Exploring racialised minority staff experiences of working in forensic mental health settings: A qualitative approach

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Abstract

Background: The experience of racialised minority staff in various work environments is characterised by long standing racialised inequalities. However, little is known about the experiences of racialised minority staff in Forensic Mental Health (FMH) settings (e.g. secure hospitals or mental health services delivered for criminal justice agencies).

Aim: This thesis explores the experiences of navigating professional and personal cultural identity, among racialised minority staff in FMH settings. The objectives were:

1. To systematically review qualitative studies that explore racialised minority staff's unfavourable experiences of working in the healthcare system (Chapter 2).
2. To explore the individual level experiences of racialisation and discrimination for racialised minority staff in FMH settings, when processing and managing cultural identity (Chapter 4).
3. To examine the systemic level experiences of racialisation and discrimination for racialised minority FMH staff in settings, and the psychological impact this has on them and their ability to serve within this setting (Chapter 5).

Method: A qualitative approach was adopted for this thesis by first conducting a systematic review with thematic synthesis to explore existing qualitative research, on the employment experiences of racialised minority professionals in healthcare settings (Chapter 2). A

qualitative study using semi structured interviews and Interpretative Phenomenological Analysis (IPA) was then undertaken to explore the experiences of 10 racialised minority staff in FMH settings (Chapter 3).

Main findings: The systematic review included 10 studies. 11 themes focused on participants' experiences of discrimination, prejudice and disadvantages. The review highlighted racialised minority staff experiences in healthcare settings and contextualised and informed the subsequent study (Chapter 2). The first part of the qualitative study highlighted five main themes about individual experiences; *carrying the burden, environmental and emotional mastery, the dilemma of staying true to myself, dismissal and minimisation of race-based experiences, unconscious racialisation* (Chapter 4). The second part of the qualitative study produced five main themes about participants' experiences of the system; *culture prevents progression, reducing inequality by changing the narrative, the complexity and contextual nature of FMH settings, using culture and identity to connect* and *buffering for psychological protection* (Chapter 5). Both parts reveal how participants navigate cultural identity, in a racialised environment at individual and system levels.

Implications: Discussing racialisation, intersectional identities and acknowledging the existence of systemic racism should occur in FMH settings. This should also consider the impact on staff and its effect on the population they serve, with the aim of making FMH services more inclusive and equitable.

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Glossary of terms

BME	Black Minority Ethnic
CJS	Criminal Justice System
CRT	Critical Race Theory
CASP	Critical Appraisal Skills Programme
EU	European Union
FMH	Forensic Mental Health
IPA	Interpretative Phenomenological Analysis
MDT	Multidisciplinary Team
MeSH	Medical Subject Heading terms
NHS	National Health Service
PICO	Population Intervention Comparison Outcomes
PIS	Participant Information Sheet
R/CID	Race/Cultural Identity Model

CHAPTER 1 – General Introduction

1.1 Background

Research suggests that a diversity aware, multicultural environment which recognises and celebrates difference, is likely to generate more positive outcomes among those from ethnic minority communities (Gündemir, Martin & Homan, 2019). Kline (2014) suggests a valued and diverse workforce is beneficial for client care, particularly in public health care settings (West, Dawson, Admasachew & Topakas, 2012). While there is a need for professionals in healthcare settings to reflect the communities they serve, the existing evidence reveals that the experience of racialised minority staff members in various institutions, occupations and work environments, is one that is characterised by injustice, discrimination, lack of support and limited opportunities for progression (West & Nayar, 2016; Bhui & Fossi, 2013; Wright, Thompson & Channer, 2007). This view sets the context for this thesis and is relevant given the recognised need for healthcare services to cater to the most deprived communities, including those from racialised minority groups.

At present, there has been no other research that specifically explores the perspectives and experiences of racialised minority professionals whilst working in a variety of Forensic Mental Health (FMH) settings. This thesis aimed to fill this gap, and provide insights into their experiences. The thesis sought to highlight the various psychological and social processes, that are significant and contextualised within the experiences of racialised minority individuals.

1.2 Important concepts and terminology

There is a shared assumption that an ethnic minority group is susceptible to discrimination, based on their ethnicity (Ferns, Stickley & Basset, 2007). For the purpose of this research, there was an emphasis on capturing the experience of those with *visible* ethnic differences, to highlight those who have been vulnerable or experience differential treatment, oppression or prejudice because of the colour of their skin. Taking this into account, participants in this thesis are referred to as racialised minority individuals, to highlight the salience of their visible ethnic difference.

Several other concepts and terms will be referred to throughout this research, therefore, it is important to consider and define these concepts to clarify the overlap and differences between them. According to definitions of '**race**', individuals can be categorised using their biological characteristics including, skin colour and hair texture. This would suggest that there are distinct, predetermined and ascribed characteristics that can only be defined by phenotype (Helms & Talleyrand, 1997). Although, that definition has been contested, and instead 'race' is understood as a social construct and a form of social classification, reflecting historical ways of thinking, talking and being, engrained in the history of colonialism (Durrheim Hook & Riggs, 2009). It underpins how racism operates, and as such, defining 'race' continues to be controversial.

