought why	

not, erm, I'm gonna be leaving uni it's something for me to do and I came to the first session.	

The individual structure of experience and search for invariant meaning

Still working with the same transcript, the next stage of data analysis involves combining the transformed meaning units to produce a specific statement. An example of participant 13's unified statement is provided (appendix 2). To carry out this task it was necessary again to use imaginative variation to decide which meaning units are necessary to describe the overall experience. As Giorgi (2012: 199) described:

> The researcher once again has to use imaginative variation in order to try to determine the most invariant constituents of the experience. An important criterion in this process is whether the structure would collapse if a potential constituent were removed.

The approach that is advocated by Giorgi (2009) suggests that the participant's final description will not necessarily be as rich as the lifeworld description. The reason for this

is due to the disciplinary language structure being more limited than the lifeworld description. However, a deep understanding of the reality of the phenomenon should be gained from the description. Once the first statement has been produced the process is then repeated for the next transcript. A specific statement was produced for each participant varying in length, from 200-600 words.

Explicating the phenomenon holistically and dialectically

The penultimate stage of phenomenological analysis involves being able to provide a textual description that describes the phenomenon for one or more people (Creswell, 2007; Moustakas, 2004). The aim is to produce a statement that conveys the common conditions of the phenomenon, including situations and context, to describe the essence of the experience. This is encapsulated by Wertz (2011: 133) who stated:

> The researcher then reflects on the person's intentionality with respect to their situation, holistically explicating the organization of constituent processes and meanings, including the person's embodied selfhood, emotionality, agency, social relations, and temporality [...] When conducted methodically, this approach is characterized by meticulous and thorough

description that achieves fidelity to psychological life.

The production of the final statement needs to acknowledge the complexity that is profoundly apparent in the lifeworld. It also needs to allow another reader to have a developed image about how the phenomenon is lived.

Giorgi's (2009) approach to constructing a final statement is the result of combining the essential parts of each of the specific statements. Whilst this stage was initially followed it became apparent that too much of the granularity of the participant's experiences would be lost by only detailing the areas that were consistently experienced. Moreover, the need to move to a higher level of abstraction in search for the essence made it challenging. For instance, should drama-therapy, CBT, and care provided by the Black voluntary sector (BVS), all just be detailed as mental healthcare? Additionally, should all factors pertaining to a person's identity (race, gender, age or mental health status) all just be abstractly summarised, as 'participants' identities were intrinsic in their experience?' Such abstract levels of thinking would be contrary to CRT and the need to pay attention to intersectional experiences (Brown, 2003). Giorgi (2009) does suggest that, if it is not possible to produce a general statement, then two or more general statements should be developed. It was unclear how many general statements would need to be produced when trying to balance the nuances of participants' experiences

and the requirement to illustrate the essence(s). Therefore, another approach was selected for the final stage of analysis to offer an enhanced view of the lived experience, whilst respecting the phenomenological method.

To achieve this, an approach used by Koivisto *et al.* (2002) was employed. They used qualitative statistical software to provide synthesised accounts that adhere well to Giorgi's approach without losing sight of the finer details of the data, including themes that are not experienced by everyone. Therefore, they find the similarities that connect participants at a broader level but discuss the differences that exist within these similarities. This approach was followed using Nvivo and resulted in the general statement that is provided within the thesis conclusion. Again, this stage involved using imaginative variation to be able to identify factors that all participants experienced. In some instances, this involved losing the details within the descriptions as a higher level of abstraction was pursued in search of a general essence.

Integrating frames of reference

Finlay (2012) suggests that many phenomenological researchers incorporate frames of reference as a final stage in the research process. This can include the use of philosophical frames or other theories from the wider

literature. Different theoretical backgrounds can be integrated to enrich a point rather than importing a theory to find the real meaning. In other words, a theory should not be used to explain something that was not actually described. As such, the emphasis for phenomenologists is to remain descriptively grounded. This is further articulated by Finlay (2012: 193):

> This is not an exercise of inputting external theory to bear to explain or interpret experience as such a move would divert the researcher away from the phenomenological path of description.

This thesis integrated theoretical literature from the fields of sociology of race, medical sociology and CRT with a discussion of the main findings in chapters five to eight.

Ethical considerations

Ethical approval was received from the School of Sociology and Social Policy, University of Nottingham, in February 2017. This detailed the standardised procedures that would be followed involving handling personal information in a secure and confidential manner and ensuring no harm was caused to participants during fieldwork. These procedures were developed based on the University of Nottingham ethical guidelines (UoN, 2013). Ethical guidelines produced by the British Sociological Association

(BSA, 2002), British Psychological Society (BPS, 2010), British Educational Research Association (BERA, 2011) and British Society for Criminology (BSC, 2015) were also consulted, relating in particular to informed consent and research involving people with heightened vulnerability. Informed consent was a necessity and mental health professionals at resident organisations offered a gatekeeper role in deciding which participants would be able to participate. BERA (2011) ethical guidelines state that vulnerability should not only be determined simply by the age of a person but based on whether or not an individual is more susceptible to coercion, pressure, emotional, psychological or physical humiliation. Whilst this is the situation, there are ethical considerations in all forms of human research (Bryman, 2004), and some people have heightened vulnerability. With this in mind, each type of social enquiry should take steps to mitigate the potential for harm (Bulmer, 1982). This was a particular consideration when interviewing young people who are experiencing mental ill-health. Please see appendices for the organisation information document (Appendix 3), participant information sheet (Appendix 4) and participant consent form (Appendix 5).

The Social Research Association (SRA) (2003) note that when designing a research project, thought should be given to its potential to cause harm. It has also been observed how dubious bargaining, deception and any form of exploitation are unacceptable (Silverman, 2006).

Murphy and Dingwall (2003) have argued that non-maleficence is vital to research. They contend that this involves participants being treated equally and fairly, given autonomy, and that research should take place without causing harm, and with the hope of beneficial results. It was therefore necessary to consider how this study was appropriate to people with mental health problems. A number of measures were taken, and plans adopted, to minimise the potential for harm. Factors related to legal capacity were not relevant as people who had been detained under the Mental Health Act 1983/2007 were not included. An agreement was reached with mental health professionals if a participant became upset. This meant the interview would be stopped. If the participant remained upset after a small break it was agreed a discussion would take place with the mental health professional and the participant about whether the interview should be terminated. These factors were relayed to the participant organisations via the organisational information sheet. In addition, participants were advised that should they feel upset at any time after the interview that the mental health professional should be contacted.

A policy for working alone was developed, which involved the researcher informing his brother of his whereabouts and that he was safe. It was agreed that travel would be on public and personal transport.

It is well recognised that ethical considerations are not static (Willig and Stainton, 2008). The procedures for recruiting participants and the ethical dilemmas that emerged during fieldwork have already been highlighted in this chapter. In line with the consent form (appendix 5), participants were advised of their rights, including the opportunity to withdraw at any point. Ongoing guidance was provided by the researcher's supervisory team when any ethical dilemmas occurred. In particular, this was relevant to the ethical considerations discussed earlier under participant recruitment. Furthermore, steps were taken to make sure that information was not shared with the wider public or other participants about the personal lives of the participants, thus ensuring confidentiality. Additionally, all information that could be used to identify the participants was removed for purposes of anonymity through the use of participant anonymisation.

All participants received a £20 voucher from a retailer of their choice for their participation in an interview. Participant payments are often used to incentivise people to partake in research whilst they have also been criticised for increasing the likelihood of harm (Cleary *et al*., 2008) or because they can be seen to influence the power dynamic between the participant and researcher (Dikert and Grady, 1999). Although these concerns were recognised, it was necessary to facilitate participation where otherwise it may not be financially possible, as recognised by the National Children's Bureau (2011).

Therefore, this token gesture was thought of as a good will offer for their participation and possible inconvenience. Guidance produced by the National Institute for Health Research (Involve, 2012) was consulted when deciding how much to provide to participants. This recommended an amount of £10 per hour. Given the participants would need to travel to the location, which is time consuming, and to take partake in an interview, a £20 voucher plus travel expenses was offered.

Personal reflections on the descriptive phenomenological method

As this section is a personal reflection it breaks with the convention of the rest of the thesis and is written in the first person. The remainder of this chapter (excluding conclusion) reflects on the limitations and strengths of the descriptive phenomenological method.

In this part of the chapter, I reflect on two broad aspects of the phenomenological method: the epoché and the need to focus on the elicitation of descriptive accounts. Each of these features brought with them different challenges, most of which only became evident as the research process unfolded. I now turn to discuss these matters.

The epoché: being open to new learning

One of the main challenges I encountered with Giorgi's (2009) version of the descriptive phenomenological method was the emphasis on epoché, particularly during data collection phase. Merriam (2009) has argued that it is inevitable that the researcher will have some influence on data collection. This is recognised within phenomenological research as the subject/object binary is rejected (Willig, 2007). Whilst this project was based on natural science methods it was accepted its roots lay in social constructionism. An investigation of this nature contends that meaning is implicated through the articulation of the research framework. I took the decision to minimise my influence in the field and to be completely open to new learning by putting to one side my pre-conceptions about how things were. As Giorgi notes, when conducting interviews, the researcher should engage the phenomenological attitude and hold in suspense 'whatever object or state of affairs' were present to him (Giorgi 2012: 4). This was an exercise that I attempted.

I had mixed experiences when attempting the epoché. In some ways, the opportunity to suspend what was known to me and trying to understand what it would be like to be in the shoes of the participant provided genuine insights. During the first interview the participant spoke about the anxiety she had speaking to her mother about her mental ill-health and also the fear she had attending care for the

first time. Whilst it was possible to acknowledge that Black people will have concerns about seeking support, the extent of anxiety is something that was new to me. This was an area I overlooked as I have never experienced mental ill-health nor have I feared accessing statutory healthcare support. I also embraced further areas of learning as a result of being open to new learning, including the immense sadness and upheaval brought to one individual as a result of homophobic bullying by his close friends.

A fundamental difficultly I had with epoché was staying in the phenomenological attitude whilst having a huge interest in this area of study. I often had to hold back the urge to engage in conversation about something a participant had mentioned. Whilst this made me self-aware of my assumptions (discussed in the next section) it also made the epoché challenging. Moreover, my aim was to show fidelity to epoché, but suspending my thoughts for 25 interviews that sometimes lasted over one hour was difficult. Part of this challenge was because I had to try and see everybody's experience as being fresh as if I had never heard it before. It was often when a participant would describe an experience similar to that offered by a previous participant that propelled me to think about these similarities and relate them to academic theory. It was then necessary for me to block these thoughts out. More often this was possible whilst at other times my mind wandered. Therefore, I agree with Polkinghorne (1989),

that in spite of serious attempts at epoché, personal involvement will always be implicated. The experience of carrying out this research shows that bias can be suspended, but this will only be by a matter of degree rather than something absolute.

The limitations of descriptive methods

A common challenge that I found with descriptive methods was the tendency for participants to offer their opinion or interpretation of events rather than a description of what took place. For example, some participants were vague, making remarks such as, 'I think this happened'. Giorgi (2009) notes how this can happen as people adopt their natural attitude. Nonetheless, I felt it was important to clarify if the experience was genuine. This involved asking the participants to take a moment to put themselves back in the time and place when it happened and talk through it. As I had to make this clarification on numerous occasions during some interviews it felt like I was questioning the validity of the participant's account. Whilst no participant expressed any unhappy emotions or uneasiness during the interviews these were considerations that occurred and were due to the search for descriptive accounts. They also had implications for me, as I felt uncomfortable needing to continuously probe for information that the participant had already provided.

A connecting challenge related to the ability of the participant to provide a description of their experience. Responsibility for deciding whether a participant was mentally well enough to be able take part in a lengthy one-to-one interview was entrusted to a mental health professional at the support organisation, followed by any concerns that may become apparent to me during the course of the interview. The consideration at the point of recruitment was focused on ensuring the participant was emotionally stable (*e.g*. that the questions would not evoke memories of past negative experiences) and that they had mental capacity. However, what was overlooked is whether the participant would be sufficiently relaxed and articulate to provide rich descriptions of their lived experience. This was also something that would require memory. During the interviews only two participants said they struggled to recall past events. Fortunately, they were still able to describe in detail their lived experience. The method felt awkward with one participant, who only offered short answers (one or two words). This made it difficult to obtain descriptions. Despite subtle attempts to encourage more lengthy responses there was no change in the length of response provided. A small number of interviews were also short (15-20 minutes). This could be due to the participant's unfamiliarity with the research process as noted by Jordan (2012). These are issues to be considered for any future use of descriptive methods and more generally they raise a concern about their suitability for research with young people.

Another consideration with the chosen approach is that it created a sense of feeling restricted from exploring other dimensions of the phenomena. At times, I felt like the method did not go far enough. Whilst a number of key findings were documented, a more interpretative endeavour — closer to the approach of Heidegger (1962) — could have revealed more. Interpretative phenomenology 'is concerned with how things appear as well as how they come to show themselves in just the way they show themselves to us' (Willig, 2007: 221). Using an interpretative approach would have allowed participants' wider experiences of life to be part of the investigation, whilst examining how they made sense of them within their broader experiences of life. The descriptive approach limited opportunities to probe. An example is provided in the following excerpt when a participant was asked to describe barriers to accessing a GP:

> I think the main one would've been my faith. I think, for me, my faith is central to me, and so, if I'm going to receive any form of counselling, I still want my faith to be involved in that. So I would say that's the main reason for me.

Using an interpretative approach to data collection could have provided further opportunities to explore participants' decision-making. For instance, it would have been possible to ask why help was sought in a Black church with a Black

mental health professional rather than help-seeking via the GP. From this, it can also be seen how an interpretative approach could have been more appropriate when used alongside CRT. Given that CRT states that racism is a part of everyday life yet has become normalised and unnoticeable, further investigation may be crucial to uncover how it operates. This did not feel possible when aiming for descriptive accounts. Thus, an interpretative approach could open doors to investigating pertinent features and provide a wider understanding of the phenomenon.

Another concern was the feeling that the intricacies of real-life were lost in the data analysis process. On the one hand, I got the feeling that the emphasis on acquiring descriptive accounts resulted in a lack of sensitivity to other forms of evidence. Giorgi's (2009) method assists with the integration of participants' accounts, but this was at the expense of losing their emotional tone and any physical expressions when sharing their story. At the same time, the emphasis on defining the phenomenon based on shared experience detracted from the idiosyncratic features that made each participant's account unique. Although Koivisto *et al.'s* (2002) adaption offered an improvement, it felt that the method pushes in the direction of ignoring themes that do not fit for the sake of the overall essence. As a result, it felt like much of the individuality was lost. It is likely this would occur with other methods due to the number of participants and the

need to generate themes. However, the risk with phenomenological methods is that experiences can be homogenised too easily. Thus, the aim towards integration is difficult to balance, and consequently individuality can be lost, resulting in analysis that is too descriptive.

The role of the researcher

Social research can never be value-free; it is therefore critical to reflect on the role of the researcher (Hammersley and Atkinson, 1995). Aspects of self-reflection are critical to illustrate how the researchers' assumptions and perspectives are part of the research process (Finlay and Gouch, 2003). Thus, being self-aware provides greater transparency about the knowledge offered by this thesis. Finlay and Gough (2003: xi) remarked on the importance of reflexivity to social research:

> In research terms [being reflexive] can be translated as thoughtful, self-aware analysis of the intersubjective dynamics between researcher and researched. Reflexivity requires critical self-reflection of the ways in which researchers' social background, assumptions, positionings and behaviour impact on the research process.

My social background had a major influence on the assumptions I brought to this thesis. One critical element

of this has been my period of employment in the non-statutory sector in the field of race equality since 2002. This involved delivering projects and developing policy in the area of mental health, criminal justice and education with a view to addressing racialised inequalities. Thus, race equality is an area in which I have a long-standing interest and one that I am passionate about. Corbin *et al.* (2009) have suggested that a researcher's positionality is informed by their identity or experience. I feel my own experience had two key influences on this research: it influenced the focus on racialisation and provided some insider status.

Taking the first of these influences, my experience of working in the field of race equality has no doubt sensitised me to processes of racialisation across different spheres of life. Meeting with many racialised minority people and hearing their stories of oppression, and meeting with policy-makers and practitioners who gave minimal attention or priority to addressing racialised inequality, led me to the conclusion that institutional racism is very much alive and kicking. Whilst CRT was the chosen frame of enquiry it also offered some insight into how I see the world as being structured. As a result of these views, descriptive phenomenological methods were selected. They are based on principles of natural scientific enquiry, which aim to reduce bias. Further, neutral questions were used in the interview framework. Each of

these steps were part of a serious attempt to minimise my influence on the research process.

My background in the non-statutory race equality sector also conferred some level of insider status. One participant mentioned my previous place of employment making it implicit he had searched my name. He went on to talk very openly of his opinions about systemic racism. As the participant was aware of my employment background this may have provided him a greater sense of security that he could be open. During this interaction I felt I was offered some insider status, which influenced the association I had with the participant. On another occasion, after reading through the participation information sheet and consent form I asked the participant if they needed anything clarified. The participant stated, 'It's ok, she (mental health professional) said you're alright.' I didn't know the said mental professional, however I did know the CEO who was aware of my work in the field. On this occasion I feel the gatekeeper provided a degree of insider status.

My positioning as a White, mentally healthy, heterosexual adult male also required critical self-reflection. It has been assumed that social identities facilitate insider status creating bonds and a shared understanding (Merriam *et al.,* 2001). However, I was familiar with examples to the contrary when, for instance, a Black video researcher was rejected from participating in a community project by a group of young Black males, because he was labelled as

being too posh. Thus, it is not always guaranteed that being Black and researching Black people will confer insider status, and as such, Allen (2004) states that each situation should be understood uniquely as they are socially constructed. There are also concerns that insider status can make researchers less objective as they are too close to the culture. Against this background I am aware that my interlocking and singular identities positioned me as an outsider. My intersectional identity as a White male afforded me a position of power and privilege that is likely to have informed each participant interview. Chavez (2008) has elaborated on the way research involving a researcher and participant of different racialised identities can create barriers. One of the initial concerns I had before entering the field was that participants might be unwilling to describe their experiences of feeling racialised to an outsider because due to the fear of a disagreeable response. Similarly, Del Busso (2007) has highlighted how gender dynamics are embedded in the research process and argued that methods should be employed to ensure women's voices are not subjugated. Therefore, my positions as a male and that of a White male, are likely to have influenced the interaction with female participants differently to that with male participants. I'm am also unclear how my position as a mentally healthy person influenced the interview setting. What is evident is there were a number of social identities I brought to the field, which always kept me in the outsider position.

Chapter conclusion

The objective of this chapter was to introduce, define and debate the chosen research strategy in light of the questions identified from the literature review. A position was adopted that knowledge is produced by analysing the meaning generated from social interaction, thus accepting a constructionist ontology and interpretivist epistemology.

It was a primary aim of this study to explore the experience of young Black people accessing and receiving non-statutory healthcare. Qualitative methods were selected as they are suited to the task of exploration. Given the desires to grasp the lived experience, minimise the influence of the researcher and to promote the voices of the oppressed, qualitative methods in the form of descriptive phenomenology were seen as appropriate. These methods were identified as overlapping with CRT's principles, particularly in relation to upholding racialised voices of authority. However, there was a tension identified between CRT and descriptive methods, and a more neutral approach to gathering data was pursued.

The sections on data collection and data analysis illustrated how phenomenological methods were applied and some of the challenges that emerged during these phases of the research. Data produced through fieldwork was analysed using an approach put forward by Giorgi (2012) and Koivisto *et al.* (2002) and the key themes that emerged

from the data were debated by engaging with the extant literature.

Various ethics-related issues emerged during the data collection and these were described in the relevant section of the research process and related particularly to the recruitment of participants due to different ways racialised identities were operationalised. A reflection on the use of the methods was also provided. Despite attempts to minimise the role of the researcher, it is accepted that within social research they will always be co-creators of knowledge. Therefore, a discussion of the researcher's role is documented and a reflection on his positionality. Each of these sections illustrated the researcher's own journey and the perspectives he brought as an insider or outsider. Finally, further and more commonplace ethical considerations were also presented.

The research findings are presented and critically analysed in the next four chapters. Chapter five looks at early experiences of the pathway to care by covering the initial stages of symptom experience and how these were typically viewed through the lens of challenging circumstances. Chapter six adds further evidence about the experience of accessing care, showing how the help-seeking journey typically involves many services contacts on the pathway to care. This chapter offers a novel contribution to knowledge as it develops our understanding about the way racialised thinking emerges and evolves.

Whilst chapter seven documents findings about the experience of accessing care in the first part of the chapter, the second half of the chapter focuses more specifically on explicating the experience of receiving non-statutory mental healthcare. This chapter has important findings as it shows how barriers to care for young Black people can be overcome. Chapter eight documents participants' present views on processes of racialisation and mental health provision, and how these have been shaped after being service-users. The final chapter returns to the overarching research questions and addresses it overtly.

Chapter 5 Social pressures and symptom experience on the pathway to care

This chapter focuses on the point in time when participants first started to experience symptoms of mental ill-health. It covers this area in two ways — by looking at how the study participants relate the onset of mental ill-health to life events, and by examining the early assessments they made in relation to these changes. The findings show that young Black people can strongly associate the onset of their mental health problems with challenging life events. The findings also show that the young Black participants in this study were able to identify changes in their mental health; however they sometimes found it difficult explaining and understanding what was happening. Some viewed their mental health changes as insignificant, and for others there was an under-recognition of mental ill-health, which participants described as being racialised.

Freidson (1988) suggested that illness behaviour embraces the varied ways individuals respond to changes in their normal functioning. For Mechanic (1995: 1209) illness behaviour denotes the multiple ways people 'respond to bodily indications, how they monitor internal states, define and interpret symptoms' and 'make attributions.' He goes onto argue that 'such behaviour is important because it shapes the recognition of illness' and 'the selection of patients into care.' The findings in this chapter expand

knowledge in this area by looking specifically at the early stages of illness behaviour among young Black people. Participants' stories show that testing life events and chronic stressors typify the way young Black people conceptualise their journey to becoming mentally unwell. The findings also challenge commonly-held beliefs about symptom experience, by showing that Black people are able to identify negative changes in their mental health. However, various social phenomena interact with how symptoms of mental ill-health are perceived, which influences help-seeking. Overall, this chapter highlights significant factors in the onset of mental ill-health, which advances understanding in this area. Covering these areas sheds light on the study's research question, looking at the pathway to care for young Black people, which is crucial for wider health promotion.

Participants talked through their experience of accessing care at the organisation where they were presently a service-user. From this a number of issues that draw on their initial experiences of mental ill-health are identified. It was apparent that participants make sense of their experience in distinctive ways. This involves a strong connection between social pressures and mental health challenges. Participants described their thought process when first experiencing symptoms of mental ill-health and their dilemmas trying to understand them. Therefore, this chapter will concentrate on the importance of social

pressures and symptom experience, and the relationship between each.

To meet this end, the first part of the chapter examines the nature and extent of social pressures; they were described frequently and can be seen as fundamental to the pathway to care. Sections looking at pressures within education and multiple complex circumstances, and the way processes of racialisation interrelate with these phenomena, are presented. Looking at social pressures is also necessary as they interact with symptom experience and in-turn influence help-seeking decisions (Brown *et al.,* 2011; Sisley *et al.,* 2009). Symptom experience stage is looked at in detail in the second part of the chapter. Covering this area provides insight into participants' early interpretations of mental ill-health—their ability to recognise symptoms, their challenges explaining them, and seeing them as insignificant—and how these operate as a barrier to help-seeking. Processes of racialisation are also discussed as a factor in the early stages of illness behaviour.

Social pressures on the pathway to care

During data analysis an overall pattern emerged that linked mental ill-health with challenging life events and circumstances. These difficulties were memorable and prominent features that reoccurred in participants' descriptions, which they connected to their mental health.

It also has implications when framing the findings within the first stage of Suchman's (1965) illness behaviour model, as they demonstrate that symptoms can be related and filtered through the experience of life events. Importantly, a perspective is adopted that sees social context, rather than only biological or genetically determined explanations, as being relevant to mental ill-health.

Social pressures in the learning environment

The findings show that factors operating within different educational settings present challenges for young Black people, which they relate to their experiences of mental ill-health. Bullying and racialised divisions were identified as particularly salient. Processes of racialisation were also evident in the way participants felt the need to group together with people of the same racialised identity to feel safe, and how they felt compelled to achieve well academically. Many of these findings resonate with the literature. Links have been made between bullying and mental ill-health (Scott *et al.,* 2014) and stressful life events more broadly (Pilgrim and Rogers, 2014). Meanwhile, arguments have been made that higher ethnic density can be a protective factor to social adversity (Becares and Nazroo, 2013). The findings discussed are crucial to understanding the way young Black people relate challenging circumstances to their mental health.

Participants frequently referred to pressures within an educational setting (school, college or university). Bullying was described as pivotal; and a factor that in some instances had long-term effects. Ralph recounts his story of bullying, moving school and experiencing ongoing trauma:

> **Ralph**: They used to bully me. They used to beat me up. It weren't only physical, it was more emotional, and erm, and socially as well … I would get changed for PE and they would steal my PE clothes, so I would have to go to the lost property and come out with a shirt too small for me. Like, I'm a large man, it's gonna be tight on me. Right, so I go out there, look like really fat and stuff, and everyone will laugh at me … Even when they took me out that school and put me in a different school the trauma was still there. So, I still used to have panic attacks … It got to a point in public school where I was constantly looking around to see who's gonna come and beat me up next.

Ralph believed he was bullied because he was exceeding academic expectations which set him apart from other pupils. His response to the bullying was to fight back. Consequently, he was disciplined, and this resulted in Ralph feeling that he was constructed as a child with problems. The extent of the bullying eventually led to him

leaving the state school and he was educated in a private school a greater distance from his home. Despite this change in learning environment Ralph felt ongoing trauma including feelings of paranoia.

Several participants shared their accounts of being bullied in school and how they connected this to poor mental health. For example, Brian was tormented because of his physical appearance, whilst David was bullied because of his sexuality. In each of these cases the participants felt isolated as a result of hostility towards them.

Bullying was also racialised. Simon and Scott talked about their experiences of racial divisions among pupils. Their examples place further emphasis on the role of the educational environment and how it is linked to mental ill-health. Simon narrated his experience of being racialised during his time in secondary school. He felt ostracised and related the bullying to a deterioration in his mental health that impacted his ability to communicate with his peers.

> **Simon**: Well in secondary school I was getting bullied … I started to feel depressed from there as well, because, I was, do you know the only Black boy in my year and I felt, it felt like I was just an easier target for everybody else. So, going through secondary school I was literally by myself, so I started to feel depressed from then … because I was the,

> literally, the only Black boy and I didn't really feel like I connected with anybody else. So, because I didn't talk to anybody I felt like, when I was in secondary school, I didn't really know how to talk to people. So, the effect on me when I was in secondary school, I mean in college, I had people that I had connections with … but I just really didn't have conversation with them.

This account illustrates the salience of race in Simon's school life that made him feel isolated. It also highlights the longer-term effects as these encounters limited his social interaction. Further, Simon described how racial boundaries set him apart from his peers and led directly to feelings of depression. From this example, processes of racialisation are viewed as being directly implicated in the onset of mental health problems. Therefore, whilst the experience of social pressures was an overall finding that participants felt played a significant role in their mental health deterioration, the feeling of being racialised, as in Simon's example, was a major sub-theme.