'Race' and 'ethnicity' are often used interchangeably, however, there are differences between the two. Definitions of '**ethnicity**' include the concept that membership to an ethnic group is voluntary (Banton, 1983). According to Phukon (2002), it has been described as "an organising principle used by a group of people in order to differentiate themselves from other groups in terms of race, language, kinship, customs, mode of living, culture and religion" (p.1). 'Ethnicity' is described as 'situationally based' and concerned with group identity and the choice to belong to a particular ethnic group (Fernando, 2002). Although, when the term 'ethnicity' is used, it tends to refer to racialised minority groups, negating the idea that everyone has an ethnicity. As such, it is not fixed, as it continuously shifts and evolves.

Like 'ethnicity', '**culture**' is also considered a fluid concept, focusing more on group practices, values and beliefs (Patel et al., 2000). It is a shared way of life and acknowledges the norms and defining characteristics of an organised group (Murry et al., 2004). It can also be conceptualised based on different demographic factors such as gender, age, socio-economic status, language or religion (Lee, 2006). Fernando (2002) states that when a person is labelled as belonging to a social group based on 'race' or 'ethnicity', they are likely to be stereotyped as holding the traits that have been ascribed to that group. **Racism** is then the term often used to describe the negative attitudes that individuals hold regarding members of different racial and/or ethnic groups, where discrimination is thought to emerge from prejudices (Rucker, Duker & Richeson, 2019).

Racism in the modern day can be more subtle, covert and disguised (Pedersen & Walker, 1997). It is also understood as an inability to accept and acknowledge cultural or racial differences, which may involve differential treatment of people because they belong to a particular group. Acts of **racial microaggressions** are another form of racism where everyday verbal, nonverbal and environmental slights or insults, communicate intentional or unintentional negative and derogatory messages. Acts of microaggressions are targeted at an individual based solely on their marginalised group membership. These hidden messages can invalidate the identity of the person, communicate that they are 'less than' or suggest they do not belong with the majority group (Sue, 2010).

1.3 Culture and employment within the UK

In the United Kingdom (UK) following the post labour migration and since the 1950s onwards, the UK has become increasingly multicultural. This was partly due to the arrival of migrants from India, Pakistan and several Caribbean islands (Connolly & White, 2006), as a direct response to the demand for labour in different employment sectors. Immigrants tended to be unskilled workers, often willing to perform lower level, lower paid jobs. Though, the increased physical presence of racialised minority individuals tended to create perceived competition for British born individuals, with a lower status and educational skills, placing them at risk of potential unemployment (McLaren & Johnson, 2007).

In the early-mid 2000s, the UK already had at least 50 non-indigenous communities with thousands of visible different ethnic groups (Wood, Landry & Bloomfield, 2006). The UK population has become more diverse since the Census in 2011, and forecasters anticipate further growth of ethnic minority groups (Lomax, Wohland, Rees & Norman, 2019). In this regard, several parts of the UK are considered 'superdiverse' (Vertovec, 2007).

1.4 Racial disparities in Brexit and COVID-19

While the UK has become multiculturally diverse, with more established minority populations, in the last six years, it has experienced two major population-level events. These events will be explored as they uncovered ethnic inequalities and racial disparities for ethnic minority groups.

1.4.1 European Union Referendum- Brexit

In June 2016, Britain narrowly voted to leave the European Union (EU) ('Brexit'). Those who voted to leave, were described as those from upper- and middle-class backgrounds, with almost three in five votes coming from these social classes (Dorling & Tomlinson, 2019). The emphasis on the campaign to leave the EU focused on reinstating the independence of the UK (Virdee & McGeever, 2019), but the outcome of the EU referendum resulted in economic and political turmoil (Arnorsson & Zoega, 2018). Shortly after, those from racialised minority backgrounds including migrants, experienced

significant racism. Over 6,000 racist hate crimes were reported to the National Police Chiefs Council, four weeks after the result was announced (Komaromi, 2016). Incidents included physical assaults, property damage and verbal racial abuse. Many individuals from ethnic minority backgrounds reported verbal abuse with phrases such as "go home" and "we voted you out" (Virdee & McGeever, 2019).

It could be that Brexit allowed racism to accelerate and be bought to the surface, causing racial division, racial exclusion and discrimination towards racialised minority groups in the UK. However, some believe that the increase in racism against migrants and minorities is confirmation of the UK's longstanding underlying attitudes (Virdee & McGeever, 2019). In many parts of the UK, threats, harassment, intimidation and physical attacks are an everyday aspect of the lives of immigrants (Mintchev, 2020), and racism and exclusion has continued.

Research conducted by Spiliopoulos and Timmons (2022), also highlighted the challenges of migrant nurses post-Brexit. The decision to leave the EU had a significant impact on the National Health Service (NHS), as the number of EU nurses decreased following the referendum result. Yet, some immigrant and EU nurses were still employed by the NHS (Spiliopoulos & Timmons, 2022). Racialised minority groups and immigrant nurses working in the NHS after Brexit shared feelings of 'othering', discrimination and racialisation (Spiliopoulos & Timmons, 2022). This highlights the racial and ethnic

inequalities that continue to exist within society, and more specifically in the healthcare workforce (see section 1.5 for more information about cultural diversity within healthcare settings).