Racial divisions within the educational setting coerced participants to associate with people of the same racialised identity as themselves. In accordance with Tatum (1997) these accounts subscribe to the idea that racialised minority people group together, especially during adolescent years, as a strategy to respond to and cope

with the social pressures of racism. This was not possible for some as they felt entirely isolated within the school environment; as Simon notes, he was the 'only Black boy in his year.' Nonetheless, the majority of examples strengthen the position put forward by Becares and Nazroo (2013), that in some situations, increased levels of ethnic density can offer a buffering effect to racial stressors. The data shows that there can be protective benefits to being in an environment with people of the same racialised identity, as it can mitigate stressors such as racism.

Another instance that shows how elements of racialisation are layered within the experience of social pressures in education was shared by Syd:

> **Syd**: So, erm, I was feeling ill during last summer and it was around the time I was awaiting my A-level results. … The symptoms didn't really make sense in terms of, they would come and go during the day, I was, physically I would feel fine and then, as soon as I would think about my results I would get worried.

Syd spoke about the pressure to achieve good academic grades. When talking about his journey through services, Syd offered insight into the way he felt his anxiety stemmed from educational pressures that were racialised. He felt he had expectations to do well in school, which he

believed were requirements for young people who identified, like him, as Ethiopian. Whilst the literature acknowledges that racialised minority groups feel they are subject to higher academic parental expectations (Naumann, *et al.,* 2012), the findings from this study are important as they show that young Black people experience these pressures and construct them as a factor that contributes to mental ill-health.

Multiple complex circumstances

Whilst the section above highlights the pressures participants felt specifically within different educational settings, in most instances, participants experienced multiple challenges concurrently. The findings suggest that exposure to a number of difficult life events result in changes in the normal functioning of young Black people. The idea that exposure to stressful circumstances can impact a person's mental health is well documented and illustrated through various social stress models (Wheaton and Montanzer, 2010). The basic foundation of such models is that people can experience stress when they come across a situation whereby their typical method of responding is not sufficient, and the outcome of not adapting can be viewed as serious. For Cockerham (2017: 99) this brings about 'a circumstance in which there is a gap between environmental demands and a person's capability to respond — possibly leading to a mental

breakdown.' Participants' accounts add to this field of study, whilst documenting some of the specific challenges for young Black people. These are now turned to.

A wide range of circumstances impacted participants. For Dean, it was the loss of his grandfather and breaking up with his partner. Simon lost his job, his friend committed suicide and he contracted a skin infection. A further example was provided by Steph:

> **Steph**: My uncle came back out of nowhere and he moved in for a while so kind of put a strain on the house. … He came to us with his girlfriend … that was like another person like to worry about … It was affecting my mum, I think that made it worse because I saw that she was trying to deal with everything and she wasn't paying much attention to the rest of, like me and my other sisters. … I'm quite a picky eater … around that time a lot of people would comment how skinny I was. … I was trying to make new friends, I felt like I had to kind of lie about what I was doing, and so people would stop asking me questions about my eating habits and everything. … And then there was my big sister. She was going through a lot of problems with her mental health so she would take it out on me. … My big sister was quite physical on me in how she

> dealt with her emotions. It got worse and then my anxiety came in. … I couldn't sleep for a while. I'd always dream of death and everything. I had like panic attacks about death before I went to bed so I couldn't get to sleep.

The story shared by Steph demonstrates the combination of pressures that she had to contend with in her home environment. This included living in overcrowded premises where she no longer had personal space. At the same time, she felt an unwanted and overbearing attention on her eating habits. There was also the challenge that Steph described as a result of her sibling being physical with her as she too had mental health problems. Steph spoke about how these difficulties accumulated and she often resisted sharing them with her mum because she did not feel the problems could be solved. This account vividly highlights the multiple and complex challenges that Steph had in her life whilst there was also a sense that she felt trapped as there was no outlet for her concerns. It is evident in Steph's story that she related her experience of sleeplessness, anxiety and suicidal thoughts, to her stressful life circumstances. This was a pattern that was replicated in other descriptions. Carlene recounted a range of social pressures that she had to manage. She alluded to the challenge of growing up within a home environment where she encountered anger, financial difficulties whilst her father was also absent. Consequently, Carlene

assumed a significant amount of responsibility as she was the main carer for her mother, and she felt coerced into making a decision that led to her mum being detained under the Mental Health Act. Following this Carlene experienced an emotional breakdown. Cree (2003) identified similar findings among carers who had significant worries and poor wellbeing more so than young people more generally. Several other participants, including Carlene, spoke about the experience of growing up economically deprived. Tausig *et al*. (2004) alluded to the connection between socioeconomic status and mental ill-health. The accounts here give a young Black person's perspective on this.

Brian talked about the pressure of providing for his young family:

> **Brian**: As a family we had some homeless issues, crazy landlords and then I was like, how am I even being a provider when I'm signing on and stuff like that? I've been fortunate because my children have never gone to bed hungry kind of thing. But you know there have been times when we have had no money, do you know what I mean, none at all … If I had ideas of what a man is, do you know what I mean … when I looked in the mirror, I didn't see them ideas.

Whilst acknowledging his financial difficulties, Brian drew attention to fear that he would not be able to provide for his young family. This illustrates the dilemmas young people face as parents. Brian recounts how he felt he was not a good father, which was a life stressor that contributed to his mental ill-health. Thus, there is a gendered angle to social expectations that emanated from this. Brian shows the challenges that arise when attempting to understand a man's experience. These struggles are replicated in the work of Robinson *et al*. (2011) when they suggest that hegemonic masculinity exerts immense pressures on Black men to conform by not displaying signs of weakness or dependency. In this research, Brian confronted the challenge of maintaining a masculine identity of being an adequate father, which brought about a 'pain of belonging and not belonging' (Frosh *et al*., 2002: 174) as he questioned his contribution and existence.

Brian's description accentuates the reality of stressful life events and the presence of enduring, challenging circumstances. Wheaton and Montanzer (2010: 175) talk about these conditions as being chronic stressors, that 'develop slowly and insidiously' as a result of continuing and problematic conditions in our social environments or role[s].' This is similar to research that considers the social determinants of mental ill-health. Whilst it is important to recognise the strong association between lower socioeconomic status and higher rates of mental ill-health

(Tausig *et al*., 2004) and the overrepresentation of Black people who experience inequality and social exclusion (Nazroo, 1998), the descriptions of participants and their experiences were not always one-dimensional. Descriptions drew on structural conditions and stressful life events, and it was often a combination of these that limited their ability to cope. This is an area developed by Menaghan (2009) when she emphasises the importance of a wide range of family circumstances which may reduce life chances. Menaghan refers to the way a combination of family linked factors, both structural and stress event-based, can have a disadvantageous influence on a young person's mental health. Part of Menaghan's thesis argues that structural factors also play a vital role in whether people are able to receive support from within their social network. Therefore, the literature base supports many of the findings from this research, which highlight the significance of structural conditions and stressful life events in the experiences of young Black people. An important finding from this research is the way these theoretical debates become real for young Black people in England. Whilst much of the literature is of a statistical nature, the experiences documented here offer some granularity to ways early experiences of mental ill-health are understood through a connection to multiple adverse life events.

Societal racism

Societal racism is the idea that racism is embedded in the attitudes and decision-making of social institutions, structures and social relations, which causes detriment to racialised minority people. It was identified as a feature of the multiple and complex social stresses in this research that contribute to young Black people's poor mental health. These findings help to build on the growing body of literature that draws a connection between societal racism and negative mental health outcomes (Wallace *et al*., 2016). They also mirror international research, which highlight the negative effect that racism can have specifically on the mental health of young racialised people (Paradies *et al.,* 2015). This generates a better understanding about the way racialised events are internalised and can manifest in the way a person views their life chances. Therefore, the findings in this study offer a new insight into the lived experience of young Black people and how they connect societal racism to their mental health. Indeed, in some instances, these challenges were viewed as being directly related to their need for mental health support.

Participants narrated the significance of racialised dynamics when out in public. This was the situation for Jason who described his thoughts about feeling isolated because he would be viewed as the only Black person in a

certain environment and how he associated this with intense emotional feelings:

> **Jason**: I feel like people are so close in the real world to jump out and do something to you because of a certain attribute you have, because, you know, you know, your skin colour or nationality or something like that.
>
> **Anthony**: How do you feel in them situations?
>
> **Jason**: Anxious, scared, just any, you know any bad feeling under the sun because you don't know what's going to happen

This example illuminates the way processes of racialisation are experienced as stressful life events. Davis and Stevenson (2006: 293) documented similar findings when they noted how 'racial socialisation experiences add significantly more predictability of depression symptoms over and above gender, neighbourhood risk and resources.' Indeed, this study's findings draw on the salience of race in young people's lives and how race and racism are very much recognisable. CRT advocates have often argued that racism is so embedded within the fabric of society that it is difficult to identify (Hylton, 2009; Gilborn, 2006). For young people in this study racism has been viewed as a central component and a tangible dynamic. In line with CRT, participants articulated the way

race and racism became a normal part of their thinking. As such, this is reminiscent of the work of Masko (2005: 329) who concludes that for some, 'thinking about racial issues is part of life. It is as ordinary as breathing.' This was the situation for some of the participants in this study as they experienced racism as a normal feature of their day-to-day existence.

The extent to which participants felt racism touched their lives varied from direct examples cited by Jason, to the structural, which is emphasised by Brian:

> **Brian**: You know people will say as a Black man you know racism is your biggest issue that you face, but when you live in an area where there's a lot of Black people racism's not really, ya know, if ya, if ya, shopkeepers are Indian, your neighbours are all Black, ya know, I'm from Brixton, do know what I mean. This is Brixton in the '90s, and the '80s and the '90s, ya know what I mean. Not Brixton now. What is racism really, ya know what I mean, it doesn't really exist. On, on the wider scale it exists, but not in my local area.

Brian talks about people in his social circle advising him to prepare to face life challenges because of his identity as a Black man. This draws attention to the way young Black people grow up and the information they are exposed to

which can influence their perceptions. Whilst Brian acknowledges that racism operates at some broader level, he contends that there is some kind of buffering effect when living in an area with a sizeable population of racialised minority people. This lends further support to Becares and Nazroo's (2013) hypothesis, as the findings suggest that young Black people feel there are some protective elements against racial stressors as a result of higher ethnic minority density.

Brian and Jason's experiences point towards a tension in the data. Brian did not feel racism directly affected him, yet he described the significance of spatial and temporal factors in which racism manifests itself. For Jason, and other participants, processes of racialisation were more profound. On the one hand, Jason described situations where he was vividly aware of being mistreated due to his Black identity. In this sense he acknowledges how he feels part of an essentialised Black community. However, at the same time, his story stresses the importance of recognising the flexibility of racialised identities as he does not always feel fully part of that community as he did not feel accepted due to his mixed-race identity.

Several of the findings in this chapter draw on the essentialist and ant-essentialism debate within CRT. On the one hand, participants' accounts of the experience of being racialised and having a shared experience or acknowledgement of the oppression faced by Black people

are reminiscent of an essentialist perspective offered by Ikemoto (2013). This viewpoint can also be seen when Syd shares the view that there are specific education parental expectations placed upon Black people. He felt increased educational pressures placed on children was an essentialist feature of racialised minority families. At the same time, Brian's experience stresses the importance of recognising multiple experiences of race and racism that draw attention more specifically to an anti-essentialist position. Nonetheless, he recognises that racism takes place out there somewhere.

Thus, whilst various dynamics influence the extent to which participants document where and how racism effects them, there was a distinct acknowledgment that racial oppression exists. This tension is best captured by the anti-anti-essentialist framework that has been offered by Gilroy (1993). In this way, there is a constant sense of Black-self that is varied in place and time, but it is linked to an acceptance that a person with this identity will experience racial oppression.

The idiosyncratic nature of symptom experience on the pathway to care

Symptom experience is the overarching theme looked at in the second part of this chapter, which forms the first stage of Suchman's (1965) illness behaviour model. The findings show the complex situation presented to individuals when

they become unwell in trying to comprehend the changes they experience. They reflect the work of Kleinman and Benson (2006), pointing to the different interpretations of mental ill-health, and that relating to the position of Freidson (1988: 278) discussed in chapter three and the importance of illness behaviour. It is further highlighted by Bhugra, Lippett and Cole (1999: 29) who state that:

> Illness, response of individuals, their carers and society at large and the social institutions relating to them are interconnected. Health care systems include patterns of beliefs about the causes of illness, norms governing choice and evaluation of treatment, socially legitimised statuses, roles, power relationships and institutions.

When discussing their pathway to care research participants spoke about their experience of realising a change in their mental health or physiological functioning which they associated with their mental health difficulties. This was a theme only discussed by a small number of participants. Nevertheless, by looking at these findings it helps to provide insight into the initial stages of illness behaviour, which also draws upon lay understandings of mental ill-health.

This presents a picture about how young Black people conceptualise mental ill-health, which is important for

policy around help-seeking. It also expands knowledge by showing that young Black do recognise changes in their mental health, how they respond to these changes, but also the confusion mental ill-health engenders. Emerging themes offer insight into some of the barriers to care that had to be overcome.

Recognising changes in mental health

Participants were able to recognise they had experienced changes in their normal functioning. Although they did not always attribute these changes to a period of mental ill-health they were aware that something had altered. Extant literature indicates that the way in which symptoms are experienced can be influenced by racialised differences often due to the assumption that there are varying explanatory frameworks about what constitutes mental ill-health (Morgan *et al*., 2009; Johns, 2002; Ndetei and Vadher, 1984). Further studies have suggested that Black groups have a higher threshold of pain (Thomas and Rose, 1991), whilst Menom (2016) and Arday (2018) have argued that Black groups do not recognise symptoms of mental ill-health. Thus, this study argues that there are different features to illness recognition that must be understood more carefully.

Participants talked about their early experiences of realising something different in the way they were able to

function. It is important to examine these findings as they provide insight into factors pertaining to illness behaviour as this relates to the early stages of the pathway to care. Elements of symptom experience were highlighted when Brian recounted how he first felt something was different for him at primary school age. Other participants were also able to recall early experiences of change. These cases illustrate that Black people recognise possible signs of mental ill-health. It also shows how mental health problems are thought to have their onset during childhood. For Brian, he did not necessarily see his changes as something that could be considered unwell when he believed that he was hearing voices. Brian says:

> **Brian**: The very first time I felt, it wasn't that I felt unwell. I honestly believe, at 11, at 11 years old I heard voices, do you know what I mean. I heard something. I heard someone saying something, it was the alphabet, over and over. I could hear it. I turned off my TV. I could still hear it. And, erm, it was in my head. And I ran around the room looking for a radio or, you know, but I wasn't. When everything was off in my room I went to my mum and said, look, I can hear something. When I went to her they stop. When I went to her, she erm, she just said, look, stop being stupid kind of thing.

When Brian thought that he heard voices he searched his room as he was convinced there was a sound being made by someone or something. From his account he described a situation where he was unable to control the noises he heard. There was a sense of panic and urgency as he described running around the room turning off electrical appliances in the hope this would cancel out the noises. Part of Brian's response also involved approaching his mother for support. When he did this his mother dismissed his concerns and implied that Brian was being foolish. Brian's example demonstrates how Black people can be aware of changes in the way they usually function, but they struggle to conceptualise what it is they are experiencing. Therefore, Brian's response to this experience was one that showed he realised an aberration in the way he functioned that was not matched by his mum's response. It is not possible to know from his mum's response whether she thought that Brian's experiences were something that should be taken seriously or if it is a behaviour that should be expected as normal and insignificant. This is not necessarily a negative response, but it is a form of inaction which is a possible barrier to understanding whether Brian was experiencing mental ill-health. At the same time, it is recognised that 'different cultures vary in their perceptions of mental illness' (Bhugra and Bhui, 1997: 103). Such factors influence how symptoms are responded to. Brian's story provides a possible example of this.

Jason also recognised from an early age that he was behaving differently. From the age of seven, Jason felt like he was unable to interact with his peers in the way he would like to. Consequently, Jason recalled adopting tactics aimed at seeking attention, which he later realised were not successful. In itself, Jason felt that his circumstances were challenging because, not only did he have difficulty communicating, this was compounded by feelings of isolation as he had limited opportunities to socialise. Evidently, from a young age Jason was able to identify that he was experiencing mental health challenges. Once again, this emphasises how young Black people are able to recognise probable symptoms of mental ill-health. This is further highlighted by Tiana's story:

> **Tianna**: I became aware of what was going on with me. I realised I actually had a lot of un-dealt with emotions. I was able to label them through reading online, Psychology Today, but I wasn't able to find resolution for them. I wasn't able to find a way to resolve them … Erm I just think I started looking for it myself because I started being a bit more aware of myself, you know when you get old and you become [a] bit more aware. I had a temper. I was quite hot-headed. I would just fight with people. I just had no rationale and I knew it wasn't normal. And, and, as much as, those times, it was you know, it was recognised, 'You

> know she's not afraid of anyone', it was also dangerous because I didn't care who I was fighting with. I didn't care what they were capable of doing, I just had to express myself and I just knew that is not something that is good.

It was following a time of reflection when Tianna thought about her own behaviour and emotions that made her realise she needed support. She viewed her action as being socially unacceptable. In Tianna's example she describes circumstances when she was involved in displays of anger and also caught up in violent altercations. She felt unable to express herself or to appropriately channel her emotions, which contributed to her violent actions. Whilst she recognised that her behaviour was abnormal, and that people within her social network observed that she was fearless, it was her own development that led her to question her behaviour. As Tianna matured, she started to look for answers to why she behaved the way she did through online searches.

Like Tianna, many participants described the time when they first experienced a change in the way they would normally control their emotions and how they had a conscious understanding that something had altered. For these young people, this meant that they realised they had lost full control of the way they would normally function. For some of the participants they realised during primary

school they were behaving in a way they thought was socially unacceptable. Although this may appear to be an obvious finding it contrasts with studies which have suggested that racialised people have an inability to recognise symptoms of mental illness (Arday, 2018; Menom, 2016). Therefore, any notion that young Black people cannot recognise that they are experiencing mental ill-health is oversimplified. What is evident from this study is that young Black people do recognise they are experiencing some degree of transformation, but which they do not always attribute to mental ill-health. Again, whilst previous research has suggested that cultural differences can influence the way symptoms of mental ill-health are perceived (Grey *et al.,* 2013; Bhui *et al.,* 2003), findings from this study suggest that they are not always masked by any cultural difference that may render them normal.

Viewing personal mental health challenges as insignificant

One of the findings from this study highlighted that participants can identify change that is negatively affecting them, yet they did not seek support because of a perception that their challenges were not serious. This is interesting, as research by Brown *et al.* (2011) has identified that Black groups view depression to have less serious consequences than White British people. The extent to which participants viewed their struggles as not

needing medical attention is another finding that can be viewed as a barrier that young Black people need to overcome to access support.

This was the situation for Steph who described being anxious when she started sixth form education. She described increased levels of anxiety that would spiral into suicidal thoughts and feelings of hopelessness. Her sleeping pattern was also affected as she struggled to sleep. With the support of her mum, Steph decided to attend her GP. She had the following thoughts before she made that decision:

> **Steph**: I guess I would say it was very like, I couldn't escape from myself. I felt quite trapped, and given my anxiety I felt if, if I didn't fit a certain box … I know people who have been through similar mental health problems, and because I wasn't like them I thought I wouldn't get support, but I knew that how I was feeling wasn't right.

Again, it is highlighted here that young Black people can be aware they are not feeling the way they would expect. This was identified by Steph and also observed by people within her social circle. Whilst Steph described a sense of being uneasy and contained within herself, she nevertheless felt that her problems needed to be categorised and bear resemblance to her friends in order

for her needs to be worthy of support. Thus, how Steph conceptualised the symptoms she experienced influenced her help-seeking. The combination of this and the way she perceived her friends' difficulties made Steph hesitant to initially seek support.

The same hesitancy was evident in the descriptions of other participants, albeit for different reasons. Pippa, Syd and Simon thought that they needed to just manage their situations when they were feeling down. For Simon, he had experienced bullying and the loss of his friend. Despite feeling low he didn't relate his problems to being clinically depressed as he thought this was too serious a disorder to reflect his circumstances. He also believed that he was 'too big' to have depression and that he could just overcome the feelings he had. This was similar to Syd's experience as he felt that he just needed to 'man up' and 'get on with it.' Sisley *et al*. (2009) identified similar patterns where Black adult women were found to be more likely to tolerate symptoms. She found that there is an expectation among Black women that they should be perceived as being strong and able to cope.

Connected to this is the literature that suggests that men tend to see symptoms of mental ill-health as something they can overcome, and this is often linked to masculine identities (Oliffe and Phillips, 2008). Whilst these ideas will directly impact help-seeking, they influence how mental ill-health is conceptualised when it is experienced. These

findings advance the literature in two directions. Firstly, evidence is offered to show generational similarities in the way symptoms are perceived among Black women who need to display signs of strength. Similarly, the masculine stereotypes described by Robinson *et al.* (2011) underpin the way young Black men in this study felt compelled to construct symptoms of mental ill-health as insignificant.

Whilst the young people did recognise that they were behaving differently there was a divergence in the way they interpreted these changes, which largely determined their help-seeking behaviour. In a number of situations participants did not associate the changes they experienced to an episode of mental ill-health. For these young people they did not frame what was occurring in their life as corresponding to mental ill-health, as the whole experience was something they had not previously dealt with. In other instances, the participants somatised their experiences, which means there was an under-recognition of mental ill-health that initially limited service access. Each of these findings mirror literature that identifies limited mental health literacy among young racialised people (Bristow *et al*., 2011). The findings presented here document how these patterns are also relevant to young Black people and why this could be important for health promotion.

Difficulties understanding and explaining new experiences

The research identified that young Black people can sometimes struggle to explain the mental health changes they are experiencing. Therefore, although a main finding shows that participants were able to recognise a change in their feelings, behaviour or attitude, they could not relate this to symptoms of mental ill-health. This is a position put forward by Dingwall (1976: 121) who states:

> Illness action is the outcome of continuing efforts on the part of the sick person, and those with whom he associates, to make sense of what is going on in light of the knowledge, resources and motivations available to them.

In light of this, decisions made by young Black people should be seen as a reflection of their interpretation of their level of understanding. Again, this has been shown to be associated with processes of racialisation. Research has highlighted that Black women are less likely than White British women to recognise symptoms of depression (Mantiovani *et al*., 2016), whilst mental health literacy has proven to be a barrier to help-seeking more generally (Rickwood *et al*., 2005). The findings presented here provide a better understanding of the way help-seeking can be prevented as a result of young Black people's awareness.

In Brian and Tianna's examples above it was evident they were aware of changes in the way they felt they would typically function; however, they were not always sure what was taking place and did not interpret it as mental ill-health. In many situations, they simply encountered changing sensations or emotions that they felt were unnatural. Several participants talked about their difficulty comprehending what was taking place and not being able to articulate this in a coherent way. For Rebecca, her ability to recognise what was taking place was affected because she was feeling low:

> **Rebecca**: Even though there was, erm, things that I was experiencing I didn't really, my [mind] wasn't concentrated enough to put it in a box where I thought actually this is depression. I could need a little bit of support from a counsellor.

Rebecca talked about recently being released from prison and how she struggled to motivate herself. This included times when she found it difficult getting off the couch because she felt there was little hope of improving her life. Whilst Rebecca had difficulties readjusting to life following incarceration, she described the state of her mind as being unable to concentrate sufficiently to be able to categorise the way she was feeling. Moreover, she did not have the knowledge and sense of awareness to understand what was happening with her mental health. Whilst Rebecca

described a set of circumstances within which she felt particularly down, it was not until her GP suggested that this could be depression that she associated her sad state of mind with her mental health.

On the one hand, Rebecca's experience indicates how challenging circumstances blurred her ability to see her symptoms as an episode of mental ill-health. Menom *et al*. (2016) found similar accounts among Black people indicating that an episode of mental ill-health can be constructed as a normal part of life which is masked by environmental and personal factors. This is not a finding specific only to people racialised as Black, as Brown (2012) has identified the same patterns elsewhere. However, at the same time, Rebecca's story suggests that young Black people will not always be conscious of symptoms of mental ill-health as their ability to comprehend and interpret what they are feeling is influenced by the negative effect of the symptoms. Limited mental health literacy has been presented one of the barriers to help-seeking (Rickwood*, et al.,* 2005). David's account further illustrates its importance:

> **David**: It's, erm, it was unfamiliar … I was going through depression, I didn't know that was depression, I just thought that I wasn't feeling well.

Whilst David's account might show a lack of mental health literacy, he and Simon described the lack of mental health awareness as being racialised. David described how he lived in a household where mental ill-health was not discussed, which he attributed to his Caribbean upbringing. He felt this influenced his ability to identify symptoms of mental ill-health due to a lack of awareness. Simon shares a similar account within which he constructs racialised identities as being part of the way mental health symptoms can be understood:

> **Simon:** With a Black person they don't really think of dep[ression], well parents really don't think about depression. For a Black person they just think it's like, a bad thing from like, if it's a Christian family for instance, they think it's just something sent from the devil, or something like that.

From this, processes of racialisation were viewed as interacting with levels of mental health literacy. Further examples that point towards a lack of mental health literacy are evident from Syd when experiencing breathing problems and sleeplessness. He knew these symptoms were unusual for him, but he did not relate this to mental health. Therefore, David and Syd both talked about the physical component of their feelings, yet they could not relate these sensations to anything they had felt before. As David, Syd and Rebecca were not familiar with the

symptoms they were experiencing they were not able to identify it as mental ill-health, which is essential for help-seeking. Jorm (2000: 396) remarked how knowledge about mental ill-health has been neglected, which leads him to suggest that 'if the public's mental health literacy is not improved … many people with common mental disorders …. may not receive appropriate support.' For a group of young people in this study their inability to recognise symptoms of mental ill-health proved to be a barrier on their pathway to care.

What is evident from the findings is the way lay understanding influences help-seeking. Similar findings have already been evidenced in the literature and there is strong evidence to suggest this can be significant in whether a person decides to seek help (Kleinman and Benson, 2006). It is also noted how various racialised groups make sense of mental ill-health differently, which then informs their response to symptoms (Morgan, 2006a; 2006b). Participants in this study displayed a variety of thoughts and actions. Hence, the findings point more towards dissimilar interpretations and behaviours rather than one of commonality. This is critically important for understanding illness recognition and the complexity encompassed at symptom experience stage.

In summarising, this chapter has focused on the point in time when participants first started to experience symptoms of mental ill-health. It has shown that the

young Black participants in this study frequently filter their experiences of mental ill-health through the lens of multiple, challenging and complex life events. The findings also offer evidence that shows some young Black participants are able to identify changes in their mental health. Nevertheless, barriers to help-seeking were identified — symptoms of mental ill-health were overlooked; they were viewed as insignificant and there were challenges understanding and interpreting the mental health changes that were taking place.

Conclusion

This study has provided insight into the thoughts and feelings of young Black people in the way they interpret life events and structural conditions. Without specific prompts that aimed to elucidate data around social pressures, the research participants described the significance of challenging social circumstances they deemed relevant to their pathway to care. One of the main findings was the importance of life events. These were of an unwanted kind, including ongoing stories of being bullied, loss of employment and bereavement. The way that participants regarded their experiences of mental ill-health as being the consequence of social pressures reflects the literature for young people (Lamb *et al*., 2012) and people racialised as Black (Brown *et al*., 2011). The data therefore reveals young Black people have a sharp awareness of the way they are exposed to a range of

stressful life events and circumstances, including bullying, financial difficulties, being without a father, the pressure to be a good father, social isolation and housing problems. These events were often multiple and complex, further demonstrating the challenges young Black people face.