1.4.2 Covid-19 Pandemic

Coronavirus (Covid-19) first broke out in China in December 2019. The virus spread worldwide affecting millions of people, with over 100,000 deaths (Ciotti et al., 2020). Over time, researchers noticed that significantly higher rates of Covid-19 were identified among ethnic minority individuals (Anyane-Yeboa, Sato & Sakuraba, 2020). There were clear racial disparities in the rates of Covid-19 cases, and deaths among people who were from ethnic minority groups (Chowkwanyun & Reed Jr, 2020). As such, race became central to conversations about Covid-19.

Pandemics affect those who are most vulnerable, exposing the structural effects of race and class differences (Sabatello et al., 2021). Those communities who already face social, economic and health difficulties, were the most impacted by Covid-19, and were at a higher risk of vulnerability (Elias, Ben, Mansouri & Paradies, 2021). Within ethnic minority populations, comorbidities such as kidney disease, obesity, heart diseases and diabetes increased the complications and fatality of Covid-19 (Lee & Ahmed, 2021). Such health conditions are highly prevalent in ethnic minority communities (Lee & Ahmed, 2021). From a community perspective, impoverished or urban neighbourhoods are more vulnerable, due to the higher

population of people in the community, with individuals occupying housing that is likely to be more condensed (Florida, 2020). Therefore, infections tend to transmit faster, compared to those living in suburban areas. There are a multitude of contributing factors that increase ethnic minority groups susceptibility to Covid-19. These exposures continue to significantly affect ethnic communities and perpetuate systemic discrimination and health and social inequities across the world (McCoy, 2020).

As well as racial health inequalities, Chinese and Asian people were also exposed to racialisation during the Covid-19 pandemic. As the virus started in China, Chinese and Asian people fast became the target of xenophobia, as they were blamed for Covid-19. News outlets began to report the racialisation of Covid-19, with some calling the pandemic the "Chinese virus" and "kung-flu" (Russell, 2020). Research shows that the spread of infectious diseases can often be associated with increased prejudice and racial intolerance, where specific ethnic groups are targeted (Schaller & Neuberg, 2012). This is often due to the emotional response to the threat of the virus, which can lead to reduced levels of empathy and stigmatisation of minority groups (Navarette & Fessler, 2006). Qualitative research conducted by Lee and Waters (2021), highlighted that Asian participants experienced microaggressions, hate crime and overt racism during the Covid-19 pandemic. These experiences likely exacerbated the level of stigmatisation and othering, for those in Asian communities leading to further vulnerability and inequality.

It is also worth noting that since the Covid-19 pandemic, a new disease known as the 'Monkeypox' virus had recent outbreaks across America, Europe, Eastern Mediterranean and Western Pacific regions. The disease was given its name after it was first detected in captive monkeys in 1958 (WHO, 2022). Although the World Health Organisation have decided to give it a new name to reduce racism and stigma (Taylor, 2022). According to news outlets, it is now rebranded as 'mpox' due to the racial connotations it carries, similar to those used when referring to Covid-19.

The significant events over the last six years highlight how racial and ethnic inequalities continue to be perpetuated through economic systems and structures. It also demonstrates the historical nature of racialisation, and the socially entrenched nature of prejudiced attitudes and actions towards marginalised communities.

Throughout both Brexit and the Covid-19 pandemic, Black Lives Matter (BLM) (founded in 2013), has also been an ongoing social movement. It emerged out of a need to reflect on the experiences of black people, particularly with how racial inequality, discrimination and systemic and individual level racism is experienced daily by those from black communities. As a result of BLM, many organisations responded by pledging to become more outspoken in acknowledging the experiences of black people. They also endeavoured to address racism, by questioning and learning about their own positionality

within the discourse of white privilege and unconscious bias, to achieve equity for black communities in organisations.

1.5 Healthcare settings

1.5.1 Cultural diversity in healthcare settings

The NHS is the biggest employer in Britain with roughly 1.3 million staff members. They also have the largest number of individuals from ethnic minority backgrounds compared to any other health care organisation (Kalra, Abel & Esmail, 2009). In 2021, 22.4% of staff working in NHS trusts in England, were from ethnic minority backgrounds (NHS WRES, 2021). This population is overrepresented in the NHS workforce in comparison to the working age general population (NHS Digital, 2021).

However, while the NHS employs many individuals from minority backgrounds, according to international evidence, employees from marginalised groups experience discriminatory workplace practices (Mor Barak, 2015). A study by Kline (2014) referred to the 'snowy white peaks' of the NHS, emphasising the fact that at the time, its managerial and senior posts were mostly held by white people. This likely reflects the current image of institutional racism and unfair treatment. Seven years after Kline's (2014) study, the NHS Workforce Race Equality Standard (WRES) 2021, indicated that a sizeable 35.3% of staff from Asian and black backgrounds experienced harassment, bullying or abuse from other staff. Although the NHS WRES are mandated to improve racialised inequities, little

progress has been reported since 2016, particularly following Brexit as discussed previously.

Research has explored this further, a literature review on the experiences of nurses and midwives from ethnic minority backgrounds in the UK healthcare system, revealed the following themes: injustice, discrimination, racism and lack of support (West & Nayar, 2016). Furthermore, a qualitative study discovered that despite working in ethnically diverse healthcare settings, participants identified that there was a lack of inclusion and increased microaggressions and prejudice. Additionally, ethnicity, migration status and language were noticeable markers of similarities or dissimilarities (Woodhead et al., 2022). As such, participants believed that subscribing to the ingroup was a way of coping with workplace discrimination and unfair treatment (Woodhead et al., 2022). These experiences have maintained inequities and reduced staff performance, impacting staff wellbeing within health service organisations.

1.5.2 The Context: Forensic Mental Health settings

Forensic Mental Health (FMH) settings differ from other healthcare settings. The client population are those who tend to be placed within an FMH environment after offending or engaging in harmful or antisocial behaviours. In FMH settings, risk of harm to self or others is often difficult to manage in the community or within other services, and clients usually experience difficulties with their mental health

(Tomlin, 2021). Environmentally, they are niche in that they aim to provide the least restrictive setting, whilst maintaining appropriate levels of physical, relational and procedural security (Seppänen, Törmänen, Shaw & Kennedy, 2018). Physical security focuses on various aspects of the environment including building design. Relational security covers interpersonal relationships between the client and professional, and procedural security highlights the policies and procedures that maintain safety (Department of Health, 2007; Reed, 2011). Relational security is particularly important within FMH settings, as staff members are expected to work closely with clients and maintain an environment that is therapeutically safe. This is significant as it enables positive therapeutic relationships and attachments to be formed, and is predictive in treatment, progression and client satisfaction (Bressington, Stewart, Beer, & MacInnes, 2011). Both security and therapeutic approaches are interweaved in FMH settings. These settings provide a therapeutic milieu approach, where clients have a safe environment in which to manage their risk and encourage their rehabilitation and reintegration into the community.

Clients in FMH settings tend to be highly complex with many displaying mental health difficulties, neurodiversity challenges, substance misuse, a history of offending or risk related behaviours and plethora of other needs (Robertson, Barnao & Ward, 2011). Risk is central to practice within FMH environments, as staff must manage the risk of violence, self-harm, sexually harmful behaviours and other

challenging presentations. Furthermore, staff face a chance of being physically assaulted, and are at an increased risk of aggression in comparison to other healthcare settings (Dutta, Majid & Völlm, 2016). Previous research highlights the attitudes and beliefs of some FMH professionals towards clients in this setting, indicating a level of stigma and negativity towards FMH clients. With this, some professionals had a desire for social distance, and avoided interactions with the clients they worked with. Other staff members had negative perceptions of danger and punishment (Lammie, Harrison, Macmahon & Knifton, 2010). This emphasises the difficult and complex nature of working in a FMH setting where staff face a dual obligation as a carer and custodian, bridging the gap between mental health care and the Criminal Justice System (CJS). This differentiates FMH staff from professionals in other healthcare institutions (Peternelj-Taylor, 1999).

In considering cultural diversity in FMH settings and in the CJS more broadly, literature has undoubtedly highlighted the disproportionate overrepresentation of racialised minority individuals (Gajwani, Parsons, Birchwood & Singh, 2016). Those from racialised minority backgrounds are detained and secluded more often than those from non-racialised backgrounds (Hui, 2018). Moreover, as mentioned previously, more staff from ethnic minority backgrounds are employed within healthcare organisations. Thus, unlike other institutions, FMH settings are statistically more diverse in both their staff and client groups. However, while the environment itself is

culturally diverse, given the existing research on racialised minority professionals working in healthcare settings, there is a question as to how racialised minority staff conceptualise their experiences in FMH settings, particularly when considering the enmeshment of cultural identity and ethnic difference on clinical work (Livingston, 2016).

1.5.3 Historical Context: Psychiatry and psychology

Psychiatry and psychology arose in European culture and originally functioned in western society, founded on western knowledge. Both disciplines have input into labelling people based on their social functioning, capacity and mental states (Fernando, 2017). Overtime, both psychiatry and psychology became standardised disciplines, but race-related ideology began to infiltrate as they developed. Both psychiatry and psychology derive from the perspectives of white males in society where at the time, colonialism likely influenced how they conceptualised mental health (Bhui, 2002; Fernando, 2017). More specifically, when considering psychology, it has been argued that clinical psychology has been developed through evidence-based practice which disproportionally represents Western, Educated, Industrialised, Rich, Demographic (WEIRD) populations (Henrich, Heine & Norenzayan, 2010). This is said to inform therapy models, NICE guideline recommendations for psychological therapies, and how professionals are trained.