The data also revealed how participants felt racialised societal processes were an everyday function of their lives that was deeply interwoven and prominent in their lived experience. The research has highlighted that some young Black people have a very real perception that they are racialised across different spheres of life. This includes parental pressures that demand educational success, which is internalised and viewed as a racialised characteristic. Further, young people shared experiences of being racialised in the area of education, employment and housing. They drew on essentialist notions of race when referring to a common experience of racialised oppression. However, ideas of an anti-anti-essentialist position were enacted as it was evident that experiences of racialisation were multiple and diverse.

The participants described a variety of social pressures they felt were a part of, and contributed to, their poor mental health status. Experiences of mental ill-health were viewed as the result of complex and overlapping social causes. There are at least three pertinent debates that this could feed into. One of these is social causation, which suggests that stressful life events contribute to the

development of mental ill-health. This is well rehearsed in the literature (Rogers and Pilgrim, 2014) and there is only space within the remit of this study to signpost it here. Another trajectory that can be followed is the way young people were at times unable to separate the difficult experience of contending with any given social pressure from the possibility that what they were experiencing was a symptom of mental ill-health. This happened during their first memorable episode of mental ill-health. It highlights the problem for people carrying out mental health interventions, as social pressures are sometimes viewed as being inseparable from a period of stress.

The third debate that can be fed into when looking at the salience of social pressures and societal racism draws upon CRT. The findings suggest that for some participants racism is a normal feature of society which has deleterious outcomes. Racially structured conditions were described as having short and long-term effects on their mental health. In this regard, as presented by Delgado and Stefancic (2013), racism is not seen as a deviation from the norm or peripheral in life, but a central component to the structure of life experiences.

One of the themes of this chapter addresses what Suchman (1965) refers to as symptom experience stage. The findings show that some young Black people are conscious that their thinking or behaviour has deviated from what they believe is normalcy. This challenges other

positions that Black people are unable to identify symptoms of mental ill-health when experiencing early onset. Moreover, when examining whether young Black people are able to recognise changes in their behaviour as mental ill-health, this research has found they are able to do so.

Data collected from the research illustrates that participants' actions were dissimilar when experiencing changes in their mental health. A range of other factors also contributed to delays in help-seeking. Some young people found it difficult explaining what it was they were experiencing. Consequently, they did not conceptualise what was happening to them as being an episode of mental ill-health. The findings revealed racialised barriers exist to help-seeking. Participants also viewed their symptoms as insignificant and not worthy of clinical intervention. Therefore, barriers to help-seeking are multiple. In this respect, whilst young people may realise they are experiencing change, barriers can occur as a result of how symptoms are interpreted, which points towards the idiosyncratic nature through which psychological change is conceptualised. This adds to the literature surrounding the social construction of mental ill-health, which is underpinned by a diversity of interpretations that define what it means to be mentally unwell. This has been shown to vary across and within different racialised populations (Kleinman and Benson, 2006). Taking account of this, the findings in this study

support a move towards a more holistic approach to understanding symptom experience stage that acknowledges the apparent heterogeneity.

Findings also support wider research that speculates on the importance of higher levels of ethnic density to better health outcomes. Data from this study reveals that some young Black people believe being among higher proportions of people who are more representative of their own racialised identity can operate as a protective factor to the way racism is perceived to affect them. This study adds to the evidence that suggests ethnic density can contribute to a positive mindset among young Black people and thus that they are less likely to be the victim of discrimination. Therefore, this is one of a number of factors that are crucial to understanding the mental health of young Black people on their pathway to care.

Chapter 6 Accessing and experiencing early forms of mental health care

Findings discussed in this chapter focus on the way participants experienced the process of help-seeking and receiving support at organisations early on the pathway to care. A range of factors were identified as facilitators to care, including the role of social networks, supportive environments and mental health literacy. The young Black people in this study also described the alternative approaches to coping with mental health challenges they utilised. Hesitant help-seeking was identified as a barrier to help-seeking, for reasons of fear, lack of trust and due to racialised perceptions of care. Overall, the experience of receiving care during these early help-seeking encounters was negative; meaningful relationships were not formed, care was viewed as unsympathetic and impersonal, which contributed to the development of racialised thinking among some participants.

This chapter focuses on participants' pathways to care and their experiences of receiving support at organisations that were part of their early help-seeking. These early forms of care were accessed before participants attended non-statutory care where they were interviewed. The findings show that some young Black people are active agents who make serious efforts to improve their mental health. A further perspective that is adopted is one that views young

Black people as persevering in their help-seeking journey when their needs are continuously unmet by mental health services. These findings are in stark contrast to academic literature and government policy that have constructed Black people as being 'hard-to-reach' (Flanagan and Hancock, 2010; Lamb *et al.,* 2012), difficult to engage (O'Brien *et al.,* 2009), reluctant to seek help on a voluntary basis (Memon *et al.,* 2016; Singh and Grange, 2006), and who only seek help as a last resort (Cauce, 2002). Therefore, an evolving position that has developed throughout this chapter is one that argues against any blame being attached to these so-called 'hard-to-reach groups' who should be viewed as resilient help-seekers.

Prior to accessing non-statutory provision, participants had previously engaged with a wide range of organisations. These were university, college or school-based counselling, a church pastor, accident and emergency (A&E) services, Improving Access to Psychological Therapies (IAPTs), youth offending teams (YOTs), child and adolescent mental health services (CAMHS), general practitioners (GPs), voluntary sector organisations, private counselling and support provided by local authority social care. One participant had been with a non-statutory organisation for almost five years and during this time had accessed IAPT twice. Another participant had accessed non-statutory drama therapy, then a college counsellor, non-statutory drama therapy again, followed by voluntary sector carer's support, and then drama-therapy again for a third time.

The general pattern showed participants attended early forms of care for one session, which typically lasted one hour with a mental health professional (*e.g.* counsellor or psychologist) before disengaging. A breakdown of the service contacts is illustrated in chapter four.

Only when being interviewed did some participants recall attending these early forms of care. This thesis initially intended to focus on young Black people who had not received care previously. However, although participants may have only engaged in a one-hour therapeutic session during their early help-seeking, it became evident that this experience influenced their future illness behaviour. It was apparent there were racialised experiences pertinent to understanding the lived experience of young Black people on their pathway to care. This data helps to draw out how participants felt when accessing early forms of care, what it felt like to receive this support, and how these experiences had an effect on later help-seeking.

There are two main parts to this chapter which make a critical and unique contribution to the literature looking at young Black people. The first part looks at decision-making on the pathway to care. This follows on naturally from the point from where participants identified they were experiencing mental ill-health addressed in the previous chapter. When focusing on the area of decision-making, the role of social networks, the use of alternatives methods of coping, and the thoughts and feelings of participants

when help-seeking or involuntarily accessing support, are examined. The second part of the chapter then moves on to present and debate the experience of young Black people when receiving early forms of mental healthcare. This looks at the dilemmas participants faced and the implications of their experience on future help-seeking.

Decision-making and the pathway to care

The role of social networks

Parents, friends and work colleagues were among a variety of people that played a critical role in the help-seeking of young Black people. Although a key finding pointed to the importance of social networks as a facilitator to help-seeking, an emerging theme pointed to the way they can also delay help-seeking—a dynamic which was racialised. Freidson (1988) asserts that help-seeking behaviours relate to the resources (*e.g*. knowledge about symptoms and service availability) held within a person's social network. Pescosolido (1992) also argues that the pathway to care is a product of the role of networks, as they provide opportunities through their resources. This position is supported by Brown's (2013) research looking at lay responses to psychological distress. However, Vogel *et al*. (2007) have emphasised how social networks not only facilitate help-seeking but hinder it as negative impressions as care are transferred from one person to the next. Ajrouch *et al*. (2001) have observed racialised

differences in the use of social networks. Therefore, the findings from this research demonstrate the importance of social networks and how young Black people are in contact with conscientious people who want to help. At the same time, the findings point to situations where needs have been overlooked.

The main reason that participants accessed early forms of care varied. In most cases, help-seeking took place because of symptoms such as feeling low or anxious. Participants also accessed support as a result of other behaviours or thoughts including feeling paranoid, self-harming, having unhealthy eating habits or displaying signs of anger. As discussed in chapter five, the overarching picture showed that young Black people felt a change in their mental health. Notwithstanding this, various stakeholders played a role in whether support was accessed. Participants' mothers were especially crucial in facilitating access to care. Ayo talked about how he was reluctant to attend behaviour improvement sessions at the YOT but he was convinced to do so by his mother:

> **Ayo**: At first I just didn't [want to] do it. I was kinda thinking [why] do I really need to [go to any intervention]? If the crime was that bad they would've arrested me. … I had a talk with my mum. My mindset changed after that. … But I was only going because of my mum.

Further instances of parental involvement were shared by participants. For Dean, it was a combination of his college tutor and his parents who encouraged him to seek support. Other members of participants' social networks were important. In Scott's example, it was staff at the care home where he was residing that observed his displays of anger whenever he had contact with his mum, which resulted in him having a CAMHS assessment. It was Brian's partner, and Steph's friends, who made suggestions that they needed to seek support.

Whilst the above findings demonstrate the way different actors within participants' social networks facilitated access to support, several cases illustrate alternative outcomes. They provide examples where help-seeking can be hindered by social networks, as identified by Ajrouch *et al*. (2001). Brian and Rebecca narrated their experiences of this. Rebecca described feeling low and drained and regularly lying on the couch with the curtains closed. Rebecca's mother thought that she was being lazy rather than someone who was experiencing mental ill-health. Rebecca was diagnosed with depression by her GP and referred to IAPT counselling but disengaged after one session. She later accessed counselling privately following a recommendation from a work colleague. Brian's experience had some similarities when he thought he was hearing voices. Brian responded by approaching his mother for support but she dismissed his concerns and implied that Brian was being foolish. Years later Brian was

supported to access mental healthcare when his partner observed he was struggling emotionally. Therefore, Rebecca and Brian's experiences highlight the way that some mental health needs can be overlooked by people within a person's social network whilst at other times they can be central to support being received.

Data collected from this study does not permit in-depth analysis on the extent to which the participants are embedded within informal or formal networks. However, Maulik *et al*. (2009) stress that there is a broad literature that points towards the importance of social networks in help-seeking. The findings in this thesis support this position, but they question the hypothesis presented by Gove and Howell (1974). They argued that less wealthy people are not as likely to be surrounded by social networks that initiate help-seeking. Whilst this may be the situation, many participants described struggling financially and yet social networks were vital to their help-seeking. Thus, the findings here show a broader level of willingness to seek help, which could point towards changing attitudes towards mental ill-health as a result of anti-stigma campaigns. The participants' accounts also indicate intergenerational differences as studies with Black adults have often portrayed mental health services as being the last option (Menom, *et al.,* 2015; Cauce, 2002), yet Black adults in this study played a fundamental role in help-seeking. Therefore, the evidence from this study shows a mixed picture and points towards the influence of the

parents of young Black people in the way symptoms are perceived and acted on.

Further factors that facilitate help-seeking

Young Black people's help-seeking can be influenced by a variety of supportive environmental and social conditions. In addition to the role of social networks the participants discussed multiple factors that eased their access to support. Many of the findings that were documented in relation to this theme mirror that of other research, such as the role of positive encouragement and strong systems of support (Gulliver *et al*., 2010). Nevertheless, these findings will be briefly discussed here to highlight their relevance to young Black people and to illustrate where these findings converge with the wider literature.

The experience of Steph provides insight into the way a number of different factors operating within the school environment encouraged her to seek help. The school provided all pupils with information on locally available mental healthcare and issues associated with mental ill-health were discussed on an ongoing basis. As Steph describes:

> **Steph**: My school's quite conscious of mental health problems. They regularly did like sessions and would give out, like fliers and

> leaflets about CAMHS and everything. Yeah, my school was like the big contributing factor. … They were just very open and welcoming about being able to speak to people and I guess because of, because I, wouldn't say lonely, because I didn't have many people I could speak to at the time, friends and everything, erm, I felt more inclined to go and speak to the pastoral team. Especially because they were adults, it felt like it was more secure. And, again, I've had previous experience of speaking to the pastoral team at my primary school, so it was kind of, I was used to the protocol and everything really.

Different features that were present in the school environment led to Steph seeking support. An openness to discussing issues pertaining to mental health was central. Steph went on to speak about how this contributed to a destigmatising environment. This echoes research by Rickwood *et al*. (2005) on the significance of a positive environment with strong systems of support. They also showed how positive past experiences of support and emotional competence can promote access to care. This was the situation for Steph who had received encouraging pastoral support at primary school. It is also possible that the school's approach to increasing awareness about mental ill-health improved Steph's mental health literacy, which encouraged her subsequent actions. Many of the

factors that Steph referred to were described by other participants who said knowing about services eased their help-seeking. Straightforward booking systems and reduced waiting times were other areas that participants shared. These are factors that are discussed more extensively by Kurtz and Street (2006). As such, this study's findings show that pragmatic steps, and positive and ongoing information dissemination, can enable help-seeking. Whilst this is evidently important it is not a stand-alone panacea. Research has shown that Black groups have been more reluctant than other racialised groups to re-engage with services despite knowing about their availability (Cole *et al.,* 1995). Yap *et al.* (2012) observed the limitations of mental health literacy and that it should only be seen as one part of a broader approach. This study has helped to provide insight into other factors operating in the school environment, which help to de-stigmatise mental ill-health and that can work alongside generic mental health literacy to encourage help-seeking.

Young Black people and alternative approaches to coping

When realising they were not feeling well some participants took unconventional approaches to find out about their behaviour or to feel better. These actions further demonstrate the steps young Black people take to improve their mental health. This conflicts with the wider literature that suggests young people become socially

withdrawn (Lamb *et al*., 2012). Rather, the findings here indicate that the young Black participants in this study remained creative in their attempts to get better. Participants adopted alternative approaches to coping, which lends support to research by Rudell *et al.* (2008) that has shown there are racialised differences in this area.

In the previous chapter it was described how Tianna gradually became aware that she was frequently aggressive. Consequently, she took action by reading psychology texts online in the hope of finding a resolution. As such, this highlights Tianna's self-driven attitude to understand her behaviour as she actively sought answers to improve her mental health. Other participants tried out different methods to be able to cope. As Sandra describes:

> **Sandra**: The way I used to deal with it was just to write, just to write whatever I was feeling, whatever I was thinking, poetry, letters, I'd just write, not in school but at home. I'd always make sure that I was alone, and I would just lie on the floor and write for as long as I could. Erm, and that seemed to have done something over time.

In Sandra's example she used writing as a way of managing what she believed was mental ill-health. She described keeping this activity secret, which relates to her desire to keep the concerns she had about her mental

health hidden. What is important about Sandra's experience is that it was relatively successful over a period of time in helping her to cope. Pippa also felt she benefited from using alternative approaches to cope with what she believed was social anxiety. After being disappointed by the response she got at her GP surgery, Pippa decided to self-manage her mental health. She purposefully spent more time with school teachers who she felt were charismatic and non-judgemental. Whilst she never informed her teachers that she was experiencing mental health challenges she found being with them supportive. Pippa felt that she still experienced social anxiety when she had finished secondary education. At this point she decided that she didn't want to seek professional help and eventually took up a volunteering opportunity at a non-statutory mental health organisation where she believed she would be challenged to overcome her social anxiety. Pippa found that her efforts were rewarded, as following her involvement in a voluntary sector mental health stigma project she no longer felt the need for support. Lamb *et al*. (2012) have demonstrated that young people can socially withdraw when they are experiencing mental ill-health. This may have appeared to be the situation for Sandra. However, what is evident from Sandra, Pippa and Tianna's accounts is that participants in this study employed meaningful approaches to dealing with mental ill-health.

Whilst Pippa and Sandra's accounts offered a glimpse of positive outcomes, Ralph's story demonstrates how

alternative approaches can be less successful. As he recounts:

> **Ralph**: I say I believe in God and that prayers are very powerful. At the same time, you know, there's only so much prayer you can do. I believe in prayer, but I also believe in like practical help, and people at church were praying for me as much as they could. But it's not really gonna help situations if it means I'm still getting worse.

Ralph's experience highlights the importance of religion for some young Black people in the way they think about, and cope with, mental ill-health. Research by Mantovianni *et al.* (2016) has stressed that Black groups consider religious observance an integral part of coping. Findings gathered here show that religion is also valued. Nonetheless, it is seen as one part of a solution, which for Ralph had limited success when he was managing mental ill-health.

Processes of racialisation were related to alternative coping strategies. For David, he defined his help-seeking behaviour as one that was influenced by Black culture. This led him to seek alternative sources of treatment rather than taking a conventional approach of consulting the GP.

> **David**: Well, so being from a … Caribbean background … I think, it's more so, they tend to rely on natural remedies. So, for example if you're not feeling well, drink some lemon and ginger tea.

David did not discuss how he made use of alternative approaches to coping. However, he did describe his family's lack of understanding about mental health, and dependence on natural remedies; this was a factor he felt contributed to his delayed help-seeking. What is important to recognise from this is that David wanted to improve his mental health, but he felt that his family's minimal mental health literacy was linked to their Caribbean background and this influenced his own conceptualisation of when and whether help should be sought.

Participants talked about how they preferred to be self-reliant when coping with mental ill-health and adopt alternative help-seeking approaches. Salaheddin and Mason (2016) identified that young people more generally do employ strategies to cope. Nevertheless, Rudell *et al*. (2008) illustrate how there are racialised differences amongst adults in the type of strategies that are used where greater dependence is placed on the use of spirituality and herbal remedies within the Black population. On the one hand, it can be seen that there are intergenerational similarities in approaches to coping, which continue to influence the help-seeking experience

for young Black people. Furthermore, the use of alternative strategies illuminates how young Black people should not be viewed as inactive help-seekers. Rather, the findings point towards a position that shows meaningful efforts in the face of challenging social circumstances.

Hesitant help-seeking: thoughts and feelings when accessing services

During data collection the participants were asked to describe their thoughts and feelings when they were making the decision to access support. This question was asked with a view to understanding whether, and to what extent, processes of racialisation could be a factor. However, the question was sufficiently broad to not lead respondents, and to allow them to narrate any aspects that were personally relevant.

The study participants described how they made very determined efforts to improve their mental health. Few participants shared positive thoughts about their pathway to care. It was more frequently the situation that a range of fears had to be overcome. Processes of racialisation were a compounding factor. Many of the findings are similar to the wider literature, which show that mental health service-users have fears of discussing personal matters (Dubow, 1990), anxieties about their engagement with the mental health professional (Brown *et al*., 2009;

Biddle *et al.,* 2006), worries about whether the care will be effective (Mojtabai, 2001) and the importance of being racialised (Keating, 2012). As a result of these challenges young Black people were often hesitant when making the decision to seek help as they balanced the need to overcome their fear with the possibility that their mental health could improve through contact with care. The idea of hesitant help-seeking has been proposed by Li and Browne (2000) when looking at Asian immigrants accessing and using mainstream mental healthcare in Canada. However, their research showed that it was poor English language ability and living in a different culture that created barriers to help-seeking. Thus, the findings presented here offer different insights, which contributed to hesitant help-seeking that touch upon a fear of the unknown, anxieties about being given medication, racialised barriers and intersectional challenges. A discussion of the findings looking at thoughts and feelings on the pathway to care is now examined.

For all of the participants there was some degree of reluctance they had to overcome when they were making the decision to access mental healthcare. The reasons for this unwillingness varied from one person to the next. One of the main emotions that participants described was a sense of fear. Young Black people often talked about being scared or that they found the experience daunting. Whilst fear was an emotion that many participants shared, the

reasons for this varied. For Fatima, she had been referred to mental health support within her school.

> **Fatima**: It was scary. It was just different, cos, usually you just go into school, and you do your lessons, and then you go home, and then sleep some more. But when you're like, 'Oh I have counselling today', so, it's like, you have to like think about what you're going to say.

Fatima said she was scared because she was anticipating what would unfold during her counselling session and how the session itself would disrupt her normal routine. During her interview she described being worried that she would need to talk about issues that she felt were personal. This was a fear also shared by Brendan. They each felt that within any therapeutic session they would be forced to discuss matters that they consider private. This is in line with Dubow (1990) who reported that young people face barriers discussing personal problems. However, the situation was compounded for Fatima and Brendan as they were nervous when they communicated more generally.

International research on barriers to mental healthcare for young people highlights that they may not help-seek because they may know the mental health professional (Brimstone, 2007) or due to a fear their information may be shared (West, 1991). Whilst participants did share their

general concerns about confidentiality, they were more specific about other fears. One significant element that contributed to participants' fears was what would happen as an outcome of their engagement. Dean described being fearful that he could be diagnosed with serious mental health problems. Megan was fearful that she would be medicated with anti-depressants. This was a prominent concern also identified by Biddle *et al*. (2006) who found that young people expected to receive anti-depressants so would not attend the GP. Several participants shared this concern. One of which was Megan, whose fear of seeing her GP stemmed from the experience of seeing her parents and sibling receive psychotropic medication. As such, this mirrors the findings of Brown *et al.* (2009) showing anti-medication beliefs to be greater among Black women. Thus, it can be seen from this that there is a general fear of what may occur following their interaction with a mental health professional.

Steph and Carlene feared their mental ill-health could be so complex or severe that they would not be able to be helped. Carlene decided to access Christian-based support privately. Prior to this she had already attended IAPT support. She recounts her experience when thinking about accessing IAPT:

> **Carlene**: I needed to talk to someone about the deep-rooted issues that I haven't really spoken about to anyone. … But then, at the

> same time, I thought are they really going to be able to help me? … I'm aware of people who have gone through counselling and they hate it. And so, I kinda had those horror stories behind the back of my head. … So, I was in between the two. Yeah, I can talk to someone about everything which is good for me, because I can release the things that are hurting or painful to me, but at the same time their reaction or their response to it could be the complete opposite and I could actually hate it. … I think I was scared, cos I was like, 'Imagine if she says no' or 'Imagine if she just can't do it, and really doing the right thing, do I really need counselling?' They were the things I was thinking about and that made me feel really anxious.

Carlene draws attention to the multiple factors she contemplated when making the decision to access support and the way this made her feel. Similar to Fatima, this was Carlene's second time of accessing support and it is evident that she did not feel confident making this decision. Participants' concerns of this nature were also identified by Mojtabai (2001) who found young people lack trust in treatment. For many participants this acted as a barrier and engendered a sense of fear.

The participants also expressed a fear pertaining to their racialised identity. Nadia shared the way racialised features of her life influenced her attitude and behaviour towards help-seeking. When recounting her experience, it is evident that she was aware of her need for support. However, as a result of family members informing her that she would only receive medication, she did not seek help for a period of five years. Nadia discusses these issues:

> **Nadia**: I had an idea that, you know, in terms of a counselling that … [I] have a need for counselling, erm, but due to family circumstances I was discouraged from it. And, I think that's another reason why it took me a bit longer to access something here because, erm, you know, family culture had told me don't go to counselling, you know, they're just gonna force you to have pills and stuff, and I actually, verbatim, my aunt said to me, you know, 'Don't go to counselling.' … So I was kinda in this place having issues but not accessing anything for five years.
>
> **Anthony**: Why do you think your parents didn't want you to go to any support?
>
> **Nadia**: It's not really done. Everything just stays within the culture, within the community. … I've seen people have issues and still not

> even talk to each other about those issues. It's this thing where everything just stays within the home, and when I mean home, I mean not even the culture or the village, I mean the actual home. … And if you do go to counselling, you should only go to counselling, you know that's for insane people basically. That's for really, really crazy people. That's, that's who counselling [is] for. It's not for anybody else besides people are very, you know, insane.

Nadia refers to the sceptical views her family members had of mental healthcare. She said this was a way of thinking that existed within Black culture. This in turn contributed to her own lack of trust making her reluctant to seek help. Carlene and David shared similar accounts were processes of racialisation prevented their help-seeking. In this way, help-seeking delays can at least be partly attributed to racialised barriers that exist in the way young Black people think. Gulliver *et al.* (2010) reported that young people do not seek support because they believe they will not be able to be helped. Whilst there are examples of this from participants' accounts, findings from this study point to a specific burden young Black people feel on their pathway to care. This position builds on the idea that Black people have a fear of mental health services (Sewell, 2009). This is referred to by Keating (2012: 213) when he suggests that racialised minority groups will not seek help 'based on their perceptions of mental health services and a belief

that these services will discriminate against them.' Keating and Robertson (2004: 438) have argued that it is the negative impressions that Black people have of mental health services, including over-use of psychotropic medication, that makes Black people view mental health services with 'suspicion and trepidation.' It can be seen how these sentiments are visible in the narratives of the participants in the way they were dissuaded from accessing support.

The fear of being stigmatised as mentally ill was present in the participants' thinking at different points in time. There is a broad evidence base that refers to the relevance of stigma in young people's help-seeking (Salaheddin and Mason, 2016) and young Black people in particular (McCann *et al.,* 2016). Therefore, only brief reference will be made to this issue here. In doing so, it is worth noting some of the elements that made the participants feel stigmatised. For Dwayne, it was the words 'mental health' in the name 'CAMHS', that made him feel like he was being told he was 'crazy'. Whilst research by Paul *et al*. (2008) identified stigma associated with attending CAMHS, it is important to observe how this is realised and internalised as noted here.

For some participants there was a combined pressure of being stigmatised as mentally ill and being racialised as Black. This was evident for Syd. When he was informed by his GP that he could be referred to counselling, his

immediate thought was that he would not tell his parents. This was because he believed they would judge him to be a person who was unable to cope. Syd described how he felt the need to be perceived as being able to manage life stressors as this was an expectation of his racialised identity. Additionally, David and Nadia talked about mental health being a taboo subject within the Black community. Part of Nadia's experience was informed by seeing other people who had 'issues' not talk about them. Lee (2002) identified similar patterns whereby people feared the stigma of mental ill-health to the extent that they took steps to conceal this part of their life. This bears similarities to David's account, which portrays mental ill-health as a taboo subject—not to be discussed. As such, he felt this reduced the access he had to important information about mental health provision. Each of these situations demonstrates that participants felt closed off whilst they shared a sense of a heightened degree of stigma about mental ill-health within the Black population. Again, this resonates with the work of Keating (2012) who argues that Black people do not access mental health services because of how they believe they will be treated because they are Black and also due to the societal oppression associated with mental health stigma.

A further component that shows a fear of stigma is the way mental health services are viewed as only being for people who are 'insane' and 'crazy'. Similar findings have been found elsewhere, as Menom *et al.* (2016: 4)

described the way 'mental illness was' … 'typically viewed negatively, or in the context of extreme cases the services were seen as serving 'crazy people only' (emphasis in the original). These impressions were evident in participants' experiences resulting in delayed help-seeking. In summarising this section, it is possible to see how a range of fears influence help-seeking motivations which then in turn impact a person's pathway to care.

Racialised perceptions of mental healthcare

Findings from this research show that young Black people are not always aware about the roles of different care providers, and their perceptions of services are influenced by processes of racialisation, which operate as a barrier to help-seeking. The wider literature illustrates that young people are not specifically confident in knowing about the role of GPs in delivering mental healthcare (Biddle *et al*., 2006) and the way that stigma associated with the topic of mental ill-health can close off avenues to care (Livingston and Boyd, 2010). However, the findings discussed here show how help-seeking can be modified due to racialised perceptions and stories about mental health provision that are passed from one generation to the next, extending knowledge in this area.