An example of how racism has infiltrated psychiatry and psychological practice, is through the rate at which 'schizophrenia' is diagnosed in

black people in the UK, often referred to as 'overrepresentation' (Fernando, 2017). In the 1980s it was found that black people in psychiatric hospitals were being labelled as 'dangerous', without an objective reason for this (Harrison, Ineichen, Smith & Morgan, 1984). Black patients were also overrepresented in those who were involuntarily detained in hospital (Fernando, 2017). This led to the perceived dangerousness of black people which resulted in excessive use of seclusion, and higher levels of medication (Fernando, 2017).

It was eventually concluded that black and white people are 'seen differently even if they exhibit the same behaviour' (Loring & Powell, 1988, p.19). This highlights the need to examine systemic processes to understand how diagnoses perpetuate racism. This assumption is commonly made by psychiatrists and psychologists (Cromby, Harper & Reavey, 2013) and often, the consequences of 'race' could lead an individual to behave in ways that align with this diagnosis (e.g. paranoia) (Oduola et al., 2019). Interestingly, black populations in Jamaica and Barbados have been found with lower rates of psychosis compared to the UK (Mahy, Mallett, Leff & Bhugra, 1999). This highlights the need to explore the relationship between racism and distress.

1.6 Conceptual Framework

The conceptual framework identifies how the researcher sees the concepts and outcomes of the proposed research and their relations with each other (Miles & Huberman, 1994). Developed from the literature search and theoretical processes, the framework highlights

important interlinked concepts that drive the research. The following areas explain the key theories and concepts used in this thesis and will serve as a foundation to understand the experiences of racialised minority FMH staff. The main areas of the conceptual framework are: cultural identity, professional identity, racialisation and the Critical Race Theory. Each of these will be explored in detail in the following subsections.

1.6.1 Identity

Identity development has been researched in some depth over many years, illustrating the process humans experience while exploring and forming their identity. A variety of different models of racial and cultural identity development have been suggested (e.g. Cross, 1995; Helms, 1995). Most of these models focus strongly on the impact of race and racism in how racial perception and identity is developed. However, while race should be acknowledged, individuals can also form their identity from other contexts and cultural perspectives (Lee, 2006).

1.6.2 Cultural Identity

Cultural identity enables people to understand their sense of self and how they relate with each other in society and within different contexts (Bernal & Knight, 1993). It has been suggested that cultural identity is constructed, but also viewed as a concept whereby individuals are a product of their environment and interactions with others (Karjalainen, 2010). Brannen and Thomas (2010) state that

developing cultural identity is not conscious, but more a subconscious outcome of existing in culturally complex environments. For example, there are cases with the children or grandchildren of multicultural households, where identity is not represented by how they look or the language spoken, but by subconscious processes such as the environment and their interactions. Here, the physical or surface level characteristics that tend to be used to distinguish cultural identity (language, skin colour etc…), may not be a clear indicator of the cultural identity the individual ascribes to (Brannen & Thomas, 2010).

Similarly, there are individuals who spend most of their developmental years outside of their parent's home culture. In this case, their cultural identity could result from their immersion and interaction with the cultural setting they reside in, or the personal feeling of belonging to the location or group (de Waal & Born, 2021). As such, they may not consciously choose their cultural identity, but instead it develops through various subconscious factors.

According to Lago (2006), it also develops within the context of belonging to a subordinate or dominant group from a social, political and economic perspective. Being in a dominant social group can influence how those in subordinate groups view themselves. As dominant groups tend to hold more power, they can construct narratives that silence minority voices and strengthens dominant groups norms and values (Bamberg & Andrews, 2004). As these values and behaviours become more widespread, the negative

consequences of dominant groups can be easily ignored as they may start to appear normal. Therefore, dominant groups can encourage others to hold onto prejudicial thoughts and behaviours impacting interactions and experiences. Individuals who are from a minority group, may begin to internalise the values and norms of the dominant group, by way of trying to get access to dominant group privileges or to 'fit in'. Achieving a healthy sense of racial or cultural identity is integral to those groups who are frequently racialised. While developing identity is complex, several models have been created to demonstrate how cultural identity is developed (e.g. Helm's 1984 white racial identity development model).

The Racial/Cultural Identity Development (R/CID) (model) (Sue & Sue, 2003) emphasises the stages individuals experience as they make sense of themselves and the dominant culture. It highlights five stages of development:

Conformity: The lifestyle, value systems and cultural features of the dominant culture are embraced, while characteristics of their own culture are rejected.

Dissonance: There is likely conflict with experiences that challenge their own current self-concept. The dominant views of their culture tend to be questioned, particularly by those who experience direct discrimination.

Resistance and Immersion: Individuals tend to hold minority views and reject the perspective of the dominant values of society, by embracing their own cultural values and beliefs. There may be feelings of guilt and shame where previously the individual may not have orientated towards their own cultural values. However, a new connection and sense of pride towards their cultural group is formed (Arumugham, 2017).

Introspection: Individuals become more thoughtful and introspective in their appreciation of the characteristics that make them different from the dominant culture.