Many of the participants in this study narrated their experience of being supported by their mother to attend

their GP. However, many young people described being unaware about where to turn. A reoccurring theme pointed towards participants not valuing or recognising GPs as a source of help for matters pertaining to mental health. Very often they were not aware what mental health services did more generally. As this is a matter that has been addressed in sufficient detail elsewhere with regards to the general population (Gulliver *et al*., 2010; Biddle *et al*., 2006) this finding is only noted here. This section will now turn to look at those experiences that were seen as racialised and those that shine light on some of the perceptions that young Black people have of mental healthcare.

David recounted the way processes of racialisation operated in his help-seeking. He related his lack of knowledge about mental healthcare to being from a Black household.

> **David**: It was hard to go to a GP when I wasn't aware of the help I can get from the GP. I think more so, because I grew up in such a closed off environment from that. Mental illness is something that you don't talk about in the Caribbean household or even in the Black household. Because we just don't understand it. So, erm, and I feel that if my parents were to actually have a positive outlook towards it, I would have known the help I was able to get.

Despite feeling unwell, David highlights some of the reasons that made him reluctant to seek help. He expressed concerns that, during his upbringing, he was not exposed to discussion about mental health, which he attributed to his Caribbean background. Hence, whilst the literature acknowledges that young people generally will not be aware of a GP's role (Gulliver, 2010; Biddle et al., 2006), David and Nadia each believed this was due to their racialised identity. For David, the heightened stigma he associated with mental ill-health meant that the topic was not discussed. This led to his lack of awareness. Hence, whilst surveys do not find any difference in the extent to which mental ill-health is stigmatised between different racialised groups (Livingston and Boyd, 2010), the findings from this research illustrate there is a lived experience that stigma is racialised and it influences perceptions about care.

David and Nadia assert that mental ill-health is not talked about in a Black household. This brings into the debate the notion of essentialised ideas about racialised groups. Indeed, it is a position Austin (1992: 389) puts forward when stating, 'there exists out there, somewhere […] the Black community' and whilst contending that this is now more of an 'ideal, than a reality', she essentialises race and continues in her writing to present an image of a Black community. For Austin, the Black community is one that is in a constant state of flux, but it is nevertheless connected in her vision as being distinguishable from the rest of the

population as a result of its experiences. Participants in this study provide support to this constructed vision. This is emphasised in the way Nadia and David talk about their community being closed in different ways to matters relating to mental ill-health. For Nadia this involved feeling disconnected, whereby mental health challenges were to be kept within the home and how this was an expectation within the Black community. Thus, some participants felt that mental health is understood and mental healthcare is perceived in a unique way for young Black people.

This point is further highlighted by Brian's story. Brian had been self-harming by headbutting the wall and punching various objects. The mother of his children witnessed these incidents and told Brian that he should seek medical attention from a GP. Brian did not want to go to see the GP and was initially more intent on attending accident and emergency (A&E). However, his partner convinced him that going to A&E would not be a good option as he would receive the 'liquid cosh' (a colloquial term to describe the powerful negative effects when taking medication (Goodchild, 2003)). Brian therefore decided against going to A&E, but did go to see his GP. The dilemma he described offers further insight into decision-making on the pathway to care:

> **Anthony**: Why did you want to go A&E and not the GP?

> **Brian**: It never occurred to me to go to the GP. You know, erm, it's, it's, it's, again, it's how my thought process was. My thought process is simply, if I'm sick, then I'll go to the GP, do you understand, but I didn't see mental health as a sickness. I just knew that I wasn't safe. I felt like destroying things, do you know what I mean, so the best place for me to be is like in the hospital or something like that … so [before I changed my mind, I was thinking] I'd just like go the hospital and go crazy like.

There are a number of elements that emerge from Brian's story and in particular his interaction with his child's mother. The perception young Black people have that they will only be administered powerful sedatives to control their behaviour is an important finding as this is symptomatic of the type of care people feel they will receive. It is not clear if this was an opinion that Brian held but it is a perspective to which he was exposed. He drew upon the idea that he would be treated forcefully in the way predicted by his partner via the 'liquid cosh.' Arguably, this characterisation of mental health services instilled a sense of fear in Brian who decided not to attend A&E. For Sivanandan (1991) Black people fear mental health services as they anticipate that they will be mistreated in the same way they are within the criminal justice system. Again, drawing comparisons with the work of Keating (2012), these findings put forward the position that Black

people expect more controlling and harsh treatment when coming into contact with the mental health system.

Brian's example also draws attention to some of the possible reasons that racialised minority young people may not access primary care services and why they do so via emergency services. With regards to Brian's thought process, his justification was that he did not see his mental ill-health as a form of sickness. And, according to Brian's rationale, he did not consider going to a GP because they only deal with sick people, which he was not. Young Black people's perceptions about GP services have already been addressed above. Nonetheless, there is tension in Brian's reasoning that requires further consideration. On the one hand he knew he had a problem in his thinking as he was aware of his desire to cause physical damage and his propensity to go 'crazy.' Still, he did not see this type of behaviour as a sickness, even though he wanted to feel safe because he felt vulnerable. These are themes that are reflective of research that looks at racialised people and mental health services. One concern in this area is the higher number of Black groups accessing mental health care via emergency services (Chakraborty and McKenzie, 2002). The account provided by Brian offers insight into why some people racialised as Black will do this as they do not interpret mental ill-health as a form of sickness, which creates a barrier to primary care services. However, there is still a desire to feel safe and a hospital environment was seen to be a place that could offer this. Hence the

importance of how mental ill-health is conceptualised and how young Black people perceive services provides further evidence about the way this influences their pathway to care.

Receiving early forms of mental healthcare

> It just wasn't for me. … I remember it very clearly to be honest with [you], I remember sitting in the room and thinking to myself, very quickly, erm, I don't even know why I'm sat here!

The second part of this chapter focuses on participants' experiences of receiving early forms of care. All of the data is drawn from interactions participants had as part of group therapy, where a mental health professional supported a group of service-users, or through one-to-one care. This focus is critical as most studies looking at racialised experiences of mental healthcare have tended to draw on the views of the mental health professional and not the service-user (Chang and Berk, 2009). A problem with this approach is that service-users' views and progress of the care frequently differ to that of the professional (Hannan *et al*., 2005). Further, it is the service-user's assessment of an intervention's value that is most strongly associated with therapeutic outcome

(Horvath and Bedi, 2002). Thus, engaging the views of service-users is critical.

This study shows that the conventional way of understanding the patient and care provider relationship—one where patients go through a process of recovery and rehabilitation following contact with a professional (Suchman, 1965)—is not appropriate to understanding the mental health pathway for young Black people. Moreover, Suchman's (1965) stages of illness model predicts that patients hand over decision-making power to the professional. What is apparent from this study is that participants resist handing over control. Too often, young Black people do not experience mental healthcare that effectively meets their needs. Young Black people access various organisations and sometimes there can be beneficial outcomes. However, the overwhelming picture is one that is characterised by a myriad factors that moderate the opportunity for effective relationships between mental health professionals and young Black service-users. An outcome of this set of circumstances is that early forms of mental health support are not satisfactory. Many of the findings reflect the experiences of Black adults in mental healthcare (Bhui and McKenzie, 2007; Keating *et al.,* 2002). They also show how illness behaviour can shape patterns of 'health practice and adherence with medical advice, and the course of illness and treatment process' (Mechanic, 1995: 1208). However, these findings are also vital to understanding how early

interactions with care providers have the potential to be precipitating factors that contribute to the undesirable relationship that Black groups have with mental healthcare.

Barriers to effective relationships between young Black service-users and mental health professionals

Findings from this study show young Black people are dissatisfied with early forms of care because of the inability of mental health professionals to establish meaningful therapeutic relationships. Many of the findings documented here have been found in research with the adult population (Fernando, 2005). A wide range of studies have illustrated the importance of specific care techniques and the role of the mental health professional (Newman *et al.,* 2015: Lambert and Barley, 2001). In particular, empathy, warmth and a therapeutic alliance have been highlighted as common factors that contribute towards good experiences and clinical outcomes (Campbell and Cobb, 2017; Newman *et al*., 2015). Meanwhile, young people have also raised concerns when mental health professionals appear unsympathetic or judgemental (Biddle *et al*., 2006) or when they fail to deal with challenging situations (Anderson *et al*., 2009), some of which are identified more specifically here. This section draws upon this literature, whilst illustrating the key

concerns of young Black service-users in relation to their experience with mental health professionals.

Participants experienced a range of emotions surrounding their interaction with professionals. Many of these mirrored how they were feeling on the pathway to care. For instance, before accessing support, Megan feared the possibility of being given medication and this was an ongoing feature of apprehension during her GP appointment. Participants shared varying degrees of anxiety, which ranged from feeling a little bit nervous to being scared. The participants also shared a sense of being 'closed off' as they did not feel sufficiently comfortable to be honest about their emotional challenges. Anderson *et al.* (2009) identified similar concerns with the adult population, whilst Davies *et al*. (2009) noted the same with young people more generally. Participants also shared how stigma associated with mental ill-health created a barrier in the service-user and care provider relationship, which is a matter discussed by Plaistow (2014). These are the types of difficult situations that Anderson *et al*. (2009) contend are likely to occur and that can separate good service-user experiences from the unsatisfactory. For the participants in this study, very frequently when receiving early forms of care, mental health professionals were unable to provide reasonable reassurances leading to service-user disengagement.

The personality of mental health professionals was a salient aspect of participants' experiences. This included the way professionals interacted through use of body language or the focus and tone of their questions. Participants expressed how these factors resulted in significant barriers restricting their engagement in the process. A very detailed and powerful example of this is provided by Megan. She talked about how her experience was influenced by the approach and physical characteristics of the professional she encountered. Megan recounts:

> **Megan**: This is painful, like I'm just sitting in a room, it's quiet … with this, erm, woman, she was a lot older than me. … I think … I saw a White middle class lady … who's qualified with a degree, sitting down with her glasses … you know, her vintage fashion, and she's just sitting there with a pen and paper, leg cocked up and she's like, 'And how are you feeling today?' And like, I was, yeah, okay, as a 17-year-old at the time, I was just like, I was like, are you serious? … It felt so cold, I'm not asking for you to overly invest your emotions in me, but it was very robotic, it was very robotic, very stiff. It was painful, like the room, we could sit there in silence and I would just look at her, and she was like 'Mmmh ok' when I was speaking 'Mmmh, and how does that

make you feel?' it was just like, 'I wanna stop!'

Anthony: What were you thinking at that time?

Megan: I want to stop, I want to stop. I was like, who, talking to you is one thing, I'm not gonna make your job hard, I'm not a difficult person, but I feel like, I'm just a pay cheque to you, this is just your job, not even just a pay cheque. This is really just your job. 'Mmmh, ok, how do you feel?' I was just like, 'No!'

Megan's story illustrates how a number of dynamics influenced her experience and made her want to discontinue the session. This is concerning, as positive relationships between mental health professionals and service-users are vital for good clinical outcomes (Campbell and Cobb, 2017). For Megan, she found the combined effect of the professional's perceived age, racialised identity and class, and also her inflexible and predictable approach to asking questions undesirable. The professional's 'vintage fashion' sense and body language were other features that were salient for Megan and created a barrier to her engagement. Against this background, Megan's description develops an impression of two people who come from distinctly different backgrounds with little or no basis of common

understanding. Additionally, the sense that Megan's needs were not genuinely considered, and that the professional was only supporting her for a 'pay cheque' points towards a great sense of disconnection. Several participants expressed similar concerns to this as they felt professionals appeared uninterested and unsympathetic. From this it would appear that participants felt there was a lack of genuine compassion. Crawford *et al*. (2013: 719) suggest that compassion can be seen as being 'sensitive to the suffering of others and showing commitment to relieve it.' Spandler and Stickley (2011) have argued that compassion is critical to stimulate hope within recovery. For participants, a lack of compassion meant they were unable to fully trust the intentions of the mental health professional, which subsequently limited their engagement in the process. Biddle *et al*. (2006) also found that young people found care providers unsympathetic, whilst Plaistow *et al*. (2014) identified that this can reduce trust, limiting the success of an intervention. The findings here illustrate some of the nuances that contribute to this. Further, whilst Crawford *et al*. (2013: 719) contend that a lack of compassion may be due to organisational tensions, time pressures and a 'production-line mentality,' evidence from this study indicates that improvement in this regard is critical due to the negative impact it has on young Black people.

A concern of many participants was the method of support, the style in which it was delivered, or the combined effect

of these components. This was evident in Megan's description when she felt uneasy with the professional's approach to asking questions. Megan narrated the way the professional continued to ask her 'how did that feel?' When reciting the professional's words Megan attempted to imitate the tone of the professional in a way that depicted it as being inappropriate to the way she should be supported. If it can be assumed that the professional was delivering the support in a way that she had been trained, this raises questions about the adequacy of such methods to young Black people. It is problematic as it points further towards a disconnect in the way participants felt they should be supported. In Megan's scenario it is difficult to unpick whether it was only the style of the professional and how they chose to deliver mental health support or whether it was also the method of counselling and the environment within which it was delivered. The same challenge was present in the descriptions of other participants. Rebecca shared how the counsellor focused heavily on her period of incarceration, which she felt was unnecessary. She found this overbearing and intrusive.

> **Rebecca**: It just wasn't for me. I just remember, I remember it very clearly to be honest with ya, but, I remember sitting in the room, and thinking to myself, very quickly, erm, I don't even know why I'm sat here, that kinda of thought. And maybe some people could say I didn't even give it a chance. But I

> didn't feel as though it was something that I needed to give a chance because I knew that it wasn't, the approach wasn't for me. So, the approach, now I don't know if that's the way all counsellors approach [it] or if there's a different way, because I'm not a counsellor myself. But for me personally, the approach did not fit the circumstance.

Rebecca went on to talk about how she felt uncomfortable as she found the connection she had with the professional 'cold', which was exacerbated as she also felt judged. Carlene, Dean and Georgia shared the same sentiments. This points towards a process that the participants found to be emotionless, unfriendly, and again unsympathetic. When describing these features, participants referred to the ineffectiveness of the support that resulted in their disengagement. Thus, whilst the literature suggests that young people will not access mental healthcare because of a perception that professionals are unsympathetic and judgemental (Biddle *et al*., 2006), the findings from this study highlight that this is also part of the lived experience of early forms of care for young Black people. Additionally, Spencer *et al*. (2001) have argued that therapeutic engagement is an essential factor, which involves service-users and care providers establishing common ground and being flexible with their delivery. In this research, the participants described numerous occasions during which the mental health professional's approach was not

sufficiently engaging or appropriate to their needs. Indeed, this provides further evidence that some forms of mental healthcare are not appropriate to young Black people as numerous barriers exist preventing effective service-user and care provider engagement.

The participants in this study specifically questioned the method of the support they received. Several participants expressed how they felt CBT was unsuitable for a variety of reasons including: it did not address the root cause of their problems, there was too much repetition, and it focused inordinately on turning bad thoughts into good thoughts, which did not deal with the problems they faced. Participants were also concerned that school counsellors had limited expertise and provided impractical guidance. For instance, Syd described how he was experiencing anxiety and had trouble sleeping. The school counsellor advised him to count from 100 to zero in sevens. Syd shared how he would not be able to do this at any other time of day not least at bedtime because his anxiety resulted in tiredness, which meant he could not concentrate. Carlene expressed her concerns about the IAPT group support she attended. Similar to Megan, she discussed how she found no bond with the mental health professional. She also discussed how the group dynamic prevented her from discussing sensitive issues. Additionally, Carlene felt that everything she was being told she already knew from her own online research.

Processes of racialisation also played a part in the way some participants experienced service delivery. This is evident in Tianna's account:

> **Tianna**: I'm sat in the counsellor's office, you know, coming from a background of being African it's not something that we do. So, to sit and talk to somebody about my feelings and things was just strange. So, I think for me it was a sense of like shame because we don't do that.

Tianna described how for someone like her who was born in Africa the idea of sitting and talking about emotions was unusual. She went on to describe a sense of embarrassment that she was not adhering to expectations of her racialised identity. The concerns that Tianna had with this support were about the method of delivery and how she felt they were not sufficiently attuned to her needs as a young Black person. Whilst on the one hand these findings illustrate how mental healthcare does not always provide culturally appropriate support, it also offers further evidence about the reasons why young Black people disengage from some services. This is important to understand as O'Brien *et al.* (2009) documented that racialised minority groups and young people are more likely to drop out of mental health services. However, much of the research relates to psychiatric services and only provides broad statistics. O'Brien and colleagues

(2009) also indicate that it is because young people are more difficult to engage in the first place, and because of stigma that they drop out of services. The findings in this research show that young Black people do access early forms of support, but they are too frequently dissatisfied by mental healthcare, because effective and trusting relationships are not established and methods of delivery do not adjust to the different requirements of young Black people.

Mental health professional characteristics

> Having someone of the same … ethnicity or culture as you is very helpful. … Before I came here and I was in CAMHS in [the] city. My psychologist was Black too so I felt like I could speak to her more about the fact that my grandparent is living with me than if it was someone of another race (Female participant).

The racialised identity of mental health professionals was an important consideration for young Black people. Racialised matching (*i.e.* matching the racialised identity of the service-user and professional) has generally produced mixed results. In a review of clinical outcomes Cabral and Smith (2011) found that racialised matching made no difference. Contrastingly, Bhui *et al*. (2015) observed how

cultural adaptions, including racialised matching, proved to be beneficial. Further, Gurpinar-Morgan *et al*. (2014) found that amongst racialised minority young people the racialised identity of the mental health professional was not important. Rather picking the right time to discuss processes of racialisation was critical. The findings discussed here add support to the idea that racialised matching is a vital consideration for young Black people, as it was frequently countered as providing added benefits.

Participants often referred to the gender or racialised identity of the mental health professional. Whilst in some situations this was not described as influencing the participant's engagement, for others it was more salient. This is evident in Megan's example in the previous section. The perceived age and race were also significant to Dean.

> **Dean**: You're in a group full of, erm, like, White people, middle aged White guys, middle aged White men and there's a young Black male sitting there. … When I sat down. … I thought … are they actually serious, is this actually my group?

Dean disengaged after his first session of group therapy because he did not feel at ease being young and Black among other White adult service-users. This made him feel his needs had been overlooked as he seriously questioned why he was allocated to the group. From this it can be

seen that age and racialised identities are social factors that can open and close relationships within group therapy settings. Several participants shared their stories about the way processes of racialisation informed their decision to discontinue early forms of care. They demonstrate how the participants can feel a lack of connection when a mental health professional who is not perceived to be of their own age, class or racialised identity can be significant.

Whilst this is the situation, Brian's experience provides findings to the contrary, but nevertheless still highlights the significance of racialised identities. Brian felt that he was intentionally referred to an IAPT psychologist who had the same racialised identity as himself. However, this resulted in a negative experience for Brian as the therapist reminded him of his Black aunties whom he associated with negative memories.

> **Brian**: I just felt the judgement. I felt that she was judging me. I felt that she was saying to me, like no, you shouldn't feel like that. But she wasn't saying that because of my mental health or other than the fact I was Black. 'You shouldn't feel this way because you're a Black man.' … I didn't feel like I had a Black man issue. I felt like I was a Black man with an issue do you know what I mean? … You know the lady was probably lovely, do you know what I mean? She was probably really, really

> nice, but she just reminded me too much of my aunties.

On the one hand, part of Brian's relationship with the mental health professional originated due to the association he made between her appearance and the stark similarities with his aunties. In Brian's interview he described how his aunties had made his life difficult and how he thought they had chased away all of the men in his family. In this regard, it was the association with his aunties that was of concern. At the same time, racialised identities were notably important because of how he felt he was portrayed as a Black man, by a Black woman. This included Brian's perception that he was not to behave or think in a certain way because of his racialised identity. The idea that racialisation is significant is further supported when Brian later made a request for additional support from only a White mental health professional. Elsewhere in the interview Brian also discussed how he preferred to communicate with White people in other aspects of his life. Taking a psychosocial perspective, it is possible to see what Dalal (2002: 97) calls the 'construction of an internal divide', and an example of the way 'power relations structure the content and direction of desire.' In this way Brian rejects Blackness, which Fanon (1982: 18) refers to as the 'mother country', in favour, of being 'proportionately White.' McInnis and Moukam (2013) have made similar arguments, which help to contextualise Brian's account. They discussed how Black people in

Britain can be removed from their racialised self because they associate it 'with both the cause of their enslavement' … 'and a continual second-class status'. Brian's preference to seek out people racialised as White is arguably symptomatic of this internal struggle and a failure to see a positive Black image. Brian's story illustrates how important it is that assumptions are not made that a young Black person will always prefer a professional of the same racialised identity. This supports arguments made by Pope-Davis *et al*. (2002) that it is important for mental health professionals to develop an understanding of how sensitive service-users can be to racialising factors. As this research has documented, young Black people's disengagement from early forms of care are related to the mental health professionals' social identity, which is an area which should not be overlooked.

The effect of previous support on future help-seeking

Young Black people are affected by their first, albeit brief, interactions with mental healthcare, which have implications for future help-seeking. Singh and Burns (2006) have suggested that one line of argument to explain the different pathways to care taken by Black groups is how their relationship with mental health services worsens over time as a result of negative service contacts. They (2006: 649) postulate that the 'relationship between ethnic minority patients and mental health

services deteriorates thereby creating a spiral of downwards engagement.' The findings here offer some support for this perspective. Participants became increasingly unhappy with care, which made them question whether they should re-engage. However, despite this, they remain determined to improve their mental health by continuing to seek help.

On many occasions, participants described how their hopes for improved mental health were reduced because they had at least one negative experience of attending mental healthcare. They felt compelled to continuously access different support organisations, which they found tiring. For Pippa, following an appointment with a mental health support worker at her GP surgery, she was only offered a 'two-minute' conversation and handed a pamphlet for IAPT. She found this discouraging and it was part of the reason that she delayed making contact with IAPT. She felt disappointed at not receiving any practical advice from IAPT and consequently decided not to access professional support again. Negative experiences of care that lead to hesitant help-seeking were a common experience of the participants. Ralph described his feelings when accessing the fourth organisation where he sought support:

> **Ralph**: Here we are again, I'm back to square one. Exhausting, tiring, boring, scary, all sorts of things at once. … It felt like I was, it was a

> lot of things, I guess I could almost say it was embarrassing as well.

Ralph shared a number of thoughts and feelings that highlight his overall level of discontent that his mental ill-health had not been resolved. He described feeling fatigued. Ralph also felt ashamed that he needed to revisit his GP and disclose personal matters, as he was worried that his family would be perceived as dysfunctional.

Racialised experiences of support also presented a barrier to future help-seeking. This was the situation for Brian. After a bad experience with a Black professional, he described being fearful of discussing his intrusive thoughts again and consequently delayed help-seeking. Scott also narrated the way his journey through services had been racialised:

> **Scott**: Yeh, because of the colour, and it's like, basically, automatic criticism, because you may have, maybe Black and have maybe plaits or be Black with an Afro and it's just straight away criticism and they just look at you and think Black, 'Ooh he's been through this and he's been through that. We're not taking him.' It's bad, it's really bad how people think.

Scott connects his racialised identity to broader processes of racialisation, which he feels have resulted in negative

outcomes. In one respect he illustrates his understanding that different characteristics, such as hair plaits, are recognised as racialised features. He then relates this to the way service providers make assumptions based on these characteristics. In the example, he suggests that service providers operate on stereotypes, which make them reluctant to engage with Black people. The association that Scott makes about the way he feels he will be perceived is fundamental to understanding the thought process of young Black people and help-seeking. Scott has developed an association with mental healthcare whereby he believes he will be viewed negatively. This is a matter Dalal (2002) attends to when referring to the way Black people can experience the feeling of being excluded. According to Dalal, Black people can sense feelings of aversion, hostility or suspicion directed towards them. In Scott's case, he has tolerated the accumulation of being rejected following multiple interactions with support services. As a result, he has feelings of rejection which are racialised that have influenced his outlook toward mental healthcare.

Positive experiences of early mental health support

There are a number of features that made the experience of accessing early forms of mental healthcare positive for the study participants. The findings from this study show that young Black people appreciate opportunities for

learning and being appropriately challenged. They also need to be reassured they are taken seriously and positively engaged. Newham *et al.* (2015) identified similar positive features associated with the mental health professionals' interpersonal skills. This section also shows how the racialised identity of the professional can interact with the way young Black people experience early forms of support.

Participants were asked if there was anything that made receiving support easy or enjoyable. Out of the positive elements that were identified some have already been documented in the literature. These include the need for confidentiality and seeing a familiar face (Rickwood, *et al.,* 2007). Additionally, Dogra (2005) and Bone *et al.* (2014) both emphasised the importance young people attached to being listened to. This was a finding that was documented in this study, whilst young Black people also appreciated that a mental health worker had dedicated their time to them. However, whilst it was important that participants had time to share their concerns and to 'let it off my chest' (Brendan's words), there was a sense that being listened to should only be a minimum requirement. Additionally, although the participants may have felt they were being listened to, they often described an internal dilemma they encountered. This is articulated by Steph:

> **Steph:** It felt like someone genuinely wanted to hear me if they'd taken an hour out of their

> time to listen to me. On the other side, I was quite cynical about it because I was thinking, you're paid to listen to me, so it's your job, so you don't care. So, there was always that battle really.

For Steph, she felt validated that she had the opportunity to share her concerns. Nonetheless, she communicated how she was not entirely assured she had a sincere relationship with the professional. Similarly, for Syd, he was grateful that his school counsellor spent an hour with him, but his overall picture was one of disappointment because of the impractical guidance he received. Therefore, whilst the literature (Bone *et al.,* 2014, Dogra, 2005) highlights the importance of being listened to, this should only be viewed as one part of a successful intervention.

Many of the positive factors that participants articulated mirrored research by Plaistow *et al.* (2014) which expounds the significance of the personal qualities of the professional. Participants expressed a strong sense of contentment when they described receiving an external viewpoint, rather than just being listened to. This was the situation for Megan, who accessed support for a fifth time at a voluntary organisation. During the session the mental health worker helped her to realise that part of her mental ill-health was due to her grieving over the loss of a friend. This was a 'lightbulb' moment for Megan as she had

associated her poor mental health with other factors. Megan also appreciated the way the professional was more compassionate and knowledgeable in comparison to past support.

Examples of compassion were also emphasised by Dwayne. He talked about the importance of the nurturing approach he received. After accessing CAMHS, A&E and a non-statutory organisation, he accessed another non-statutory organisation where he felt the professional made him feel safe.

> **Dwayne**: The way she was very nurturing. So, she was very like, I don't know like, nurturing in'it. … It's how it's meant to be. I think that's how you're meant to do it. Whatever way you want to articulate, make me drop my guard, make me trust them, make me believe she's genuine, or, whatever, it worked. … It just felt open. You didn't feel all closed in that room. You [were] in a room but you didn't feel all closed, like oh shit, I need to answer these questions to escape and get out. It's some quality time with myself and there happens to be a person there to kind of, coordinate the dialogue in my head, if that makes sense.

For Dwayne, the professional was sensitive to his needs and appeared intent on helping him. He talked about how

this helped him to trust the process of receiving care. Other participants were happy they were encouraged to deal with intrusive thoughts or told that they should not be ashamed of them. Scott was also content when receiving an external opinion on his situation. However, in Scott's case, the opportunity to hear from a professional of a different racialised identity appeared to offer further reassurance:

> **Scott:** After the assessment, I was quite happy, cos I felt like, wow, I've just let a lot out, do you know what I mean? Talking to someone who's not … I'm not going to be racist in anyway, but not Black or not me; so they're seeing things from a very outside point of view and looking in.

Scott believed that his anger stemmed from his difficult life. Therefore, when he found out from a White mental health professional at CAMHS that he did not have serious mental ill-health, and that she thought his anger developed as a result of his challenging life circumstances, this confirmed his own concerns and made him feel validated. It was of greater significance to him that this endorsement came from a professional who was White. This resembles Brian's experience and how racialised thoughts can be internalised and interact with how support is received. The significance of racialisation was also apparent when Syd described his experiences:

> **Syd:** Ok, I don't think race affects how someone hears something, but it affects how they perceive it. Me telling the Australian lady I was so worried about my exams, because my parents this, this, she's hearing me. … But to her it was so … trivial, it was just trivial to her. … But talking to someone who was, not of the same race, but more of a similar background; so, you know Asian families are known for being strict with education or whatever. … If I had an Ethiopian doctor, then he would know exactly what I was going through. But, yeah, as in there was such a difference between the first doctor, the Australian lady, and the Asian one.

Syd talked about how he felt his Asian GP had a better understanding of the educational pressures placed upon young racialised minority groups because he come from 'a similar background.' Statistics have shown that racialised matching mental health professionals with service-users can produce better service-related outcomes for young Black people (Jerrell, 1998). Findings gathered in this study also demonstrate that racialised identities can be significant. Of relevance is the way Syd described a common understanding with the GP because he was a racialised minority person who would understand racialised parental educational pressures. Syd also puts forward a

position that a mental health professional with the same racialised identity as himself (Ethiopian) would fully comprehend his concerns. This example provides further evidence about how crucial racialised identities can be to the receipt of care.

Thus, whilst there were limited examples of positive experiences of early mental health support, the findings in this study lend support to literature that points to the importance of establishing common ground between young Black people and mental health professionals. In agreement with Davies *et al.* (2009) active listening is important. However, this research stresses that it should only be a constituent part of any effective process. Young Black people have diverging mental health needs and the racialised identity of the professional can influence young Black people's experiences. Nonetheless, in the positive examples that were shared, young Black people benefited from hearing an external and credible perspective on their circumstances. Whilst this contrasts with Plaistow *et al.* (2014) who suggests that young people want to be self-reliant, it supports the position that the personal qualities of mental health professionals are critical to effective service-user and care provider interactions.

In summarising the findings discussed in this chapter, it can be seen that a range of factors enabled the research participants to access care. This included the influence of social networks, supportive educational environments and

increased levels of mental health literacy. The participants also adopted alternative coping strategies, some of which have been identified elsewhere in the literature among Black adults. One of the main findings was the hesitant help-seeking behaviour described by participants as a result of the various fears, often racialised, they held about receiving care. Additionally, the experience of receiving care during these early help-seeking encounters was negative; meaningful relationships were not formed, care was viewed as unsympathetic and impersonal, which contributed to the development of racialised thinking among some participants.

Conclusion

An unexpected finding of this study is the extent to which some young Black people make repeated and unsuccessful service contacts. In the broadest sense this is interesting and problematic, as it highlights that mental healthcare does not always operate in a way that is intended. The pattern of unsuccessful service engagements is also noteworthy as it challenges the perspective that young Black people are difficult to engage. Conversely, the picture from this study shows that participants actively pursued opportunities to improve their mental health despite encountering multiple barriers.

Social networks play a crucial role in supporting some young Black people into mental healthcare. In particular,

the role of parents has been fundamental to participants accessing care. It has often been the situation among adults that mental healthcare is viewed as the last resort. Whilst there are examples of racialised barriers to help-seeking based on family perceptions, the role played by participants' parents points towards a potentially positive intergenerational shift in attitudes. These kinds of changes do not however happen in a silo and various interweaving and wide-ranging factors facilitate help-seeking. Schools have been shown to play an important role by creating non-stigmatising environments, which can simultaneously improve mental health literacy but also normalise discussions about mental ill-health.

The way that some young Black people try out alternative approaches to formal mental healthcare demonstrates that mental ill-health involves a journey of exploration. The idea of mental ill-health self-management is not new among young people (Reavley *et al*., 2012). However, the use of alternative approaches that are found to be more prevalent among the Black adult population points toward a Black cultural legacy in the types of approaches that are adopted.

Young Black people face a range of emotional challenges when making the decision to access support. There is a great fear of the unknown. Fear of medication, stigma and being racialised are present. The idea that this is a journey of exploration involving tenacity and courage is highlighted

by the way young people overcome challenges about the way mental health services have been presented to them. A Black legacy of viewing mental healthcare sceptically had to be surmounted. This again, displays evidence of intergenerational similarities and differences as old knowledge has been challenged and new knowledge has been acquired.

It has been documented in the literature that racialised minority people are less likely to access mental health care, and more likely to discontinue because of stigma (O'Brien *et al.,* 2009). The findings in this research show that young Black people actively seek out support. However, they typically disengage because they are frequently dissatisfied largely because effective and trusting relationships have not been established and methods of delivery do not adjust to the different requirements of young Black people.

Too often, when young Black people experience care on their journey through services it does not meet their expectations. When young Black people attend mental healthcare there is a difference between what would make them feel comfortable and what they actually receive. For the participants in this study, the professional's method and style of delivery are too far from the reality of young Black people's lives that most support is rendered ineffective. The racialised identity, age, class, and other personal characteristics of the mental health professional

play a role in alienating young Black people. Similar or shared racialised identities can be important—at least—in building commonalities between mental health professional and service-user. Whilst emphasis is often placed on encouraging people to help-seek, significant improvements are needed to ensure that young Black people are receiving some benefit from their own investment to improve their mental health.

Young Black people's experience of early forms of mental healthcare is best represented by the image of multiple revolving doors, as they access and disengage from different services. Applying the old adage, 'once bitten, twice shy', participants in this study are being bitten, three, four or even five times. It is therefore critical to recognise their concerted efforts in the face of limited success. Lastly, this research has shown that negative experiences can operate as a barrier to future help-seeking, and racialisation is a factor that can be central to the way young Black people comprehend these events

Chapter 7 Young Black people's experiences of accessing and receiving non-statutory mental healthcare

The findings discussed in this chapter show that when mental healthcare is more closely aligned to the realities of young Black people's lives that their experiences of accessing and receiving care can be more positive. The data gathered in this study shows that fears can still exist when participants access non-statutory support organisations; however the findings also show these can be mitigated when safe places of entry to care are established through opportunistic engagement practices. Pluralistic help-seeking was also highlighted as an important feature that facilitated individuals into care, whilst further illustrating the importance of understanding illness behaviour. A main finding from this study was the way different models and aspects of care, including more informal arrangements, group therapy with racialised matching, and practitioners that displayed competence with interpersonal skills, were fundamental to improving the participants experience of receiving support.

The twin aims of this study were to understand the lived experience of young Black people when accessing and receiving non-statutory mental healthcare. This chapter is divided into two main parts presenting the findings that help to expand knowledge in these areas.

The first part is concerned with participants' experiences when accessing care. The literature pertinent to help-seeking was reviewed in chapter three and largely points to Black groups following coercive pathways to care. After reviewing the data from this study, it was evident that there are different ways of understanding this area of scholarship. The findings show that young Black people face a range of dilemmas when making the decision to seek help. Past unsatisfactory service contacts contribute to low service expectations, which presented a barrier to help-seeking. This was combined with anxieties that arise due to the prospect of being in a new environment, with new people, and the fear of being judged. Processes of racialisation are significant as they operated as a barrier and facilitator in the pathway to care; previous racialised experiences of care made young Black people question whether they should access support again, whilst the opportunity to receive support with people of the same racialised identity engendered hope and excitement. A further theme developed throughout this chapter is the importance of the social environment and how places where people naturally associate, such as churches and drama activities, can offer safe points of entry to care. Participants also shared how critical faith was within their mental health experiences, which demonstrates a void within the present structure of statutory mental healthcare where this is not a feature of service delivery.

The second part of the chapter looks at participants' experiences of receiving care in the non-statutory sector. In most situations young Black people shared positive accounts, contrasting those of past care documented in the previous chapter. Participants generally described how they handed over the decision-making power for their care to the mental health professional in line with the stages of illness model defined by Suchman (1965). From this, it should be acknowledged that young Black people are perceptive about who they will accept as their care provider. A number of factors contributed to this. Professionals needed to demonstrate they were competent and to show service-users that they were valued. Informal care-giving arrangements also improved how care was viewed. Care that was delivered in a more relaxed way, based on friendly interactions, or where the professionals made an extra effort, helped to establish good foundations. These positive examples of care are to be welcomed against a body of literature that portrays the relationship between Black groups and mental health services in unfavourable terms (Rogers and Pilgrim, 2014). Problems with non-statutory care were described. This involved inconsistent provision, impractical advice, the fear of stigma or the financial burden of paying privately. Once again, processes of racialisation were significant. On occasions it created a barrier to interaction between the service-user and professional. At other times it cemented a bond through which young Black people felt assured there was a common understanding that helped them to be

open. Group therapy was a specific area of provision that proved to be valuable. Service-users talked about their initial anxieties about accessing group therapy. These were overcome as relationships with other service-users were formed based on shared social identities and life experiences.

The lived experience of young Black people accessing non-statutory mental health support

How young Black people felt when deciding to access non-statutory mental health support

Participants were asked to talk through their experience of accessing non-statutory support. Some participants provided detailed accounts of their location and emotions, whereas others narrated their experiences more broadly. There is no academic literature that addresses how young Black people feel when they specifically access non-statutory care. This research has revealed how this group of young people faced a variety of challenges and many mixed emotions. Varying degrees of anxiety were common; in its most concerning form, it manifested itself in a strong sense of fear. This was often due to past negative experiences of support, the prospect of being in group therapy or the fear of being judged. This research also uncovered how many of these challenges were racialised and thus created an additional burden. At the same time the prospect of receiving support brought

feelings of hope and excitement. Again, this was an experience that was racialised for some participants as they believed being with other service-users of the same racialised identity could help form meaningful relationships.

Whilst there does not appear to be any literature looking specifically at the experience of young Black people accessing non-statutory support, closely related research provides some background. Studies looking at young people and help-seeking highlight a general fear of the unknown (Woodgate, 2006). Wider evidence of perceptions of care is discussed in the previous chapter. This includes the role of social networks, the adoption of coping strategies, worries about confidentiality, and being concerned about discussing personal matters and mental health stigma. When addressing the subject matter of racialisation, the main focus is on adults with severe mental ill-health (Dogra, 2012). One of the main theories to address the subject of help-seeking among Black groups is offered by Keating (2012). He asserts that Black males in particular have a fear of being treated differently because of their racialised identity and mental health status. When looking at young people in particular, Kurtz and Street (2006) highlight that racialised minority groups perceive they will experience racism from mental health providers. This thesis moves beyond perception to look at the lived experience of help-seeking.

Participants described the challenges they encountered when accessing support. Many of these were similar to those identified in chapter six where it detailed how young Black people were sceptical about whether they could be helped or if their concerns would be taken seriously. Many of the fears participants had when accessing early forms of support were no longer salient when accessing non-statutory care. For instance, there was no mention that they feared being given medication or being diagnosed with severe mental ill-health. This may have been because they were more familiar with procedures and outcomes. Hence, there is some evidence to suggest some fears decrease with multiple experiences of help-seeking.

Nevertheless, a number of factors made participants unwilling to seek help. One of the main findings was the varying degrees of anxiety. Brian described feeling brave that he overcame a fear of accessing care. For others, they described a fear of being judged by different people, including their parents, mental health professionals and friends. This was an ongoing concern for Syd, who felt that he would be constructed as someone who was unable to cope. In a number of situations, it was a fear of the unknown. This can be seen in Georgia's account when she described her general feelings of anxiety:

> **Georgia**: We got a letter, and it was like, arrr you've been put in a group. And I literally said I don't want to be in a group cos I thought that

> it wouldn't help, and I would feel too anxious to say anything in the group. But my mum said, erm, just try it for like one week or two weeks […] It probably helped that my mum drove me […] In the car [on the way] there I was probably pissing myself a bit … [Because] I didn't like have control of the car I couldn't just turn around.

Georgia was specific about her concern of attending group therapy, a feeling shared by other participants. This is relevant as it highlights a barrier that must be overcome, whilst also showing that the offer of group therapy may deter service access. Although this was a barrier for some participants, when racialised elements were interwoven with the offer of group therapy it had a more favourable outcome. This was the situation for Brian, Sandra and Simon. They described how the opportunity of receiving care with people of a similar racialised identity made accessing care easier. Brian's experience was not straightforward as he did not want support from a Black woman. However, he found the chance of being amongst Black men appealing. He felt this would help him to be 'accepted' and part of his own community. This points towards an interesting dynamic whereby the presence of intersectional identities, involving racialised and gendered thinking. The possibility of being with other Black males was important for Simon. He believed this would be a

positive turning point in his circumstances when describing his thoughts on receiving his referral:

> **Simon**: I felt like it was just gonna be like a therapy session. And to be honest I didn't really feel like one-to-one [support] would help. … Then, when I called up [they said] that it was like an all Black men's group. I felt like, this may actually be a good thing because I [would] actually have [a] connection with somebody that's my colour. … Like, there's gonna be loads of Black boys here, we're gonna be all talking and stuff, having like conversations and stuff, trying to get to know each other, but then, I was excited, yeah […] Because I felt like I [could] actually fit in somewhere for once. I could actually open up.

When Simon found out he would be in group therapy with young Black men he was excited as he believed he would find common ground. This is significant given concerns that Black people are more likely to access care through adversarial pathways (Morgan, *et al.,* 2009). These findings demonstrate that racialisation can be a feature of help-seeking and it can be decisive in encouraging young Black people to engage in care.

From Simon's description it is possible to see how he contrasted the prospect of being in a group with service-

users of his own racialised identity, to receiving other forms of support. Other participants spoke about how their past experiences of care created doubt, which made them sceptical about accessing support again. Jason was one participant who described how memories of past care were part of his decision-making. He recounts what he was thinking shortly before his appointment:

> **Jason**: Frantic! … I'm there in college doing my work normally. Then it just hits me, you're going to therapy in two hours, and you haven't done this in years, well in, well, I've never done group therapy. But CAMHS was shit, last counsellor, that behaviour thing I don't even count that because it was that shit. … And then it hit me. I was just like, this actually might be good for me. … Even though I was going around panicking, thinking 'fuck, fuck, fuck, I don't know what to say', then, it just hit me, why don't I just tell them what's happened.

In chapter six it was discussed how negative experiences of past care influenced future help-seeking. Jason's description shows how these feelings were replicated when accessing non-statutory provision. Syd, Rafael and Sean also had vivid and negative memories of past care which made them hesitant and reluctant to seek support again. Despite these anxieties, they felt compelled to persevere in their help-seeking journey due to a desire to improve their

mental health. Whilst the participants were determined, it was evident they were frustrated due to the impact of poor past experiences with care. As noted in chapter six, these findings offer some support to the idea put forward by Cole *et al.* (1995) and Singh and Burns (2006), which suggests that Black adults resist help-seeking due to previous negative experiences. Based on the accounts gathered from this study past negative experiences do hinder help-seeking but some young Black people remain willing to overcome these challenges.

Another factor that made participants unenthusiastic about accessing support related to their racialised identity. This was particularly the situation for Rebecca whose thoughts about her own identity evolved during her help-seeking journey. At the point of being interviewed Rebecca had already consulted her GP and was referred to IAPT, where she attended one session. After disengaging from IAPT, Rebecca received care privately with a mental health professional who was a friend of her work colleague. Similar to the accounts shared above, Rebecca was unsure about receiving support, again based on the poor experience at IAPT. After attending IAPT, and prior to receiving private support, Rebecca described how her racialised identity, alongside other factors, became more prominent in her thinking:

Rebecca: I was discriminated because of my criminal record and I was discriminated because of the colour of my skin.

Anthony: And those things you say were going through your mind when you were thinking of accessing support as well?

Rebecca: At first it was just the criminal record. Because the colour was highlighted to me. … To me it was just the record; I can't get a job because of the record. But obviously as the journey continued and time moved on, erm, it was highlighted to me, well actually it's your colour as well as your record. Your colour is actually the thing you see before your record. So that actually started then making me think about the colour as well as the record, so it just added on.

Rebecca alluded to the internal challenges she faced due to the oppression and stigma of being racialised and criminalised. This example draws on Goffman's (1963) ideas about spoiled identity, in the way a person's identity causes them to experience stigma. Her experience of being racialised is also reminiscent of Phoenix's (2003) research on remembered racialisation, and how identity becomes salient due to adverse events. Rebecca was informed by her friend that her racialised identity was likely to be a

greater barrier to her progress as it is a physically identifiable characteristic. Rebecca's experience of surviving multiple oppressions is relevant to ideas around intersectionality put forward by Crenshaw (1991). According to CRT advocate Arriola (1994: 431), intersectionality acknowledges the way 'numerous factors compose an individual identity' … [and] 'discrimination in fact stems from stereotypes about a person's entire identity'. Rebecca's experience illustrates the way her racialised identity and her status as a former offender created a barrier to care. This research has added an understanding to the way participants were presented with an impossible task of disentangling any specific and singular component of their identity as the source of adverse circumstances they encounter and how this interacts with, and adds to, their experience on the pathway to care.

Rebecca's account illustrates how her interlocking identities contributed to her perception that she would receive inferior treatment. Indeed, this resonates with Keating's argument about the intersectional concerns of Black men; being stigmatised because they are Black and experiencing mental ill-health (2012), or because they are racialised and also perceived as mad and dangerous (2016). Rebecca shows how this model is also applicable to the experience of young Black women. These findings also advance the work by Kurtz and Street (2006). They showed that different racialised minority groups may

sometimes perceive they will experience discrimination. The findings here demonstrate young Black people with mental ill-health expect to be treated differently. This influences the extent to which they will feel accepted and makes the help-seeking journey challenging. Thus, there is an additional burden placed upon young Black people on their help-seeking journey as a result of processes of racialisation.

Creating safe points of entry—the unique role of the social environment in motivating help-seeking

This research highlights that young Black people can be encouraged to access mental healthcare when they feel the environment is safe. The findings show that a number of factors contributed to participants feeling confident that the environment they enter will be affirming; this includes seeing professionals and other service-users of the same racialised identity, and the structure and processes through which care is delivered. This also demonstrates how mental ill-health stigma can be mitigated through thoughtful and creative interventions.

There is very little research that looks at the way non-statutory interventions can provide safe points of entry to mental healthcare. Evidence in the UK shows non-statutory care has been effective at engaging historically excluded groups (Milbourne, 2009), and that a greater proportion of

racialised minority groups tend to receive support in this sector more so than the White majority (Duncan, *et al.,* 2019). It has been argued this may be because there are fewer thresholds to receiving care alongside a perception that they are less likely to be discriminated against (Fernando, 2005). Meanwhile, Keating (2012) has noted that the BVS is a preferred option of many racialised minority groups because services are delivered based on their own cultural frameworks and this is seen to be a safer option. The findings discussed here expand this evidence base by illuminating some of the factors that contribute to safe points of entry.

The main reason that participants accessed care was to improve their mental health. However, a striking finding that emerged was the different motivations that led to some participants coming into contact with care. Participants described how they had socially-driven motivations, which resulted in them receiving care. An example of this was provided by Carlene. She attended an organisation that provided drama therapy. This was not advertised as a mental health intervention but as a youth drama activity. Nonetheless, it was the aim of the professionals organising the intervention to deliver holistic care in a non-stigmatising way, covering areas including anger management and self-esteem. Carlene describes her thoughts about accessing the support:

> **Carlene:** A friend told me that her friend needed dancers. … I thought, 'Oh yeah, I'd like to dance, I haven't danced in a long time.' … Then I came to one of the sessions. … I just thought we were gonna come and dance, but I didn't know the other side of it which was dealing with your whole issues.

Carlene's example shows how somebody who is not actively help-seeking can be engaged in mental healthcare. Very little literature demonstrates how people access care unintentionally. Bevington *et al.* (2015) did identify similar work with gang-affected young people who were involved in general youth activities (*e.g.* rapping) and had the option to access mental health professionals via the same organisation. Whilst this approach is uncommon it can help to overcome some of the barriers that are associated with traditional mental health services. Several participants in this study had accessed support that was advertised as social activities (*e.g.* dance and drama). One participant was looking to socialise, another attended along with her boyfriend and wanted to take part in creative activities, whilst one person was trying to find like-minded people. Tianna also narrated how she found out about a youth organisation by watching them perform:

> **Tianna:** I knew that I had to get rid of these emotions and from having gone to see the play [I realised] this is the place where I will be

> able to do that. It had a creative element and that matched perfectly with who I am. … A lot of the girls there were like me; were all loud and chatty and, erm, interesting characters, so I didn't feel foreign. … I just knew this was the place that I could get rid of these emotions and be able to implement new think, learning. … I saw young girls that looked like me, of my complexion, of my culture, so it was like, 'well then, talking about your feelings is normal then,' type of thing.

Tianna was attracted to the organisation by at least three factors: the opportunity to improve her mental health, the idea of discussing mental health in an environment where it was acceptable and being able to identify with other service-users based on gender, racialised identities and personality-types. In the previous section, the role of racialised identities in facilitating help-seeking was noted. Tianna's example confirms that racialised identities can facilitate help-seeking, whilst they agree with Cooper (2006) who argued that gender can also be an influencing factor. Hence, a number of these findings are pertinent to understanding the experience of young Black people accessing care. This is a novel finding as it shows that intersectional identities are a part of help-seeking decisions. It also highlights that groups typically described as 'hard-to-reach' can be engaged in service provision

based on the intersectional identities of other service-users and mental health professionals.

Tianna accessed the support because she found the activities engaging. Allen (2013) has shown how opportunistic practices, such as meeting children in court, in a stairwell or park, can facilitate service engagement. Hatzidimitriadou *et al.* (2012) have shown how mosques and temples have been important for engaging racialised minority adults. The findings from this research also identify that approaches to mental health engagement in places and through activities where people normally associate can be effective. A further example of this is highlighted by Sandra:

> **Sandra**: I was excited because I didn't feel like I was turning up to an intervention if that makes sense. I think because of the fact that it's structured in a way that uses the things that I naturally enjoy—drama, poetry and creativity. So, it doesn't make me feel that I'm a very strange individual.

Sandra felt reassured going to drama therapy as it did not feel like a mental health intervention. This was in stark contrast to the 'nerve-racking' emotions she described when accessing support previously. David, Nadia, Jacob and Ralph each discussed how they accessed support through their church. In each of these cases the

participants stressed how important it was to be in an environment that encouraged openness to discussing their problems. Nadia described the factors that contributed to her decision to approach her church.

> **Nadia**: [In] a lot of churches that I know of it's very taboo for people to even speak about mental health. So I would say one thing that made it easy was knowing that, whether it is through the sermons or whether it is through just the pastor on the mic, just knowing that something is said that, 'You guys, this is a place … where you should feel transparent.' … So, I would say that made it easy for me to open up because I knew that whatever I say I'm not going to be Blacklisted.

Nadia acknowledged that all churches are not as open to discussing mental ill-health as it remains a stigmatised topic. Nevertheless, she articulates how a positive atmosphere existed at the church she attended where dialogue about mental health was promoted. This was achieved through activities that involved members of the congregation sharing stories of their challenges and successes. Thus, the social environment is absolutely crucial to help-seeking motivations.

There is little research looking at how non-statutory organisational structures and processes can facilitate help-

seeking for young Black people. Schneider (2009) has argued that closer and more equal relationships between the community and mental health services can build service–users' social capital and make mental ill-health less stigmatising. However, minimal attention focuses on the intricate parts of the way non-statutory organisations operate that can overcome the barriers presented by mental health stigma and the fear Black people have of mental healthcare. Participants' descriptions help to fill a gap in the literature by showing how unorthodox approaches to delivering care are considered to be safe points of entry. Additionally, given the right circumstances, young Black people find open dialogue about mental health a stepping stone to facilitating access. Therefore, data presented here demonstrates that it is integral for care providers to fully consider their approaches to engaging young Black people.

A search for pluralism within health provision

Evidence collected from this study shows that when young Black people experience mental ill-health they would like the care they receive to have a faith-based component. It has been acknowledged that religion is relevant to the mental health of Black people (Smith, 1981). Black churches (known singularly as the Black Church (Adkinson-Bradley *et al.,* 2011)), are led and attended predominantly by Black people (Beckford, 2000), and have been

recognised as playing a significant role in the delivery of mental healthcare in the USA (Allen *et al.,* 2010) and to a lesser extent in the UK (Rudell *et al.,* 2008; Friedli, 2000; Edge *et al*., 2004). The role of the Black church and its role in supporting the mental health of young Black people is an area that has been under-researched. Against this background and given that religion does not feature within standard forms of statutory care, the findings documented here help to build an evidence base and offer an opportunity for learning across various areas of mental health service provision.

Most faith-based support that participants received was delivered by Black people who attended a Black church. Care was provided by either a church leader who had obtained a professional mental health qualification with the aim of specifically offering support to church members or a member of the congregation who worked as a mental health professional in their day-to-day life. Several participants decided to access support that had a faith-based component. This was the situation for Ralph. He explained that he was influenced by his mother's social network to attend Christian-based care. He described how this was seen as the 'obvious route' to dealing with mental ill-health for his mother. This helps to emphasise how important religion is considered to be and its influence on young Black people. David also explained how he regarded the role of the church:

> **David:** Yeah, the church [has a] massive role. It's a massive, like, influence within the Black community. … You go counselling at the church more so than what the government has provided.

Participants' reasons for wanting to seek support specifically within a faith-based framework consistently pointed to a desire for their mental and spiritual needs to be attended to. This is emphasised by Jacob:

> **Jacob:** I wanted to speak to a counsellor. I also wanted someone who could appreciate my faith and kinda, still guide me [and] be able to combine mental health with my faith.

Jacob had been receiving guidance from his pastor. Nevertheless, he believed he needed to see somebody who had mental health expertise who would also be respectful of his Christianity. This led to him receiving support online via a trained Black professional based on a recommendation that she specialised in Christian-based support. Nadia described how she was receiving support informally from her pastor before a new structure was established within her church delivered by trained mental health professionals. These examples illustrate the desire of young Black people to receive mental health support that is delivered within a faith-based framework. They each felt that their needs could only be met by a person

who had recognised knowledge from within the field of mental health whilst also attending to their Christianity. This way of thinking was articulated by David when he shared the reasons that led him to see his pastor:

> **David:** The first time I had counselling support … was through my church. … It wasn't a case [that] I could go to my university. … [It was my housemates, who were also] Christians, who were essentially bullying [me]. So, it was of a spiritual matter, more so than … what my university could handle. So, my pastor, he was able to give context to that side.

David's account elucidates how he felt traditional care would not effectively deal with his challenges. The desire of participants to have their intersectional needs met reflects Tribe's (2007: 22) view on health pluralism, who refers to health pluralism as a:

> …multi-layered or diverse range of explanatory health beliefs, and a concomitant wide range of coping strategies or help-seeking behaviours, as well as a varied range of designated healers.

Whilst these findings have been documented globally (Fernando, 2014), as Dogra *et al.* (2012) assert, very little is known about racialised minority young people in the UK.