Integrative Awareness: There is an appreciation for their own heritage and for all cultural groups (Atkinson, Morten & Sue, 1989). Individuals develop a sense of security within their culture, and dissonance from previous stages are resolved (Arumugham, 2017).

The R/CID model offers one perspective for understanding how cultural identity can be developed. However, it is understood that all individuals do not experience the above stages in a linear and undeviating manner. Lee (2006) believes that the development of cultural identity is non-linear and can be influenced by various situations and experiences. Nevertheless, the R/CID model and other cultural identity models can be used to consider the context through which identity is developed.

1.6.3 Professional Identity

Within the context of this thesis, professional identity must also be considered. Professional identity has been conceptualised in many ways. For example, it has been defined as the "attitudes, values, knowledge, beliefs and skills shared with others within a professional group" (Adams, Hean, Sturgis and Clark, 2006, p.56). It has also been described as the meaning individuals attach to themselves within employment (Dutton, Roberts & Bednar, 2010), and the image of who they are as a professional (Slay & Smith, 2011). It takes into consideration the attributes, motives and experiences that people use to define themselves in their professional capacity (Schein, 1978). Identifying with a profession, enables individuals to align themselves with a community which includes individuals who share a common approach to a specific line of work (Van Maanen and Barley, 1984).

Forming a professional identity can be a subjective experience that is influenced by the interpersonal interaction's individuals have with others, about their role and their work (Caza & Creary, 2016). Based on connections with others in the work environment, individuals may absorb the expectations of their role and of others (Caza & Creary, 2016). Pratt (2012) states that individuals take an active role in forming their professional identity (Caza & Creary, 2016), and this identity tends to be adapted and adjusted during transitional periods in their career (Ibarra, 1999).

While the process of navigating a professional identity can be complex, it is also important to consider the interplay between personal and professional identities, as they are not always mutually exclusive and are intertwined. For example, this can be seen in those who work within spiritual care as part of the wider healthcare discipline. Spirituality is now deemed an approach of care for healthcare professionals (Pesut & Thorne, 2007), and it can be viewed as being rooted in one's personal values and beliefs. This poses the question; how does one navigate these competing identities? It is possible that some individuals who work in spiritual care may uphold both their personal and professional identities equally, when engaging with patients and within the work environment generally. Similarly, the source of their expertise may derive from both potentially competing identities, causing the distinction between the two to be blurred.

Another example can also be seen in medical professionals who are immigrants. Foreign medical professionals who migrate from their homeland using a work permit, may possibly give more attention to their professional identity. This could be due to the need to remain in the country and to prevent jeopardising their employment and residency (S. Chou, pers comm). A journal article by Fagan et al. (2020) highlights how the visa process for foreign medical professionals, was expedited to recruit more healthcare staff during the COVID-19 pandemic. This demonstrates how the interplay between their identities is likely to be weighted towards their

professional identity, due its importance and value. This is in comparison to their colleagues who have full citizenship and where the risk of deportation may be lower.

1.6.4 Conflict in negotiating multiple identities

Multiple identities are held by many individuals in various circumstances for different reasons. The dynamic between examining how professional and cultural identities coexist is a complex process and one that is key to this conceptual framework. There are many reasons as to why developing a professional identity is different for those who are from ethnic backgrounds (Slay & Smith, 2011). One suggestion for this is that in society, those from ethnic minority groups have been stigmatised, and can be viewed as 'non-professionals' (Slay & Smith, 2011). Another suggestion is that during the process of developing a professional identity, feedback is useful (Pratt, Rockmann & Kaufmann, 2006). However, being fairly evaluated can be infrequent for professionals from ethnic minority backgrounds, as they commonly receive negative feedback and can attribute this to prejudicial behaviour (Major et al., 2016). Therefore, ethnic minority individuals may experience some incongruence and conflict between their cultural and professional identities, and struggle to integrate aspects of both.

A study by Dickens and Chavez (2018) demonstrated how black women within their respective careers, shift their identities to manage the stereotypes of black women. They found that participants

assimilated to the white dominant culture to achieve professional advancement and to be accepted as professionals. These individuals shared that connecting to their black culture within the work environment could result in negatively impacting their career progression. There was a risk of being 'othered', or further marginalised within the professional setting, and so to be successful in their positions, they had to learn how to negotiate their identities effectively. This provides evidence for how negotiating cultural and professional identities is a complicated and complex process, and one which is highly relevant to this thesis.

1.6.5 Racialisation

Exploring race and ethnicity relations, helps to understand their concept and construction. The term 'racialisation' was first introduced by Fanon (1963) to conceptualise the dehumanisation of different groups of people, by structuring them in terms of their 'race' in the way that Europeans identified people who were subject to slavery. Although the term is now used more widely and not for its original use. Malik (1996) describes racialisation as the lens or medium through which 'race-thinking' operates. It highlights how discrimination and oppression can be enacted through culturally defined groups (Fernando, 2017), and how these experiences or social situations that draw attention to skin colour or racial status have been fundamental to the individuals that view themselves as becoming racialised.