Hence, whilst Tribe (2007) signifies the importance of seeking help from a range of healers, for the young Black people discussed here, their explanatory health beliefs have directed them to have multi-layered needs—in the form of attention to faith, mental health expertise, and delivered by Black professionals. These findings add to the limited evidence by illustrating the importance that young Black people attach to the Black church and unconventional forms of help. They also provide an opportunity for mainstream mental healthcare to learn from these methods of delivery to improve the delivery of services for all. It also points to the benefits of providing care in places where people naturally associate and feel comfortable as this can overcome barriers to access.

The lived experience of receiving non-statutory mental health support

This study aimed to understand the lived experience of young Black people receiving non-statutory care. The non-statutory sector has been recognised as a key source of mental healthcare for Black people more generally (Bhui and Bhugra, 2002). The remainder of this chapter sheds light on this area, highlighting the value of services for young Black people in particular. Participants were asked to describe the care they received, and they were prompted to describe any factors that made this experience favourable or challenging. The findings from this are presented under three main headings: making

support work for young Black people, challenges within non-statutory care and the group dynamic.

Making support work for young Black people

Interpersonal skills

Participants described feeling valued as being a key element that contributed to their positive experience of receiving care. Buston (2002) has explicated how integral empathetic listening is for young people. This study finds support for this position. It also adds to the evidence about the importance of other interpersonal skills, including the acknowledgment of pain, displays of compassion, and the need to demonstrate an interest in the service-user.

A finding highlighted in the previous chapter and put forward by Plaistow *et al.* (2014) is the importance of a professional's personal qualities. This was an important feature for participants attending non-statutory support. When describing the factors that made their experience positive, participants frequently expounded how the professional was able to make them feel valued. For David, he described a sense of being loved by his pastor. This made him feel reassured that he was cared for which encouraged him to be open about the problems he faced. Nadia's experience was similar, as she described knowing that the relationship with the care-provider was one where she also felt genuinely loved. Several participants

described a sense of being valued when their pain was acknowledged. This was the situation for Jacob. He received care from a psychologist online that was Christian based. Jacob thought the practitioner truly empathised with his experience of a relationship breakdown:

> **Jacob**: When I shared with her how I was feeling and what someone has done [to] me, she was just like, 'My heart breaks for you.' … She was really feeling the pain I was going through. It wasn't just my pain in a sense, but she kinda made it feel like, she kinda like empathised with the pain and I really appreciated that.

Jacob felt the practitioner was truly empathetic, which gave him a sense of security and made him aware that he was not isolated in the pain he was feeling. Several participants appreciated that the practitioner was able to relate to and share the feelings they had to confront. Thus, a key finding was the ability of the practitioner to empathise.

Several similar accounts identified a feeling of being 'warm' as a result of the practitioner's compassion. This was in contrast to experiences in many of the early service contacts described in chapter six where participants found the process to be cold, emotionless, unfriendly or unsympathetic. The importance of displays of compassion

are prominent in the literature (Newham *et al.,* 2015; McAndrew *et al.,* 2013), and the findings here show how it is pivotal to young Black people.

Syd's experience helps to shed light on other elements that made him feel more valued compared to past care where he felt his needs were viewed as insignificant. He described some of the reasons for this:

> **Syd**: The cool thing is like, it seems small but … he doesn't get out his notes every session as in the case we talked about last time. It's like he actually remembers kind of what you talk about. Which is quite surprising considering there's a two to three week difference [between sessions]. Obviously, he probably does read his notes or whatever to remind himself, but as long as he doesn't do it in front of me I don't really mind to be honest with you.

In addition to remembering his case, Syd also talked about the importance of the practitioner displaying an interest in him. This shows how different approaches can help young Black people feel valued. Buston (2002) has also suggested that communication skills should be a priority for professionals working with young people. This thesis shows this is specifically an issue for young Black people. Given that the participants had many negative experiences

in the past, it is important that genuine empathy is highlighted as a component to help establish positive foundations within the service-user and practitioner relationship.

The nuances of informality within mental healthcare

When reflecting on his observations of the BVS in comparison to statutory healthcare, Fernando (2005: 432) said he was struck by the 'informality of approach by the staff towards clients.' Participants described how this was relevant to them in the present study as it made them feel valued when professionals operated outside of expected procedures. This was the situation for Simon who had difficulties meditating during a group therapy session at the non-statutory organisation he attended. When the practitioner telephoned him during the week he described feeling 'great, knowing that someone from an agency like this will actually call you and check on you out of their own personal time.' Jacob and David shared similar experiences of feeling valued by the special efforts of practitioners. Nadia described how she believed this was a feature that distinguished statutory from non-statutory healthcare provision:

> **Nadia**: That's the difference between counselling through the church and other services, because she made herself available.

> … I remember there was one time when I went through a sick situation that triggered a past memory […] I became very sensitive and a bit fragile and I just called her straightaway and she made herself available […] It felt great, it felt really good. It made me feel that I'm valued.

Nadia paints a picture of responsive non-statutory services. It illustrates how services are oriented to the demands of young people. This is very different to standard practice where appointments must be booked and out-of-hours calls are uncommon. Tianna offers a further example of informality when receiving holistic support:

> **Tianna**: It hasn't just been that 'Ok we're just here for your emotions and that's all we're here for.' They've been involved in my personal life, been financial supporters for me, written letters on behalf of me. [These are] things that are massively important [to me].

These examples illustrate how Nadia and Tianna felt valued when a practitioner carried out additional activities for them. These form part of the extra-therapeutic factors described by Lambert and Barley (2001), which can include social support and that have been shown to improve the experience of receiving mental healthcare.

Another interpretation of informality was provided by Dwayne, Elizabeth and Rebecca. Dwayne narrated how he used to joke with a receptionist, which made him feel relaxed. He contrasted this with previous support where he felt overburdened by what he thought was a more serious approach. Elizabeth shared similar experiences where she described how a laid-back approach made her less anxious. Rebecca provides a similar account when she compared accessing support privately to IAPT:

> **Rebecca**: It was more of an informal setting, and it just made me feel relaxed instantly, as opposed to [IAPT] where it was a bit sterile.

In Rebecca's example it is not clear whether it was the approach of the professional or the physical environment, or both, which made her relax. Nevertheless, there was something about the informality that was appealing. For Megan, it was much more vivid in her description that the informality of the intervention contributed to her positive experience. She stressed how critical it was for her to be able to address issues associated with mental ill-health in a way that did not engender fear. This was important to her as she had described a strong fear of medication when she had attended the GP. She described the significance of informality in drama therapy:

> **Megan**: I didn't realise self respect was like what you allow in your relationships. … I didn't

> really know the depths of it until I actually was forced to look at it, in a[n] informal way. … I'm here having fun, looking at all these issues, looking at the stuff, going through it informally, putting on a creative project, a play, but it's not overwhelming, it's not too 'Oh my gosh I can't deal with it, I can't, it's therapy, it's therapy.' No, it's therapeutic, but it's in a really nice form. It's not as scary.

Ralph's experience offers further insight into the receipt of informal support. Ralph attended faith-based support that he had to pay for privately. He was certain that he found the informal conversational-style approach more appealing. Previously he felt like he was being interviewed. Ralph also spoke about how he attended the same church as the professional and would often see him in the community. Ralph noted this could be seen to 'blur the boundaries' within the professional and service-user relationship. Notwithstanding this, he felt comfortable as it was familiar to him and stressed this was an arrangement that was normal within the Black Christian community.

What has been described in the majority of cases are arrangements that diverge from standard forms of care. This was a pattern noticed by Fernando (2005: 432) when he compared 'traditional ('White') mental healthcare with [the BVS]'. Not all of the organisations involved in this study were part of the BVS. However, informality was

commonly described as a beneficial component in organisations that were led by Black people, or organisations that predominantly or exclusively supported young Black people. This is an important finding that adds to the literature and demonstrates how young Black people appreciate models that are less clinical or not based on rigid and structured interaction. Fernando (2005) draws on similar ideas when looking specifically at adult services within the voluntary sector. He (2005: 432) found that few boundaries were drawn between service-users and practitioners' engagement 'between what is appropriate and not appropriate for discussion [during sessions].' Fernando (2005: 432) went on to suggest this makes it more likely that service-users will 'discuss personal problems of a social and political nature including racism and ways of dealing with racism.' Less strict rules about time keeping and an overburden on managing risk were further differences observed by Fernando (2005). When comparing the experiences of participants as service-users at early forms of care, and in particular IAPT provision, with that of non-statutory care, these sentiments are also present. This study reveals how various aspects of informal care-giving arrangements can improve the experience for young Black people, by making them feel valued and relaxed, which has helped to keep them engaged.

Mental health practitioner competence, experience and identity

Findings from this study show that young Black people are not passive recipients of care. Rather they make astute ongoing assessments about the competence of a mental health professional's ability to help them. When looking at early forms of care, the findings from this study point towards a pattern of service discontinuation, as no connection was established with the professional. Participants shared a wide range of moments relating to non-statutory care that facilitated their continued engagement. In many situations they attributed these improvements to the experience of the practitioner. Ambresinet *et al*. (2013) also identified that the success of an intervention was often dependent on the competence of the professional. They found that competence was tied in with the professional's ability to manage challenging situations, which contributed to satisfactory outcomes. The findings from this study build on this and go further to illustrate how competence was perceived, whilst also highlighting how processes of racialisation were layered in young people's experiences.

A number of participants described how they felt that the professional had an appropriate skill set to be able to attend to their mental health needs, often comparing past care with non-statutory care. This was the situation for Ralph. He detailed how his first four service contacts

brought little symptom relief as they could not get to the 'root of the problem.' When Ralph received support from a Christian-based professional he found the guidance helpful. Ralph accessed Christian-based care via mental healthcare provided by a Black Church and had to pay a fee for each one-hour session. He talked about how different aspects of the support he received improved his mental health. This included comprehensive guidance relating to his self-harming that encompassed the physical dangers (*e.g.* the loss of too much blood), the professionals' candid concerns about Ralph's desire to want to be able to tolerate pain, and a perspective about why God would not want Ralph to self-harm. Straightforward talking was a feature that Ralph and other participants found supportive. This is accentuated by Nadia:

> **Nadia**: It wasn't like she would sugar-coat anything. She would let me speak, let me voice my concerns. … What I loved was, [she would listen to] what I was saying, but at the same time be able to acknowledge my feelings and my thoughts, and be concerned about them. … At the same time, kind of encourage me, this is what you need to change, you need to change how you see yourself. … That's something that was very novel to me in the sense that I had, it was quite new to me to have someone to actually listen, take it on, share that they knew the upset about what I

> went through, show empathy, but at the same time say, yes what you went through is bad but you know, you can't stay at that place, and I think that was a balance that I had never seen before. … She was kinda able to stay like within that medium.

Nadia described various aspects she found affirming. Being able to consistently take on board Nadia's challenges then offering clear guidance was something that was appreciated. A number of participants shared similar experiences. Elizabeth and Scott described how they each felt reassured that the mental health professional had experience supporting young people. Meanwhile, Jacob felt confident when he knew the practitioner had experience dealing with people who had been in his situation. This all provides evidence to show that when young Black people find a professional who they believe is competent, mental healthcare can be successful.

Participants also appreciated it when they had opportunities to learn. This was another factor that demonstrated a practitioner's competence. An example of this was shared by Sandra who was attending drama therapy, as this activity meant she could release her emotions:

> **Sandra**: I started crying when I was like speaking out the poem because I was

> reflecting back on the time I wrote it. But I also felt really embarrassed actually because I was crying. … When I'd finished it … I felt completely light. … I'd voiced the issues. I was now free because I was never able to voice them. I'd never sat in the patient chair.

Sandra described hiding her emotional challenges. However, it was the social environment created by the professional where she felt safe and meaningful opportunities that were devised by the practitioner that meant she was able to obtain relief. Steph had a similar experience to Sandra and explained how it helped to release her from suicidal thoughts. Megan also shared how she had previously attended three forms of care before attending drama therapy. Megan narrated how drama therapy provided her with an opportunity to reflect on her need for self-respect within her relationships. Simon's experience of receiving effective support builds on this. His friend had committed suicide and he described how he felt partly responsible. He was informed by the professional that he should not feel down as he could not always control the actions of others. Simon described this experience:

> **Simon**: On my first day [I] was just feeling depressed. … I started to cry. … We were talking about friends and people that were close. … Cos even though he did commit

> suicide and stuff, I was still feeling guilty at that time. … I started to think about it and it's like, I can't have control of somebody else's actions. So that's when [I] really start[ed] to think about … how I was gonna move forward from it basically.

The guidance provided by the practitioner was critical in Simon's progress. He also found other aspects of care beneficial. For instance, being part of a group of young males of the same racialised identity was instrumental in the positive thoughts Simon shared. It was the professional's aim to use some of the sessions to address societal pressures that can inordinately affect young Black people. One aspect of this involved looking at Black history before slavery, which Simon said occupied his mind and improved his situation:

> **Simon**: It feels good because, it makes me feel like, as a Black man, it makes me feel like I'm empowered. Yeah that's the word I should really say. Yeah, empowered. It makes me feel empowered because learning about things like before slavery we were living like kings and queens basically. And it makes me feel empowered knowing that we used to live like that. And through slavery we kind of lost all of it. But I still feel like we still have the power we need. … And coming [here], it's kind of

> opened up … my eyes to what potential we have.

The sense of empowerment that Simon felt is likened to research by Davis and Stevenson (2006) looking at racialised pride. They found that when young racialised minority people reported higher rates of pride with their racialised identity this was associated with better levels of mental health and higher levels of self-esteem, than groups who did not attribute positive connotations to their racialised identity. Other participants that attended care that focused on racialised issues noted how they found it appropriate. This included sessions that focused on the valuable contribution Black people had made to society or talks about the significance of societal racism. These examples illuminate the ability of practitioners to devise care that is meaningful and beneficial to service-users. Fernando (2005) makes a similar point when he suggests the BVS will bring in social and political issues within sessions, which are less likely to be brought into discussion within statutory provision. He suggests this means that a greater variety of personal problems can be considered including those which are racialised. These efforts can be seen to make the experience of receiving care more personal and appropriate.

Participants also felt that the racialised identity of the professional encouraged a greater understanding of the

problems Black people face. Nadia described how this was important to her:

> **Nadia**: The fact that the people I have spoken to are Black maybe that made it easier to identify with them in comparison let's say for instance to CAMHS where psychologists are predominantly White. … I think having counselling with someone that just understands … my whole kind of cultural identity, I think makes it easier. … When I was able to speak with K about the mentality that I was brought up in at home, that you don't show any signs of vulnerability, she could understand what that meant, what that experience is like you know. … African parents, how they show love is not always about saying 'I love you.' There [are] other circumstances and they're [just] very [different] in terms of giving and supporting […] Someone from that background is able to understand what that means.

Nadia's experience shows how racialisation plays a key role in creating bonds. This was also the situation for Ralph. He believed that because the practitioner was of the same racialised identity as him that he was less likely to be stereotyped as a young Black person involved in knife crime or from a problematic background:

> **Ralph**: Most of the counsellors … were Black. ... They didn't come in with a pre, a pre-determined, er stereotype about Black people because they them self are Black so there's nothing there. To be honest with you I didn't care who I got. But the fact that he was Black made things better in a sense.

Taken together, this all provides evidence to show that when young Black people find a professional who they believe is competent and experienced, and sometimes of the same racialised identity as the service-user, mental healthcare can be successful. These findings add to the literature looking at young people and their experience of receiving support. They concur with findings by Ambresinet *et al.* (2013) that point to the importance of medical competence. However, given the context set out in the previous chapter defining the poor early service contacts, and how this can hinder future help-seeking, the necessity to mitigate these effects is more urgent. Therefore, the evidence collected in this study stresses the need for young Black people to be supported by capable mental health professionals. These findings also clearly reveal the way racialised identities can help to form relationships between service-users and professionals, which can be a foundation for common understanding.

Challenges within non-statutory healthcare provision

A variety of problems were described relating to the receipt of care. Challenges included impractical guidance, financial burdens, logistical dilemmas, a fear of stigma and personal barriers to opening up. Racialised features were also present. The literature looking at the challenges young people face has already been covered in the previous chapter. Therefore, this section will briefly touch on some general findings to help provide a context to the challenges that were faced. Findings that are original to this thesis will then be presented and debated.

Participants shared concerns that related to the logistics of service delivery. This included sessions that were too short and inconsistent support. These factors are highlighted in the wider literature (Harper *et al.,* 2013) and were only noted in a small number of cases. The reasons for inconsistent support varied. For Nadia, she was frustrated as she had to wait a few weeks to speak with a mental health professional at the Black church she attended. This was because the service had only recently been established and they were deciding how they would allocate the service-user to the professional based on the service-user's needs and the professional's area of speciality (*e.g.* one professional dealing with more severe cases, such as girls traumatised from gang violence and another dealing with more general emotional challenges). Consequently, there were delays when Nadia had to change from one practitioner to another. For Scott, his

concern about inconsistent support related to the pattern that had seen him continuously moving from one service to another. As a result, Scott felt he had to keep repeating his life problems. Thus, it can be seen that the practicalities of service capacity can be detrimental for some young Black people.

Several of the concerns that participants described related to Christian-based care. Jacob accessed care privately online. One of the reasons he decided to discontinue with this support was because of the cost. On the one hand this research has shown an interesting pattern of young Black people seeking support privately as there is little research into this realm. At the same time, it illustrates how young Black people feel compelled to seek care through private means where there is a cost implication rather than obtain support through more conventional means, such as through the GP. Furthermore, it highlights the financial barriers that young Black people face, which prevents ongoing care.

David and Nadia also accessed Christian-based care in the Black church. Their challenges related to the fear they had of discussing their mental ill-health. Although they were both aware the mental health practitioners cared for them, they still felt a degree of reluctance to open up due to a fear of being stigmatised within the church environment. This is an important finding as there is an absence of literature looking at the way stigma manifests itself in the

Black church for young people. Nadia and David's decisions were influenced by the negative stories they heard about mental healthcare when they were growing up, making them feel hesitant about discussing their problems. A further problem for David was that he thought some of the guidance he received was impractical. He was the victim of homophobic bullying and the professional advised him he should love his enemies. David found this guidance difficult to agree with as he felt the perpetrators should be punished. Hence, David experienced a large amount of internal tension about what he thought was best practically, and what he was advised to do according to the professional's interpretation of the bible.

Some participants also felt that their experience of non-statutory support was racialised. Syd described an initial barrier to his engagement. He had a negative experience of receiving care from a White professional previously where he felt she was of a different class. These memories returned to him when he first met another professional:

> **Syd**: I came here for the first session, met the counsellor. Upon first glance there was that difference of, different race. To be fair he's not that old but, in the way he spoke you could tell there [were] class differences.

Syd's first meeting with the counsellor was one where he felt a limited connection due to racialised and classed

barriers. Syd continued to engage in his care at this service and described how it did not respond to his needs as a Black person. Dwayne's experience was similar, yet he believed the professional made judgements about him based on his racialised identity:

> **Dwayne**: When people say Black people, I think of you know, a nigger, a Black or an African individual with no sense of himself, or has allowed himself to become degraded. … So, they look at me like some Black, 'Who's this lost little Black kid?' … I'm not saying that's what they said, but I can tell they're looking at me. [I] couldn't open up as much as [I didn't] feel safe. … I think race is … the articulation of what they're looking at, but I think it's just more. It is the race but the personality and the culture. Because I feel like their cultures are different. As in, everybody that worked there was from a certain culture. Maybe not a posh culture, ghetto culture, but whatever culture they were from it was not from what I was from. … So, you're a psychiatrist or whatever. … You're trying to help all walks of life people. But you don't know all walks of life people. So, that already is the flaw. So, it makes me think he didn't even care about me enough.

Dwayne described how he felt there was a barrier that prevented him from being open about his mental ill-health. Whilst he acknowledged that the different professionals working at the organisation he attended had different upbringings or cultural differences, processes of racialisation played a central part in this disconnect. One element that stems from this is the way young Black people feel they are perceived by professionals. The literature pertinent to this is discussed in Scott's experience in chapter six that draws upon Dalal (2002). Accordingly, Black people sense they are viewed with suspicion and aversion. In another way, Dwayne felt he was being measured and defined based on the views of a White man, which bears similarities with the position offered by Du Bois (1968: 3) when he stated that Black people look at themselves 'through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity.' These findings are critical to understand as they shed light on the racialised challenges that exist and the need to build bridges in the service-user and care provider relationship.

This line of thinking builds on Sewell's (2012) perspective, which suggests Black people experience mental health services based on toxicity. Whilst this example occurred on only two occasions within non-statutory healthcare provision, it demonstrates how processes of racialisation are salient in differing contexts relating to the provision of care. This evidence runs contrary to the findings put

forward by Farran (2014) who has argued that young minority people gravitate towards people of different ethnic and class backgrounds within mental healthcare. As was seen in the previous chapter this was the situation for Brian who, in one instance, sought out White professionals. However, the broader direction of findings from this study challenge the idea that Black people will always seek non-Black people, and such a position oversimplifies what is a complex terrain.

The group dynamic

Participants attended group therapy that came in the form of drama therapy, or gender-specific groups that were only for young Black people. What became evident during the analysis was how being in a group brought about a different experience because participants were with other service-users. This next section focuses on the importance of this interaction with other services-users and its value to the experience of young Black people and their receipt of care.

Participants' accounts show that, despite initial anxieties about engaging in group provision, the format of this type of intervention is generally valued. Challenges do exist. These include personality clashes and anxieties about communicating in groups. It also sheds light on how integral it is for participants to be with peers who are of a similar age, gender and racialised identity when receiving

care. These are factors that increased feelings of relatability, acceptance, and made participants feel like they could be more open. It has not been possible to identify research that looks specifically at this area of provision. Further, the literature reviewed in chapters two and three of this thesis show that Black people have continuously been dissatisfied with mental healthcare (Fernando, 2014). Against this background, the positive findings documented here make a distinctive contribution to the evidence base, which is critical to understanding the value of group therapy.

Challenges of group therapy

Research looking at group therapy has mainly shown that reduced service-user motivation can be a barrier to involvement (Lecomte, *et al.* 2003), whilst Spidel *et al.* (2006) have shown that travel arrangements can limit engagement. These were not factors identified in this study. This research has shown that the main concerns about group therapy are due to different personalities. Lecomte *et al.* (2002) highlighted that social anxieties can be a barrier to group engagement. The anxiety of talking in a group was an initial concern shared by a few participants. However, this reduced as they became more familiar with the environment, the other service-users and as they started to realise they were in a safe environment where all of the service-users had their own challenges.

Carlene and Elizabeth each described how they initially felt anxious during earlier sessions. This was emphasised by Elizabeth who described being concerned she would be judged as someone who exaggerated her problems:

> **Elizabeth**: Sometimes I'm worried about people judging [me]. … I think [I was] nervous. … I don't [want other services users] to think I'm making a big deal out of it.

The pattern of initially feeling anxious about group therapy, followed by a feeling of being in a safe space, was a theme across most female participants. These findings are important as they highlight that there are steps that could be taken to offer further support to future participants, as this could be a factor that may prevent them from attending group therapy.

Another challenge of group therapy was spoken about by Tianna and Pippa. This related to the way they impacted, or were affected by, other service-users' emotions. Pippa got frustrated as she thought other service-users used their experience of mental ill-health to seek attention. Meanwhile, Tianna was informed that her outgoing and vocal personality upset other service-users. Although all of the participants spoke positively about the group therapy, these findings demonstrate that challenges exist. This includes tensions between different service-users, and also the anxieties that participants have about being in a new

environment. These are factors that service providers need to consider when implementing group provision.

Finding common ground in group therapy

Suffering from mental ill-health and being in an environment with other sufferers might be a reassuring factor, as service-users could share ideas and find common ground. Age, gender and racialisation were factors that facilitated a shared understanding. In particular, participants described being with peers of the same racialised identity as advantageous as it engendered feelings of being accepted and understood. It also helped participants feel safe about sharing experiences they believed were unique to Black people.

Whilst there is little literature looking at group therapy and young people more generally, research looking at the adult population illustrates the benefits of collaborative models of practice (Teggart and Linden, 2006; Wood *et al.,* 2001). Evidence about the value of group therapy with young people is limited (McGillivray, 2014; Crabtree *et al.,* 2010). Therefore, this study provides insight into the value of drama therapy, and practitioner-led group therapy in the non-statutory healthcare sector specifically targeted towards young Black people.

During interviews, the participants described how being with other services-users improved their experience. One of the reasons for this was that they felt there was a sense of relatability. For Elizabeth, she felt better knowing she was with people who had experienced mental ill-health:

> **Elizabeth**: I think because it's group therapy you can relate to other people, and sometimes if you don't want to talk it's good that there are other people to take the attention away. I think it's helpful.

Another benefit for Elizabeth was that she was not always the main focus point during the session as in one-to-one support. This was an experience shared by other participants. A further factor referred to by Elizabeth was the opportunity group therapy provided for sharing strategies about coping. Simon, Jason and Megan echoed how this was important to them. Dean also talked about how he found group therapy:

> **Dean:** It was an eye opener. … To see people who were going through similar problems to myself, cos I felt alone, I felt isolated, and I felt very lonely. … [The group therapy] motivated and empowered [me] to try and overcome my problems, overcome [my] hurdles, overcome my struggle.

Thus, being amongst people where there is common ground was important in the above examples. Age, gender and racialised factors also brought about feelings of relatability. Participants shared how the characteristics of other service-users helped to improve their experience. Steph talked about how it was important that young people who were very close to her own age were in the group. Megan also described how the age and gender of other service-users created a bond:

> **Megan**: It was just really nice to be around, not necessarily just youth, but also older women that are erm going through that experience, experiences in life, erm, having those intimate times where we can all talk, you know bond as women, we can chat about things that are going on in society that are affecting us. It was literally a safe space.

What can be seen in Megan's example is the way that young people can sense they relate to others as a result of personal characteristics. On many occasions it was the racialised identity of service-users that was of relevance. This was the situation for Simon. He described how hearing other young Black people sharing their mental health challenges helped him to share his own difficulties:

> **Simon:** When I'm actually hearing like all the Black people speaking about it, it just makes

> me feel like, alright I'm actually having somebody that's Black, like me, actually going through the same thing as me. … It makes me feel I can actually open up. It makes me feel more comfortable about it as well.

Dean also spoke about how being among Black men encouraged him to talk. These examples illustrate that racialised identities are important for establishing a bond which allows young Black people to feel safe. Added to this was the way participants felt sharing the same racialised identity as other service-users assisted in removing barriers that had existed in previous support, whilst offering a space for issues specific to Black people to be discussed. Georgia recounts her experience of this:

> **Georgia**: They split the groups by race. … It sounds terrible, but I think it's probably useful because of the way your parents act which usually affects how you act or the way you feel a lot of the time. Erm, I think that changes your experience of it slightly. … When I'm in a group, I'm in a group full of people who are either mixed race or Black, and it's just there so we can talk about things and it's relatable. …There are just things that like a Black family would do and a White family wouldn't. So, when someone says, 'I know when that happens and it's really annoying' or 'Yeah that

> happens and it's funny'. … I guess if the therapist was White, they would never bring it up. So, it's, it's helpful, cos I don't think as a Black or mixed-race person you would bring something up if the other person didn't know what it was.

A theme emerged that young Black people were more comfortable to have conversations about racialised issues when they were with other service-users of the same racialised identity. This was a finding shared across a number of participants. Mental health professionals set aside specific sessions to discuss societal racism, and its effects, which participants found helpful. However, more generally, participants felt inclined to introduce other dilemmas they felt were racialised in group sessions, which they did not feel comfortable discussing with a past White therapist. Elizabeth offered one example of this. She did not talk about her problems of living in an over-crowded household, which she felt was more common among racialised minority families. She also felt there was a greater burden among racialised minority families to look after extended family members. Elizabeth did not feel her past White mental health professional would understand these racialised dynamics and did not therefore raise it as a concern. However, this was a subject she discussed openly in a group of young Black females. Steph described a similar experience of initially not wanting to talk about dating people of a different racialised identity, but thought

this was more understood in a group of young Black women. Thus, there is evidence that young Black people can repress some of their problems due to racialising factors, but these barriers can be overcome within BVS groups when care is delivered specifically to people of the same racialised identities. A factor that overlapped with this was the way participants felt part of a community when being with other service-users of the same racialised identity.

> **Jason:** It's more a sense of community. … Like, we all call each other brother, you know, it's a small thing, but it's a big thing once you actually come to think of it. It's hard to describe though, it's just so welcoming. … Well it's like, it's like happiness, it's like warmth, it's like knowing people have actually got your back in a sense. It's like knowing you're not alone in whatever you feel.

Brian shared the same thoughts as Jason about belonging to a community of Black men. He felt this gave him connections that he would not have otherwise. For Brian there was also a strong gendered dynamic as in some circumstances he believed Black women had impacted his life negatively yet being among Black men created for him a bond and self-confidence. Thus, the evidence presented shows how identity in its diverse manifestations is interwoven with the way support is experienced. Moreover,

age, gender and racialised identities can operate simultaneously or individually to open and bond relationships.

Whilst the overwhelming picture was one that highlights the benefits of being with people of the same racialised identity, differences were observed for Tianna and Jason. Tianna described how her upbringing on the African continent meant that her life experiences and perspectives contrasted to that of other service-users. For Jason, he felt that being mixed-race meant that on occasions he felt 'too White for the Black [kids]'. As he recounts:

> **Jason**: None of them are the same shade. … It's not even bad, it's just a bit, like, not even annoying just, something, it's just something that's like there, it's just like [sigh]. … I mean it's like you know, you can relate heavily, but you can't relate completely.

Although Jason felt too White for the Black kids his experience of receiving group therapy with other young Black people was more positive than his past experience of attending a group with older White people. Overall, he described how he felt greater bonds, and that he could 'relate heavily.' Yet, still, his mixed-race racialised identity set him apart in a way that he did not feel fully accepted. Thus, for Jason and Tianna they felt a racialised bond with other service-users, but there was still a feeling of

difference within that overall bond. Winnant (2009: 678) has referred to this as part of a 'certain flexibility and fungibility' among Black people that was 'formerly rare.' These accounts draw on CRT's ideas around essentialism and anti-essentialism. It recognises that there is something that is essentialist that unites Black people. There was something that connected the Black service-users in their receipt of mental healthcare and the experiences they brought into that space. In this way there was a Black experience that was articulated by ideas such as being with 'brothers', a 'sense of community' and 'heavily related.' However, what the examples show is there are multiple Black experiences, which overlap but are nevertheless distinct. This draws on the anti-essentialist stance and emphasises no unified Black experience. Given this context there is something that loosely ties participants' nuanced and fragmented experiences together and arguably, this points towards a position of Black experiences within the Black experience. Gilroy (1993) advocated a similar perspective when he termed the anti-anti-essentialist stance; he recognised there is a Black consciousness that is ever shifting and evolving. Thus, in the case of the data collected there is consciousness of the broader experience of processes of racialisation, which include living in a world of racialised oppression, but an appreciation that there are differences within.

The evidence gathered here points towards the various strengths of homophily. As Kagan *et al.* (2011) assert, positive attachments can be made as a result of sameness. Again, this provides further evidence that contests the argument made by Farran (2014) who observed no advantages to homophily. Participants in this study often described how they did not realise the benefits of homophily until they were able to compare the support provided by a White mental health professional with that of a Black one. This is a critical finding as any study that looks at the significance of racialised identities in the service-user and care provider relationship and bases their findings on the experience of a Black service-user seeing only a White professional may overlook important features. Additionally, the findings show the importance of age-related, and gender-specific mental health group therapy for young people. The participants expressed how sharing characteristics with other service-users made them feel more comfortable. Racialising factors played a more significant role. It was influential for a larger number of participants as it fostered commonality between service-users, creating a sense of acceptance, whilst overcoming barriers to promote dialogue on sensitive matters. It is therefore an important factor when considering the provision of mental healthcare for young Black people.

In summarising the main findings of this chapter, a cross-cutting theme of significance is the value of contextualising care to the realities of young Black people. The findings

show that when mental healthcare is more closely aligned to the realities of young Black people's lives that their experiences of accessing and receiving care can be more positive. This was evidenced through the existence of opportunistic practices for engagement, and care that built racialised pride whilst providing situations where common ground could be established among service-users. Pluralistic help-seeking was also highlighted as an important feature that facilitated individuals into care, whilst it further illustrated the importance of understanding illness behaviour.

Conclusion

It was noted at the outset of this chapter that most research on young people's mental health focuses on the statutory sector (Gibson and Possamai, 2002). It was also acknowledged that young racialised minority people access non-statutory support more so than other racialised groups (Duncan, *et al.,* 2019). Despite this there is little research looking at what this experience is like especially for young Black people (Dwivedi, 2005). Therefore, the findings from this study help fill gaps in the literature by looking specifically at young Black people and non-statutory healthcare provision.

The lived experience of accessing non-statutory care is one marked with challenges that young Black people overcome. Against a background of fear, a burden of being

racialised, and vivid memories of disappointing past service contacts, this research shows there can be safe points of entry to mental healthcare. Familiar environments where young Black people commonly associate can provide a gateway to care. Meanwhile, race was a discernible factor that operated as a doubled-edged sword. In some instances, seeing people of the same racialised identity facilitated service access. At the same time young Black people can become more aware of their racialised identity, which impacts their help-seeking experience. The provision of youth activities and church-based care offer unique points of access that help young Black people overcome various barriers.

Gaps in service provision, a fear of stigma and the financial challenge of paying for care were some of the difficulties that young Black people encountered. Notwithstanding this, the findings discussed in this chapter paint a more positive picture than what is normally expected when Black groups access care (Bracken and Thomas, 2007). Out of all of the participants accessing non-statutory support only one decided to discontinue. This was in comparison to a pattern of repeated short-term engagement and service discontinuation that epitomised early forms of care. There were a number of factors that made non-statutory support successful including the practitioner's skills and experience. Participants also felt more suited to an informal approach of care provision. For some of the participants in this study, the racialised identity of the

professional was significant; in several situations, when mental health professionals had the same racialised identity as them, they felt they could be open in their interactions and there was greater connection. Similar patterns were replicated for group therapy where despite their initial anxieties about attending, participants found BVS care affirming. What became apparent was the way groups where the support was directly tailored towards young Black people or where there was an organisational culture of working with this service-user profile, very positive experiences were reported. This was not only about racialised matching. Rather, racialised matching operated hand-in-hand with an environment that was attuned to the needs of young Black people and delivered in an environment, where relevant topics were discussed, and with other service-users where they felt safe and a sense of relatability. This starts to develop a position which suggests that standard ways of working—that are based on principles of formal equality, and in particular colour-blind approaches—are too frequently unsuitable for young Black people

Additionally, care that is delivered within a religious framework fills a gap in service provision, which is not presently met by statutory support. These findings lend support for the tailoring of services to individual needs. Indeed, this would require a flexible approach that involves specific and targeted engagement. In this study it took place in locations where people would normally participate

in social activities. The evidence collected also suggests that services need to be aware of strategies that are effective to empower young Black people to improve their experience of mental healthcare.

Chapter 8 The development of racialised thinking, institutional racism and evolving perceptions of mental health and care

This chapter focuses on showing the need to recognise the ongoing and changing lifeworld of participants, within which previous experiences and interactions with mental healthcare continuously shape their views. The findings discussed in this chapter show the way participants increasingly viewed their mental health encounters in racialised terms. A part of this was how participants felt the care they received was inappropriate to a person with their racalised identity. A further key finding highlighted in this chapter was the way participants' views about the value of mental healthcare evolved which informed their decision-making about whether care could improve their mental health.

Participants received support at a range of different organisations. As a result of this they were able to describe how these experiences informed their present perspective on racialised issues and mental health. These findings are critical to understand as they are likely to influence any future help-seeking. Participants' descriptions showed that processes of racialisation became increasingly salient as a result of different negative service contacts. Race also emerged as a prominent factor due to the generic way that services were delivered. Furthermore, how participants

conceptualised their mental health, their need for support, and how they decided which organisations could support them best, were also factors that evolved throughout the help-seeking process. Therefore, the findings presented in this chapter fill a gap in the literature by providing insight into the thoughts of young Black people after they have experienced a variety of care.

Racialisation as an unfolding and ongoing experience

This thesis demonstrates that young Black people think increasingly in racialised terms on their journey through mental healthcare, mainly as a result of dissatisfactory service contacts. In particular, participants felt they were portrayed negatively because of their racialised identity. Whilst research by Phoenix (2003) pointed to the significance of individual events that racialise minority people in society more generally, these findings show the racialisation of young Black people as a result of their engagement with mental healthcare and other support services. The gradual development in the way participants viewed their experiences as being racialised is problematic as it poses a barrier to potential help-seeking as the value and appropriateness of care is brought into question.

The findings from this study show that when young Black people have poor experiences with a range of other support services this can contribute to the way they view mental healthcare. In chapter six, it was discussed how

Scott became more sensitive to his racialised identity as he believed he would be viewed by service providers as somebody who was a troubled young Black person. For Scott, this was a viewpoint he reached following years of multiple service contacts. Rebecca shared a similar experience. In the previous chapter it was discussed how her awareness about belonging to a racialised minority group was brought to her attention. Thus, as her help-seeking journey unfolded her racialised identity became increasingly prominent in her thoughts. This made Rebecca question whether she should access care. Rebecca provided further examples that illustrated how she became further sensitised to her racialised identity. She recounted her experience of accessing a support organisation where she found out that the female support worker had been assigned by her manager to work with racialised minority people because her grandchild was also a racialised minority:

> **Rebecca**: I look back at the support that I got from that lady […] She actually told me she felt a little bit uncomfortable because she was [handed] all of the Black people to support because she had a mixed-race grandchild. … I remember her showing me this picture of this grandchild. She was going, 'yeah this is my grandchild, she's mixed race.' It made me feel bad. The lady felt uncomfortable that she was

> showing me the fact that she had some form of a relation.

Rebecca's example reveals the way different types of service contacts were racialised. Consequently, this made her more sensitive to the way processes of racialistion were likely to influence subsequent life events. Participants' descriptions of the significance of race also evolved in response to their engagement with mental healthcare. Steph had multiple experiences of receiving support with different professionals. When talking through her thoughts she described how she now believed it was more beneficial to receive support from Black professionals as certain issues that are more salient to Black service-users are less likely to be 'brushed under the carpet.' Based on her experience of seeing professionals of different racialised identities, Steph shared how she could be more open with Black professionals. She narrated how racialised issues had not been the main thought on her mind on her help-seeking journey. Rather she describes how this was a part of her thinking that evolved following service interactions:

> **Steph**: It hasn't been [something] that's always been on mind; that if I had someone of a different race that it would impact me. … Now that I've had people of the same race and culture it's made me realise I guess.

Reflecting on the racialised identity of different professionals Steph provided insights on her present thinking, which highlights how her viewpoint changed over time. Racialised thinking became more prominent. This was a pattern that was replicated for several participants for different reasons and at different times. Ralph's experience adds to this. He talked about how, when he was actually receiving support, that he did not feel it was racialised. However, when looking back on the care he received he felt racialised issues were intrinsic to the way a professional viewed him:

> **Ralph**: There are so many Black youths on the road doing all these things, like, knife crime. … They must have thought I was one of them. … I just knew. It was almost as if they came pre-prepared what to say to a Black youth. … I know that I was being questioned like, 'How are things at home?' Trying almost to imply that things weren't good at home. Almost as if they want something to be wrong with me so they can try to exploit it. Almost as if they get so used to Black boys in these situations that every Black boy they meet is in the same situation so they come prepared what to say.
>
> **Anthony**: How did that make you feel when you felt that, that was?

> **Ralph**: So, at the time I didn't really think much of it. But when I think back it was actually quite insulting. … At the time, I wasn't as self aware; I mean I didn't really understand race issues and stuff like that, I wasn't really into it. But as I got older, more mature, and I started to think about what had happened in my past, I think about situations that happened to me, and I said to myself, 'There's something that shouldn't have happened.' It's a bit racist, a bit racist.

Ralph's example illustrates the growing presence of racialised thinking that influenced how he viewed past events. In one respect it seems Ralph and other participants became increasingly sensitised to the presence of racialisation. Hence, in his present mindset, Ralph believes mental health services treat young Black people differently. This was also the situation for Dean. Earlier on his journey through services he had accessed NHS group therapy following a referral from his GP. When attending he felt out of place as the other service-users were old and White. He later received group therapy with other young Black males. Reflecting on these experiences Dean felt there were processes of racialisation operating at NHS group therapy. He described how the mental health professional who led the group viewed him differently based on his racialised identity.

> **Dean**: At [NHS group support], there was a bit like a preconception there. … I can't prove it, and I'm not saying they did and this was the case. … [But at the BVS] I'm dealing with people who come from a similar background to myself so I don't feel like there are preconceptions.

Dean's experience was similar to Ralph's as he felt he was perceived in a certain light due to his racialised identity. These findings lend some support to a conclusion reached by Gilvarry *et al.* (1999). They argued that Black people more frequently interpret challenging life events through the lens of racism. Meanwhile, they agree with the position put forward by Dalal (2002), discussed in chapters six and seven, that Black people can sense when people are hostile towards them because of their racialised identity. Dean also stressed how the BVS care he received was better equipped to embrace his needs as a Black person because he was with people of 'a similar background.' During NHS group therapy Dean was aware that he felt racialised. However, his racialised experiences became more salient when he was able to compare NHS group therapy with BVS care. These findings are particularly important as they show a pattern of change in the perceptions of young Black people and how they feel they will be treated by mental health services. Hutchinson and Gilvarry (1999a; 1999b) argued that Black people feel they will be treated differently in the health care system. The

evidence from this research lends some support to this hypothesis. The consequences of this are important to consider. Indeed, Keating and Robertson (2004: 445) emphasised how Black peoples 'sense of shame is more acute as a result of racism, and the pejorative ideas about Black families and individuals' when they are accessing care. They argued that past adverse service interactions result in Black services-users delaying their help-seeking. Whilst in the previous two chapters it was identified that negative service contacts resulted in hesitant and reluctant help-seeking, it is not possible to reach the same conclusion when considering participants' future help-seeking. Nevertheless, the findings point to the way racialised thinking unfolds along the help-seeking journey. Additionally, there is a concern that participants become more aware of their racialised identity and relate this to there being a greater likelihood of being treated unfairly. This in turn could create a barrier to future help-seeking.

'I feel like I'm being treated on what the handbook says'

When participants described their present thoughts about mental healthcare, they articulated very clearly the limitations of a one-size-fits-all approach that was not attuned to their needs as young Black people. This points towards a challenging set of circumstances where Black people do not believe they will get the support they need. This is likely to influence their view of health services

generally, whilst it may also impact any future help-seeking specifically in relation mental ill-health.

Most research looking at the way Black groups feel about care focuses on the adult population, whilst that based on young people is predominantly epidemiological (Green *et al.,* 2005; Dogra, 2012). Wider literature shows that mental health professionals have expressed difficulty in knowing the right time to incorporate discussions about race into mental health sessions (Gurpinar-Morgan *et al.,* 2003). Dogra *et al.* (2007) have also shown how mental health professionals do not always feel comfortable and are reluctant to discuss matters associated with service-users' racialised identity as it may alter their perceptions of the professional. The findings presented here show that young Black people value discussions about societal racism when it is delivered as part of BVS support. Adamson *et al*. (2011) and Fernando (2004) have argued that mainstream mental healthcare is not culturally competent and is institutionally racist. Data collected from this study supports this perspective as multiple forms of care have not demonstrated they are sufficiently knowledgeable in supporting young Black people.

One of the main concerns that was shared by participants was how they thought the standard way of delivering care was not suited to them. Elizabeth felt that, when she accessed care delivered by the BVS, she believed it was easier for her problems to be comprehended by the

professional. She described how this was in comparison to mainstream support where she felt restricted in being able to communicate her dilemmas as they would not be understood:

> **Elizabeth**: [My problems] can be related to African culture whereas I think more formal therapies would look at your thinking rather than the environment around you. … I think at like CAMHS I would never have mentioned my hair and how it affected the relationship with my parents because the focus would be on changing my thoughts. But I think [within the BVS I attended], it's understandable why that can cause a rift between me and my mum
>
> **Anthony**: Your hair?
>
> **Elizabeth**: Yeah, cos she thinks straight is the only way and I think that's really in culture so it's more understood why it is a conflict issue.

In Elizabeth's example it was not so much the racialised identity of the professional that she describes as being critical but the need for an approach to care that embraces racialised differences (*e.g*. 'African culture'). According to Elizabeth, mainstream care did not consider how factors within the social environment had a differential impact on her. For her, a professional within the BVS was able to

understand this source of tension with her mother as well as changing cultural norms about how Black hair should be worn. This is seemingly critical given that evidence in chapter five shows that young Black people see social pressures as being heavily correlated with their experience of mental ill-health. Participants also described how the conceptual structure upon which training was delivered, and how professionals were trained was inappropriate. This was the situation for Syd. He described how he felt the standardised model of care and a generalised way of training professionals did not fulfil the needs of racialised young people:

> **Syd**: Having now seen two White counsellors … I feel like they would've learnt from a handbook on how to handle children or how to conduct CBT. … And it's just like, the race of the doctor shouldn't matter. … But I don't think relying on a handbook should be the basis for sessions. That handbook would've been written years ago [based] on kids from other races. … I feel like I'm being treated on what the handbook says. … That doesn't give the doctor an understanding of me in a sense. … My background determines how I want to receive the treatment and how I want to leave this feeling a certain type of way. … All doctors studying a general idea of how they should help kids, it works in a sense, but I don't think

> the difference in the patient is being considered enough. We've all come from different childhoods. And childhood is usually determined by race; as in how you are raised is determined by your race. So it's like. … I don't think there's enough of a consideration for the difference race makes in how services like these should be run.

Syd recognised that there are elements of care that can be consistently applied that will have some benefits for most young people. This mirrors some of the findings in the previous two chapters, which stress the need for professionals to show service-users that they are valued, to actively listen and to be empathetic. A further point that Syd made is that he currently believes that generic support will not be suitable for all young people. Moreover, he contends that the racialised identity of young Black people is not fully accounted for by professionals and the institutions that train them. Related thoughts emerged in different ways for other participants. Pippa felt that Black people are not listened to when they access mainstream care. Meanwhile Rebecca felt that most professionals will not be aware of her experiences as a Black woman with a criminal record. Nadia also shared her position, explaining that she felt that a service that does not consider a user's racialised identity, in other words that based on ideas CRT would construct as colour-blind, is unhelpful:

> **Nadia**: It's just dangerous to have a system or have any sort of interaction where they try to remove that important identity. … I think it's quite weird to give counselling without understanding someone's whole entire context. … I'm not saying that you can't be counselled by someone of a different race because you can. I'm saying understanding their cultural background, and living their cultural background helps.

Again, in this example it is evident that a service-user's identity should not be ignored whilst it is also vital that the professional has a lived understanding of their identity. A position that stems from these findings is that standard forms of care do not offer enough attention to the needs of racialised people. When considering the literature in this area one way of explaining this tension is to question the adequacy of the intervention. This links into a perspective put forward by Fernando (2010). He has argued that the training of professionals is delivered predominantly through a Eurocentric lens. Browne (2009) suggests that a consequence of this generic White approach is that issues that specifically impact racialised minority people are overlooked. For instance, participants accessing generic support did not share how any aspects relating to societal racism were addressed. However, this was a feature incorporated into BVS support. This points towards a gap in provision, whereby factors that are likely to affect some

racialised people are not explored in mental health sessions. McKenzie (2009: 616) is critical of the way in which professionals are trained:

> Health disparities are brought about and perpetuated not only by culture, class and socio-political forces external to medicine, but also by the ideology of the medical profession. This ideology leads to ineffective or no action in the face of disparities and to a lack of concerted effort to teach or discuss racism in medicine in undergraduate and postgraduate curriculums.

This corresponds with Syd's thoughts when he noted the limitations of the 'handbook' for training mental health professionals. In relation to their experience of receiving mainstream support, no participants described any service adaptations that took into account their racialised identity. It was only in BVS support that participants talked about factors such as racism and its affects. Hence, one of the problems of mainstream support is that it is less likely to consider social pressures that apply differently among various racialised minority groups.

Participants also felt they were racialised due to the way professionals constructed their behaviour. It was noted earlier how Ralph felt that he was perceived by the professional as a troubled Black person. Scott had similar

experiences that were shared in chapter six. When reflecting on her time accessing support in school Carlene explained how she felt racialised as an angry Black girl:

> **Carlene**: I was reserved, but sometimes I'd have outbursts. … They kept on telling me you need anger management. So, no-one ever saw anything beyond anger whereas I could have told you this is what's going on in my life; I feel depressed and I'm very insecure about myself. … They were just like, 'You need anger management, you need anger management'. … I think because I was a Black girl that's what they saw. … I'm just being an angry Black girl.

This gives another perspective about how young Black people can feel they are pathologised and treated differently. A connection can be made between this and the literature, which shows that professionals can have stereotypical views about people racialised as Black as being Big, Black and Dangerous (Keating, 2007), loud and difficult to manage (Keating *et al*., 2003) or more threatening than other racialised groups (Pipe *et al.,* 1991; Lewis *et al*., 1990). Moreover, there is a wider literature that discusses how Black people have their behaviours misinterpreted as a form of mental ill-health (Pinto *et al.,* 2008; Hickling *et al.,* 1999; Horwitz, 1983). Thus, according to the participants in this study professionals

operate on the basis of racialised stereotypes, which influence how they receive support.

Taken together, the findings show that participants find aspects of generic support inappropriate to their racialised identity. Fernando (2010; 2017) has suggested that generic models of care, that are typically based on psychiatry and psychology, are institutionally racist because they have been developed based on Western ideas about what is normative. When considering how MacPherson (1999) defined institutional racism, as the 'collective failure of an organisation to provide an appropriate…service' to people because of their racialised identity, alongside the findings from this study, it is possible to see how this is evident in the participants' experiences. According to McKenzie (2009), actions that are taken to address racialised inequality, and the priority that is given to them, are one way of determining whether an organisation is institutionally racist. Applying this concept to the care participants in this study have received seems apt. Participants felt they were racially stereotyped. They also observed a lack of attention to issues such as racialised differences in upbringing and divergent social pressures. As such, it can be seen that many mental health organisations providing generic care were not active in providing an affirming environment that may improve the experience for young Black people.

It is not suggested that the inadequacies described here are deliberate—professionals and support organisations do not intend to provide a poor service. What is clear is that young Black people have not felt that they were effectively supported when accessing generic forms of care. Given the scale of racialised inequality in mental health and the length of time this has prevailed it seems that change is urgently needed. McInnis and Moukam (2013: 2) have argued that radical action is needed:

> [If people of] African ancestry acculturated in both European culture and European psychology need to understand that if we continue with the same Westernised approaches, with a different-colored face, and expect a different result, then we are truly insane.

McInnis and Moukam (2013) suggest that Black people need to realise they will struggle to improve their mental health if the techniques used to support them have been developed by and for White people. Taking this line of argument—and making care providers rather than service-users responsible—much greater and more visible efforts need to be made to standard models of provision that are based on the liberal ideal of treating everyone equally, that of formal equality. This way of working has proven to be largely unsuccessful for the participants in this study. Thus, in line with CRT's critique of liberalism, data has

been gathered that suggests a race-conscious approach is more helpful for young Black people, thus challenging the orthodoxy of service delivery and the colour-blind model. The data collected in this study supports a position that care needs to be tailored more closely to the needs of young Black people and more responsive to the challenges they face.

Evolving perceptions of mental ill-health

When reflecting on their experience of receiving different forms of support, participants' perceptions about what constitutes mental health and mental ill-health evolved. The way they viewed the role of mental healthcare was shaped by their experiences. This is likely to influence future help-seeking behaviour. There is a paucity of research that looks at how young people adapt the way they access mental health services due to increased levels of awareness. Research has focused on the importance of the service-user voice (Tait and Lester, 2005), whilst emphasis has also been placed upon factors that contribute to young people accessing support for the first time (Rickwood *et al*., 2007). However, the findings presented here add a further dimension by documenting the thoughts of young Black people who have received various types of care, and how this has influenced their thoughts about the way services can assist with mental ill-health.

The findings discussed in this section are based on the experiences of participants who attended various types of care, including statutory and non-statutory healthcare support. What the research reveals is the way participants felt different services improved their mental health in different ways and, as a result, how they decided to alter the support they accessed at different times. This was clear from Megan's experience. She attended drama therapy, went to see a GP, received college-based counselling, returned to drama therapy, received counselling via another voluntary organisation then accessed drama therapy for a third time. She acknowledged that each time she attended drama therapy, and when she accessed voluntary sector support, that her mental health improved. Whilst Megan was attending drama therapy on the second occasion, she simultaneously attended other voluntary sector support. This demonstrates how Megan felt she had different levels of need and this would be met by the various kinds of care available. This pattern is further illustrated by Brian. He initially accessed a non-statutory group for Black fathers. Whilst attending this he sought support from his GP and attended IAPT. He continued to attend the fathers' group and accessed two further forms of support at a later stage over a four-year period. He described how these different forms of support dealt with the various mental health challenges that he had:

> **Brian**: Within myself I feel like I've got layers of issues. … Let's say the first GP dealt with about 10% of my issues. … The second one I was still scared … the first day I didn't talk about my intrusive thoughts … [But that] lady taught me how to deal with intrusive thoughts. … I'd say, I dealt with at least, 70, 75% of my issues.

Brian went on to talk about when he attended a developmental weekend with an organisation that put participants through their rites of passage to become a mentor. He found this challenging but said, 'I dealt with 99% of my issues.' Megan and Brian became aware of the different types of support that were on offer and the different benefits this brought to their mental health. This highlights how young Black people make use of different forms of support as they become more aware of their mental health, and the value of care; and it provides a further example of pluralistic forms of help-seeking as described in chapter seven. Tianna also explained how she used support as she felt it was needed. However, this was only as a result of experiencing different services and knowing what worked for her. When looking back on her experience she described how she conceptualised her mental health and the support that she received:

> **Tianna**: I did counselling when I was much younger. But I didn't like the fact that they

> opened me up and they just left me. I almost felt like it was someone digging a hole and just leaving it empty. … I felt like … drama therapy, it gave me something to put back into the holes. … All the hurt, and the things that the mind sits behind, you know, how I felt about things.

In her interview Tianna described how she would not consider accessing statutory healthcare support again as she felt she was aware of the qualities of different services, whilst she was also able to manage her mental health challenges. Ralph shared a similar experience. He had accessed five different organisations and on reflection described how he could now deal with mental health issues while carrying on with life. He realised that his mental health challenges 'cannot be cured in a couple of weeks.' Whilst his awareness about his own mental health developed, he also had a better understanding of the support that worked for him.