Racialisation can occur both at a micro and macro level, (Gonzalez-Sobrino & Goss, 2019) and some researchers are of the view that it can occur through a top down or bottom-up approach where groups may 'racialise' themselves (Miles, 2004). The most common concept of racialisation derives from its emphasis on processes which differentiates people, such as biological criteria separating individuals into distinct groups (Inwood & Yarbrough, 2010). Although it is also said that all individuals in racialised societies are racially preconditioned, where majority white groups, as the dominant racial group have always been central to the role of racialisation (Gans, 2017).

Racialisation in society can be seen through societal and political practices and behaviours that lead to reproducing advantages for some, and disadvantages for others (Bonilla-Silva, 2021). This process is seen throughout literature on racial discrimination, that looks at how white majority groups treat ethnic minority groups in different contexts, such as in schools, employment and in neighbourhoods. For example, in housing, some white majority groups pay a premium to live among themselves, to perhaps to get better access to public schools, with race being an influential factor in their decisions about neighbourhoods. While these choices are not limited to housing or neighbourhoods, they can impact many decisions, and therefore, living in a predominantly white community can sustain the racialisation of the housing market. With this, white majority neighbourhoods may be valued higher than homes in

predominantly ethnic minority communities, perpetuating the racial wealth gap (Thomas, Moye, Henderson & Horton, 2017). This is an example of how the dominant race may defend the system, reproducing racial inequality and racialisation.

When considering wider societal issues, processes such as racialisation can be used to understand diversity within society, and how inequality is reproduced through racialised social systems and collective practices (Small, Harding & Lamont, 2010; Lamont, Beljean & Clair, 2014). Recognising the process of racialisation in various institutions can aid the understanding of the mechanisms by which it functions, why racialisation occurs for specific groups (Gonzalez-Sobrino & Goss, 2019), and the experiences of those who have been racialised. This thesis is principally concerned with processes that have racialised people, as it aims to explore the processes by which concepts of race are reinforced and perpetuated in FMH settings.

1.6.6 Critical Race Theory

The Critical Race Theory (CRT) was developed from critical legal studies in the USA during the 1970s, to address overt forms of racism and offer a perspective on 'race'. It shaped how people think more widely about law, racial categories and privilege (Harris, 1993), by tackling racialised inequality. Since the 1970s, the CRT has been introduced into other fields of study such as sociology, as it focuses on the experiential knowledge of ethnic minority individuals, and their communities in relation to 'race' (Delgado & Stefancic, 2001). The

theory analyses how 'race' and racism operate within social contexts in society, and how it directly and indirectly affects ethnic minority groups, both individually and collectively, through different institutional and systemic processes (Yosso, 2005; Stovall, 2005).

The CRT perspective was also developed to recognise, acknowledge and uncover the deeply embedded and subtle manifestations of racism (Berry & Candis, 2013). It can be seen as a framework that offers a current perspective on race and racism, as it suggests that racism reveals itself in the everyday interactions of life, reinforcing the dominance of majority groups over minority (racialised) groups (Solorzano, Ceja & Yosso, 2000). CRT suggests that racism is ever-present and organically part of the fabric of most systems. It is so entrenched in these economic, social and cultural structures that it has become ordinary and at times unrecognisable (Graham, Brown-Jeffy, Aronson & Stephens, 2011). As such, CRT views racism as a central feature of life, resulting in negative or lower outcomes for racialised individuals.

According to Parker and Lyn (2002), the goals of the CRT are as follows: (1) to share narratives about discrimination from the perspectives of those from racialised minority groups; (2) to argue to eliminate racial oppression; and (3) to deal with other issues of dissimilarity and injustice experienced by different communities. The CRT takes into consideration racialisation and the construction of racialised groups (Delgado & Stefancic, 2012).

The principles of CRT and racialisation provide different perspectives to conceptualise the presence of race, racism and prejudicial behaviour in everyday life. Both racialisation and CRT are used in this research to discuss human differences that allude to the social construction of race. It also emphasises in this research the processes that generate and maintain these racial categories, from an individual and systemic level. This is important to understand as it is related to exploring the experiences of the participants in this research. CRT is a versatile framework that has shaped this thesis at various points. For example, it informed the research aims and chosen methodology, as it gives voice to racialised minority individuals using narrative accounts and perspectives. It provides avenues whereby marginalised groups can describe the impact of 'race' and their experiences with cultural identity and racialisation. CRT also informed the interview questions (see chapter 3) and the data analysis and findings (see chapters 3 and 4). It is also important to note, that as CRT originated from legal studies with its focus on individuals in the system, the participants in chapters 4 and 5 are staff in FMH services, who are likely part of the same system, but situated within a different component of it. Therefore, it is important to think about how this theory applies to this population.

CRT situates the context of race with racialised minority staff members identities and explains the processes that racialise people. Additionally, it helps to examine the complex relationship with

identity and explore and analyse the dynamics of how identities are shaped. With race being a pivotal component of this research, CRT examines how race intersects with identity and working as a FMH staff member. In this thesis, all participants had a relationship with race where it pertained to their identity, and CRT sees that social identities such as race, can create oppression and marginalisation (Francis, 2021). This highlights the salience of CRT for this research.