The findings that have been presented here show that young Black people increased their knowledge of the value of different forms of mental healthcare during their pathway through care. Along this journey they become aware of what services worked for them. Additionally, young Black people become increasingly aware about how to manage their mental health. As a result of these two ongoing developments they became the decision-makers

about their mental health. This adds another stage to the model put forward by Suchman (1965), which suggests that service-users hand over responsibility to professionals. The evidence gathered in this thesis suggests that there is an ongoing relationship where service-users take the opportunity to reclaim their power to make decisions about what care they feel is best for them.

In summarising, the main findings presented in this chapter, consolidate a position that points towards the development of racialised thinking among the study participants along their pathway through services. This chapter highlighted the importance of recognising the ongoing and changing lifeworld of participants, within which their experiences and interactions with mental healthcare continuously shaped their views. The findings discussed in this chapter show the way participants increasingly viewed their mental health encounters in racialised terms. Their view that mental health services were not appropriate was a constituent part of this way of thinking. A further key finding highlighted in this chapter was the way participants' views about the value of mental healthcare evolved, which informed their decision-making about whether care could improve their mental health.

Conclusion

The significance that young Black people attached to their receipt of mental healthcare is an area which is under-explored (Gurpinar-Morgan, 2014). The findings from this research suggest that racialised thinking grows in significance and becomes a key part of the ongoing thought process in the way care is viewed. Young Black people who have experienced multiple service contacts are less likely to consider standardised models of care, that are based on colour-blind principles of formal equality, as places where their needs will be met.

The evidence presented throughout this study shows that any notion that service-users access care, receive support, and then continue with their life is deeply flawed. Traditional models characterise service-users as handing over power to professionals (Suchman, 1965). The findings in this study show a different pattern for young Black people in their attempts to improve their mental health. Indeed, participants become more familiar with their mental health. How they conceptualise their need for support also evolves. Young Black people develop an awareness about the ability of different forms of care to respond to their needs. These factors operating individually and in combination modify the way young Black people view their options for treatment. This demonstrates how it is important to have alternative forms of care available. At the same time, it illuminates a shift in the way help-

seeking is understood as young Black people become selective about the care they receive.

Chapter 9 Conclusion

This study set out to understand some of the factors that contribute to racialised inequality in mental health. Decades of research have seen a range of theories put forward to explain these disparities (Nazroo and Iley, 2011), whilst major policy initiatives have been largely ineffective at reducing them (Fernando, 2017). Despite these efforts, inequalities persist and there are gaps in our understanding about why this is so. Most research attention has focused on the statutory healthcare sector, with the result that little is known about the role of non-statutory healthcare providers and whether they offer approaches that effectively support young Black people. Existing literature has mainly been interested in the adult population and those with serious mental health problems. Less emphasis has been placed on young Black people and mental health more broadly. These are gaps this study aimed to fill, as interactions and experiences that happen earlier in the life course may influence later help-seeking and the relationships Black people have with mental health services. This study also wanted to give a voice to those who have been racially oppressed and who have been the recipients of services, rather than prioritising the views of mental health professionals. This thesis has fulfilled these initial aims and this conclusion will reiterate how this has been achieved.

A further aim was to examine whether, and to what extent, racialisation featured in young Black people's experience of accessing and receiving non-statutory care. An idea put forward by Keating (2012) suggests that Black people experience a spiral of oppression whereby their pathway to care is more challenging because of a fear they will receive unequal treatment as a result of their racialised identity, compounded by the stigma associated with mental ill-health. This thesis sought to explore how applicable this hypothesis was in relation to young Black people and non-statutory healthcare provision. Given this aim, CRT and the literature on racialisation were used to frame different aspects of the research. In particular, CRT holds that racism is not an aberration, but a normal part of everyday life. This position aligns with Keating's hypothesis that draws on the salience of societal racism, and helps to shed light on the issues this study sought to explore.

Twenty-five young Black people from across several English cities who had accessed non-statutory care were interviewed between October 2017 and May 2018. A phenomenological approach was adopted in conducting interviews and analysing the resulting data. An adapted version of Giorgi's (2009) descriptive methods was followed. This entailed remaining close to participants' accounts of their lived experience and fitted well with CRT's perspective, which contends that those who have been racially oppressed have the experiential knowledge and authority needed to articulate the challenges they

have faced. CRT and the literature on racialisation suggest that power is embedded in the social construction of racial groups. This perspective underpinned the identification of research participants, acknowledging the political, cultural, economic and historical processes that construct people as Black.

CRT, and the notion of racialisation drawn from the literature, were also used as conceptual tools through which the findings could be contested, debated and analysed. A broad history of studies on racialisation was used to explore participants' accounts in relation to the care pathway and their experience of receiving care. CRT provided further principles that were used to conceptualise the research findings, including views on intersectionality, anti-anti-essentialism and a critique of liberalism. Therefore, CRT and racialisation were used theoretically, methodologically and analytically at each stage of the thesis.

The overall aim of the study was to research the lived experiences of young Black people when accessing and receiving non-statutory mental care. This involved developing an understanding of the obstacles young Black people face and how they were overcome. The next part of this chapter summarises the main research findings.

When looking at young Black people's lived experience of accessing care a number of key and novel findings were

identified. In most cases multiple and problematic social circumstances were linked to the onset of mental ill-health. A range of structural and stressful life events were shared, including living in overcrowded accommodation, fatherlessness, financial problems, feelings of isolation and bullying. Whilst many of these experiences were described as being racialised, wider societal racism was identified as being critical to the way mental ill-health was interpreted. Thus, participants typically described these encounters as part of their journey to accessing care.

Young Black people's experience of accessing care was also influenced by their ability to identify changes in their mental health. Their actions following their first episode of mental ill-health were idiosyncratic, illuminating the importance of illness recognition to help-seeking. Participants were able to identify changes in their normal functioning, running contrary to literature suggesting Black people are not able to recognise signs or symptoms of mental ill-health (Menom *et al.,* 2016). Notwithstanding this, how they, and their social networks, conceptualised these symptoms had a significant influence on their illness behaviour. Challenging environmental and personal difficulties were sometimes viewed as an expected part of life and masked the presence of symptoms. This pointed to the need for improvements in mental health literacy. The importance of understanding mental ill-health was also identified as a barrier to help-seeking as young Black people somatised their problems, viewed them as

insignificant or had difficulties explaining them. Further, young Black people related their inability to recognise symptoms of mental ill-health to a wider lack of awareness of mental health in the Black community. Thus, symptom experience was a personalised experience that was often racialised. When considered as part of the experience of accessing care it brought about a range of emotional challenges, alongside feelings of confusion and uncertainty.

Once young Black people made the decision to improve their mental health they responded in diverse ways. Coping strategies included writing poetry or letters, engaging in social activities or reading psychology texts online. Some approaches were viewed as being specific to Black groups as they reflected illness behaviour found to be more common among Black adults. For this study's participants, it included a belief in the use of natural remedies and a commitment to prayer. These findings highlight the unique ways that mental ill-health is responded to, as emphasised within social model approach to mental health, and how help-seeking behaviours are racialised.

Social networks influenced young Black people's pathway to care. Where participants were unsure of their symptoms, different actors in their social networks—parents in particular— facilitated access to care. Contrastingly, participants shared examples of stories that

circulate within the Black community, and through families, about the poor experience Black people will have when using mental health services, which resulted in delayed help-seeking. Therefore, social networks had a mixed effect on participants' experiences; sometimes they provided comfort and direction, whilst at other times they created a barrier to help-seeking.

A major part of young Black people's experience of accessing care was the fear this process engendered. When they decided to seek mental healthcare for the first time, they experienced a range of, mainly negative, thoughts and emotions. Hesitant help-seeking stemmed from multidimensional fears, including a fear of the unknown, worries about the outcome of service engagement and concerns about whether they could be helped. Whilst these findings are identified in the wider literature, young Black people had a specific burden on their pathway to care. Fears were decidedly racialised and encompassed thoughts of being medicated or receiving harsh or controlling treatment. Their negative characterisation of mental health services, which was thought to be common within the Black community, installed a deep sense of fear, which resulted in delayed help-seeking, in one case up to five years. Further, there was a belief that mental ill-health is a particularly taboo topic within the Black community, which increased feelings of being stigmatised among some participants. These findings reinforce Keating's (2012) version of the spiral of

oppression. They show how fear influences help-seeking behaviour, and how processes of racialisation are especially problematic for young Black people and their pathway to care.

At the outset of this study, it was assumed that participants would follow a straightforward pathway to non-statutory care. Whilst this was the case for a small number of participants, a picture emerged showing the majority had previous service contacts with multiple mental health support organisations. Young Black people's experiences at these organisations were part of their overall care pathway, which had a profound influence on their engagement with, and thoughts about, mental healthcare.

Upon accessing and experiencing mental healthcare for the first time, participants typically attended one session then disengaged. This pattern was then repeated up to five times as young Black people resisted handing over control to mental health professionals for their recovery and rehabilitation. Whilst some positive experiences were shared that included opportunities for learning, being made to feel safe and valued, and the importance of compassion, experiences were generally negative and reflected those of Black adults in mental healthcare (Bhui and Mckenzie, 2007). Mental health professionals failed to establish meaningful relationships with, or meet the needs of, young Black mental health service-users.

Young Black people found the care they were offered unsympathetic, judgemental, lacking compassion and sincerity, which made the interactions feel cold, sterile and uncomfortable. Mental health professionals and the service-users' racialised, gendered and classed identities were also relevant in this context. In some situations, it made the service-user feel alien as if someone of their racialised identity did not belong in a therapeutic setting. At other times, when the professional's racialised identity matched that of the service-user, young Black people reported feeling safe. These early service contacts also revealed that the type of mental health intervention being offered was problematic. There was a general perception that care was only skimming the surface of the mental health challenges they encountered. In essence, the approaches were viewed as inappropriate and too basic. Overall, these early service contacts resulted in dissatisfaction and disengagement.

This iterative pattern of accessing and disengaging from care had adverse outcomes. For some participants it reinforced the way they viewed mental health services and their treatment in racialised terms. For others, it started this way of thinking. Whilst it is critical to report on these processes and points through which the development of racialised thinking manifests itself, this thesis offers new insights by showing how these factors significantly alter how young Black people engage with mental healthcare, and in particular how it influences help-seeking behaviour.

These findings expand on the ideas within Keating's spiral of oppression by reporting specifically on the detrimental impact of early mental health service contacts with past support organisations. Such experiences made them question whether they should seek support again, and whether care could ever be effective. Thus, participants started to develop an awareness about the value of different types of mental health interventions and the trust they could put in them to solve their problems. They became increasingly hesitant about seeking help as they started to feel a sense of exclusion that made them increasingly unlikely to engage with services. These findings are critical to understand, as negative interactions that occur early in the life course, influence perceptions about the value of services and the likelihood of future service engagement.

Despite the growing feelings of exclusion, young Black people continued to try to improve their mental health. This calls into question the view that they are 'hard-to-reach' or difficult to engage. Thus, young Black people reveal themselves to be resilient help-seekers as they repeatedly overcome fears and challenges in their determination to improve their mental health.

This study's findings also show how services can be designed more effectively to engage young Black people, making their experience of accessing care easier. Processes of racialisation were key for some participants.

When young Black people became aware they would be attending group therapy with service-users of the same racialised identity, and that were also gender-specific, this engendered feelings of hope and excitement. Additionally, services that used opportunistic practices to engage young Black people into care also made their experience of accessing provision more comforting; when participants accessed care in places they would usually associate, such as drama-group or the Black church, they found this less stigmatising and fearful. Overall, these are novel findings as they demonstrate how safe points of entry to mental healthcare can be established.

The experience of receiving non-statutory care was a key area this study aimed to investigate. For most participants, this experience was generally more positive than those in past care. Challenges did emerge that mainly centred around issues of inconsistent provision, impractical guidance, and the financial burden of paying for care privately. Nevertheless, the overwhelming picture was one that showed young Black people stayed engaged with non-statutory healthcare provision and described it favourably. A number of features were important to young Black people. This included professionals being able to demonstrate they were competent and displaying their expertise when dealing with different situations, acknowledging service-users' concerns, and showing service-users they are valued. Participants also felt that when care was provided in a more relaxed environment

and delivered in a friendly and informal way this improved their experience. The racialised identity of the professional matching that of the service-user was described as beneficial. It fostered a common understanding and broke down barriers, thus enabling dialogue to take place. Thus, the experience of receiving various forms of non-statutory care was generally positive.

Further features of care provided by non-statutory organisations were crucial to positive experiences. One of these was group therapy, delivered specifically to young Black people, and often gender-specific. Being in group therapy with people of the same intersectional identities created a shared understanding of challenges among service-users, and in some instances a sense of community. Participants shared how they felt safe to discuss racialised issues, whereas in early service contacts they described a barrier that prevented them from doing so. Young Black people also sought out, and benefited from, care that was delivered within a Christian framework, from predominantly Black mental health professionals. This illustrates how participants sought pluralism within health provision, and how this type of provision can result in satisfactory service outcomes. Group therapy and other forms of non-statutory care offered elements of provision that were more familiar to the life of the service-user, including racialised, gendered and age-based matching, or Christian-focused care, each of which resulted in encouraging outcomes. These features

were important. However, they worked best when the content of sessions reflected the challenges and realities of Black people. This involved sessions that took steps to empower service-users and acknowledge the pressures of societal racism. All of these elements of service delivery helped to ensure the interventions were contextualised to the needs of young Black people, thus challenging the idea that mainstream services—those CRT would critique as a form of liberalism and delivered on a colour-blind basis—can fulfil their expectations and mental health needs.

A void in the literature has been filled by researching young Black people who accessed and received non-statutory mental healthcare. Black people's relationship with mental health services has typically been understood through quantitative data, serious mental health problems and experiences of adults receiving statutory healthcare provision. This thesis's findings add to this area of scholarship. They mirror the work of Small (1994) who argued that racialisation unfolds over time as idioms of race continue to be evoked. The findings have illuminated the experiential nature through which racialised thinking emerges, evolves and becomes salient for young Black people along their help-seeking journey. This shows how, at different points in time and for different reasons, racism in its diverse forms, as CRT contends, is not an aberration, but a normal part of the way society functions. CRT's perspectives on anti-essentialism and intersectionality were also important. They are critical to understanding the

unpredictability and indefinability of identity, and how intersectional identities are constantly negotiated, whilst acknowledging a shared history of struggle and oppression.

Young Black people's decision to disengage from various forms of previous care challenges the idea of a linear help-seeking journey. It also highlights how they reclaim power to make decisions about what care they feel is best for them. Thus, based on the study sample, young Black people are perceptive about who they will entrust with their care. In this way they are conscientious and discerning help-seekers.

Findings from this study could help to address some of the factors that have been linked to racialised inequality in mental health; that of racialised barriers on the pathway to care, and the poor experience of mental health provision. A one-size-fits-all approach to mental health service delivery was shown to be ineffective. Evidence gathered from this thesis suggests that services need to be contextualised more appropriately to the lives of young Black people. Based on young Black people's experiences there is a need to tailor care to facilitate access in ways that Black groups find affirming. This thesis indicates that services that offer a flexible approach, that has relevance to the racialised identity of the service-users can have positive outcomes. Thus, service options that are customised to Black people's challenging experiences must

be an important consideration. Whilst racialised matching can at times be one part of a solution, it proved to be most successful when combined with professionals' competence to engage young Black services-users on matters that are pertinent to them, including an acknowledgement of the presence of societal racism and sensitivity to build service-users' racialised pride and resilience.

The experience of accessing care is challenging and complex, encompassing many events that put young Black people at a disadvantage because of their racialised identity. Young Black people's experience of mainstream services early on the pathway to care compounds this dire situation, by contributing to, and reproducing feelings of marginalisation. Activities delivered by some non-statutory organisations provide opportunities to overcome these difficulties by challenging the delivery models of orthodox healthcare practices, which have contributed to the injustices Black groups encounter in their relationship with mental ill-health and statutory mental health provision.

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Appendix 1: Interview guide

Help-seeking/accessing support

1. Can you talk me through how you came to access support at (insert organisation name)?

    What was going through your mind when you made that decision?
    Was anyone else involved (referral, parents)
    What issues did you hope to address at [insert org name]?

2. Once you were advised about the services provided by (insert organisation name), were there any difficulties you faced before you received support?
    Can you put yourself back in that place and tell me how it felt on that occasion?

3. Were there are further difficulties you faced?
    Can you put yourself back in that place and tell me how it felt on that occasion?

4. Can you tell if there was anything that made accessing support at [insert org name] easy?

5. Can you tell me if you think there was anything about you in particular that may have made you experience different?

Receiving support

1. Can you talk me through your experience of receiving support at (insert organisation name)?

2. Can you describe your thoughts and feelings whilst you have been attending [insert org name]?

3. Have there been any difficulties you faced in your time at [insert org name]?
   Can you put yourself back in that place and tell me how it felt on that occasion?

4. Where there are further difficulties you faced?
   Can you put yourself back in that place and tell me how it felt on that occasion? (describe the experience)

5. Can you tell me if there was anything that made receiving support at [insert org name] easy?

6. Can you tell me if you think there was anything about you in particular that may have made you experience different?

Appendix 2: Unified statement for participant 13

Three years ago, she self-harmed due to mental ill-health. A year later, she took steps to prevent this reoccurring so went to the GP. She felt very nervous going to the GP, in particular when at the surgery waiting to be called out. After seeing the GP she was referred to a counsellor for a six week programme. She found the long waiting time unhelpful however she was optimistic she may get better. After one or two sessions she did not find talking to someone who felt like a stranger of any psychological benefit. She felt very down at the time and wanted this to improve. She felt the counsellor was not capable of providing sufficient insight into the problems she experienced, and the sessions often made her sadder. She also found aspects of the service design contributed to her anxiety. She related some of these feelings to her own persona of being anxious and acknowledged that the service did try to be welcoming.

A year after first going to the GP, she believed she was going to experience mental ill-health again during the summer holidays and that these episodes also occurred simultaneously with her menstrual cycle. Also she wanted to get help as she constantly felt down. She acted by deciding to seek mental health support again. She felt it was a challenge that she would have to ask her mother to book a GP appointment and this is an action that she had significantly delayed. She did this because she was concerned about how her mum would respond. She eventually explained to her mum that she was feeling down and her mum asked questions that she avoided answering.

She was referred to NSMHS following a GP appointment. Her relationship with the GP, and the way the GP was supportive eased the process of seeking support. Following the GP appointment, a letter was received from a NSMHS provider inviting her to attend mental health support as part of a group. She was anxious about being in a group and was reluctant to attend as she

doubted her ability to contribute in the presence of an unknown number of strangers. It helped that she received persuasion from her mother to attend and that her mother dropped her off at the venue as otherwise she may not have attended.

She did not contribute for most of the first session but did find it surprisingly enjoyable. Continuously attending the group with the same people made it easier to attend and she looked forward to. Despite a small degree of hesitation to contribute to groups sessions, she appreciated the way that people can support one another in dealing with and talking about problems with life in general, and the knowledge of the therapist when discussing these matters. Matters that made her sad were addressed in an appropriate way. She also reflected on the race-specific focus of the support and how this opened up opportunities for dialogue. For the participant, the racial matching of group participants brought a sense of relatability that was helpful for matters important to her identity.

Appendix 3: Organisational information

Study title: A Critical Race Study of Non-Statutory Early Intervention Services for Young Racialised People

Who am I and what am I doing?

My name is Anthony and I'm a researcher at the University of Nottingham. I am carrying out research to look at how young people access and experience mental health support. In particular, I am interested in interviewing people who have not accessed statutory services (GP, doctors, NHS) to receive mental health support. This is important as it will help to inform a better understanding of the journeys young people who self identify as Black make into services and the barriers they face along the way. By developing such an understanding I hope my research contributes towards addressing long-standing inequalities that Black people encounter in relation to mental ill-health. My research is also likely to draw upon the value of non-statutory support organizations. I will be sharing these findings across academia but also with government departments including NHS England.

How can you help?

I have made contact with {insert organisation name} as you deliver a mental health intervention to young people that is not part of the statutory sector. In short, you can help me by advertising for people to take part in my research and potentially providing any support they may need before, during or after they have participated. I have broken down the different steps about how you can assist here:

1) I would first like you to help me advertise the opportunity to take part in my research in places where you think young people will see them. I am hoping to recruit young people who meet the following criteria:
    - Age: 16-25 when they accessed support,
    - Self-identify as being Black,

- They have not received mental health support previously other than that they presently attend,
- An ability and willingness to engage in a lengthy one-to-one interview.

It is important that young people decide for themselves to take part in the research and they are not put under any duress to do so. It is therefore important that young people agree to take part on their own free will.

2) If a young person is interested in taking part they will initially inform a designated and appropriately qualified member of staff (hereafter professional) within {insert organizations name}. I would like your organisation to nominate a designated professional. If the professional considers that the child is in the right state of mind and is able to participate I would like you to forward their preferred contacts details to me so that I am able to communicate with them.
3) Once I have received acknowledgement that the young person would like to participate I will have a conversation with the young person to answer any questions and confirm they understand the nature and purpose of the research.
4) Following the discussion I have with the young person I will provide them with the participant information sheet to sign.
5) Once I have provided the young person with the participant information sheet they will be provided with at least one week to further consider their participation. Young people will be informed verbally and via the 'participant information sheet' (provided with this document) that their identity and the information they share will be treated confidentially thus establishing their right to privacy. They will also be advised of their right to withdraw from the research at any point.
6) I would like for the interview to be carried out in a quiet place where the interview will not be disturbed. If there is a room which can be used at a venue of {insert organisation name} and the young person is happy to be interviewed at the

premises I would be grateful to be able to use that option. If the young person would like to be interviewed at another venue then I would like to agree a protocol with you about their welfare. This is discussed further under point 7.

7) It is extremely unlikely that the involvement of young people in my research will result in any harm. However in the unlikely event that the interview does cause the young people any distress I would like to arrange of protocol with {insert organisation name} about the correct actions to follow in this situation.

What are the benefits of taking part for the young people?

One of the aims of my research is for there to be service improvements. This may even contribute to new programmes or facilities being created. Also, as I genuinely appreciate the time and experience young people provide I would like to provide them with a voucher to the value of £20 as a token of my appreciation. If they have any expenses these will also be reimbursed upon presentation of a relevant receipt/travelcard.

Contact

If you have any further questions or would like to consider taking part you can contact the main researcher (Anthony Salla) by email: anthony.salla@nottingham.ac.uk or mobile: 07975-626-275.

Complaint procedure

If you wish to complain about the way in which the research is being conducted or have any concerns about the research then in the first instance please contact my supervisor Prof Dixon: William.dixon@nottingham.ac.uk. If this does not resolve the matter to your satisfaction then please contact the School's Research Ethics Officer, Dr Simon Roberts (tel. 0115 846 7767, email simon.roberts@nottingham.ac.uk

Appendix 4: Participant information sheet

Participant Information Sheet

Who am I and what am I doing?

My name is Anthony and I'm carrying out research as part of my doctoral studies. I would like to understand more about the way young people experience how they access and receive mental health support that is not provided by the government. Most research looking at mental health focuses on services provided by the government. Most research also focuses on the experiences of adults. Therefore I would like to understand the perspective of young people. Also, I am interested in interviewing people who have accessed support that is provided by third sector organisations such as [insert organisation name].

How am I doing the research?

I would like to do an interview with young people on a 1-2-1 basis that will last no longer than 45min. This normally only requires one interview. During the interview there are two broad questions that I ask:

1) Can you talk me through how you come to access support at the [insert organisation name]
2) Can you talk me through your experience of receiving support at the [insert organisation name]

Very often I will ask the young person to tell me further information about their experience so I can understand more about each of the above questions. For example, I may ask if anyone else was involved in supporting you to access the [insert organisation name]. The interview will not be video recorded. I only use a small voice recorder. This is so that I can have a full record of the important information that you provide. As described below, this information will be stored securely and nobody will find out your name.

Who can take part?

I would like to interview people who meet the following four criteria:

- Age 16-25

- Young people who have used non-statutory mental health support (e.g Brandon Centre).
- People who self-define as black (e.g. Black British, Black African, Black Caribbean, African-Caribbean, Dual heritage with one black parent). It can also include people who define by country of origin, such as Nigerian, Somali and Jamaican
- People who have not received government mental health intervention (inpatient support, sectioned).

When and where will the interviews take place?

The interviews can take place where you feel comfortable. It may be possible that we could do the interview at the [insert organisation name]. Alternatively there may be another public venue where you will be more comfortable. We can agree on this before the interview.

Will I be harmed in anyway?

By taking in my research it is very unlikely that you will be exposed to any harm. There is no expectation for you to share any information that you would not like to share. You can always end the interview at anytime if in the unlikely event the interview causes distress.

Do people who take part need to answer all of the questions I ask?

No. You will not need to answer all of the questions. Also, if you feel uncomfortable at any stage during the interview or if you change your mind you will not need to carry on.

What will happen to the information I provide?

It is important to know that all of the information that you provide will be kept confidential. This means that your identity will be protected at all times. To make sure that all of the information you provide is documented precisely I will use a recorder. Your recording will be deleted once I have typed up the interview. Everything you provide will be password protected. There will be occasions when I cannot keep your information confidential. This includes if you are age under 18 and I feel that your welfare has been put in danger or feel your safety is at risk or if you share information of serious criminal nature.

What are the benefits of taking part?

If you take part in this research your experiences may help to improve services. Your experiences may also contribute to new programmes or facilities being created. As I genuinely appreciate your time and experience you will receive £20 for your participation.

Complaint procedure

If you wish to complain about the way in which the research is being conducted or have any concerns about the research then in the first instance please contact my supervisor Prof Dixon: William.dixon@nottingham.ac.uk. If this does not resolve the matter to your satisfaction then please contact the School's Research Ethics Officer, Dr Simon Roberts (tel. 0115 846 7767, email simon.roberts@nottingham.ac.uk

Appendix 5: Participant consent form

School of Sociology and Social Policy

University of Nottingham

Participant Consent Form

A Critical Race Study of Non-Statutory Early Intervention Services for Young Racialised People

In signing this consent form I confirm that:

I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me.	Yes ☐	No ☐
I have had the opportunity to ask questions.	Yes ☐	No ☐
I understand the purpose of the research project and my involvement in it.	Yes ☐	No ☐
I understand that my participation is voluntary and I may withdraw from the research project at any stage, without having to give any reason and withdrawing will not penalise or disadvantaged me in any way.	Yes ☐	No ☐
I understand that while information gained during the study may be published, any information I provide is confidential (with one exception – see below), and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published.	Yes ☐	No ☐

I understand that the researcher may be required to report to the authorities any significant harm to a child (up to the age of 18 years) that he/she becomes aware of during the research. I agree that such harm may violate the principle of confidentiality.	Yes	☐	No	☐
I agree that extracts from the interview may be anonymously quoted in any report or publication arising from the research	Yes	☐	No	☐
I understand that the interview will be recorded using electronic voice recorder	Yes	☐	No	☐
I understand that data will be securely stored	Yes	☐	No	☐
I understand that the information provided can be used in other research projects which have ethics approval, but that my name and contact information will be removed before it is made available to other researchers.	Yes	☐	No	☐
I understand that I may contact the researcher (Anthony.salla@nottingham.ac.uk or supervisor *William.dixon@nottingham.ac.uk* if I require further information about the research, and that I may contact the Research Ethics Officer of the School of Sociology and Social Policy, University of Nottingham (simon.roberts@nottingham.ac.uk), if I wish to make a complaint relating to my involvement in the research	Yes	☐	No	☐
I agree to take part in the above research project.	Yes	☐	No	☐

Participant's name (BLOCK CAPITAL)	Participant's signature	Date
Researcher's name (BLOCK CAPITAL)	Researcher's signature	Date