The following theories and concepts drive and guide the thesis, and highlight the processes that will be explored further though the qualitative research.

1.7 Thesis structure and research aims

This research thesis aimed to provide a qualitative investigation into the experiences of racialised minority professionals within FMH settings. The main focus of the thesis was to explore the experiences that may arise for racialised minority FMH staff when navigating cultural identity, both professionally and personally. It highlights how this population navigate identity within this environment, both at an individual and system level, and addresses issues and gaps within the field relating to current societal issues, and matters pertaining to cultural diversity, identity and professionalism in FMH settings. The thesis encompasses six chapters, consisting of: an introduction, a qualitative systematic review, a methodology chapter, a two-part qualitative research study and a discussion chapter. Each chapter

addresses a specific aspect or step towards answering the overall research question.

The introduction chapter provides an overview of the topic. With the incorporation of literature it lays the foundation for later chapters and frames the entire thesis.

Chapter two is a qualitative systematic review. Its aim is to systematically review the qualitative studies that explore racialised minority professional's views, and positive and unfavourable experiences of working in the healthcare system. It examines the existing literature, and as this is the first systematic review of its kind, it provides a perspective that illustrates the common themes that have impacted this populations experiences. The review shares how racialised minority healthcare professionals often encounter various unfavourable situations that have been deemed as discriminatory. It further documents how these individuals respond to and navigate discrimination in this environment. As the review is unique in its aims, it identified the knowledge gaps to be filled by the primary research. It also informed the primary research methods and analysis (IPA) as it uncovered broad themes which could be investigated in more depth.

Chapter three presents the methods of qualitative research. It explains what Interpretative Phenomenological Analysis (IPA) is and how this approach was used to collect data for the primary research

studies. This chapter also sought to provide a critical analysis of IPA, to explore its quality and ability to capture accurate experiences. While the limitations of this method are discussed, the chapter justifies its suitability for the current research, and highlights the theoretical and philosophical underpinnings of the method, and how the research is designed conducted, and analysed.

The results on the individual and micro level experiences of racialised minority participants in FMH settings are presented in chapter four. This chapter aims to explore the views and perspectives of racialised minority FMH professionals as they encounter and respond to racialisation and prejudicial events. More specifically, the study examines how this population process and manage their cultural and professional identities, whilst serving in their respective roles. The research reports data from 10 participants who have been employed at various FMH settings, where the in-depth information from interviews was analysed using IPA. Chapter four responds to the following research questions:

1. What are the individual experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

2. What are the individual lived experiences of processing and managing cultural identity within FMH settings?

In chapter five, the diverse experiences of racialisation, discrimination and prejudice that were perceived as deriving from systemic level experiences are presented. This chapter examines the wider structural and system issues, and explores participants experiences that were perceived as significant, as they impacted professional relationships, clinical practice and employment progression within the FMH setting. The psychological impact of their experiences are also discussed. Chapter five focuses on the following research questions:

1. What are the systemic level experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

2. What psychological impact does the experiences of racialisation and discrimination of racialised minority staff have on them and their ability to serve within this setting?

Chapter six concludes with a discussion, integrating findings from the four main chapters. It amalgamates knowledge and reflections across chapters and examines salient and significant insights from racialised minority professionals in FMH settings, situated within the context of the CRT and the process of racialisation. The chapter then explores recommendations and directions for future research, to add to the current findings and increase the knowledge base in this area. It also

provides potential implications from the research, proposing how the wider Forensic Mental Health system can practically implement suggestions based on the findings. Finally, the research presents an overview of the strengths and limitations of the thesis and overall conclusions.

CHAPTER 2 - The employment experiences of racialised minority healthcare professionals: a qualitative systematic review

2.1 Introduction

2.1.1 Ethnic minority professionals in employment

Ethnic minority individuals make up 14% of the United Kingdom's (UK) working population, and in 2051 this is expected to rise to 21% (Wohland, Rees, Norman, Boden & Jasinka, 2010). As the number of ethnic minority individuals entering organisations and services is increasing, managing inclusivity, diversity and equity within the workplace is essential. While research identifies the importance of diversity within the workplace, marked differences between ethnic groups exist in the type of work they engage in.

Occupations that require an intermediate skillset such as nursing assistants and other roles within the public health sector, tend to employ those from African or Caribbean backgrounds. Data from a 2019 NHS England report states that there were 16,112 more staff from ethnic minority backgrounds across all NHS trusts in 2019, compared to 2018 (NHS England, 2020). Most of these staff members were those who were employed in frontline jobs (Bailey & West, 2020), resulting in a disproportionately high number of ethnic minority staff members in lower-level medical roles. Overall, access into lower paid or lower status jobs is more common amongst ethnic minority individuals (Brynin & Güveli, 2012).

McGregor-Smith (2017) found that ethnic minorities are disadvantaged in relation to rates of unemployment, earnings, and occupational attainment (Wright & Pollert, 2005). Research

repeatedly demonstrates the significant disparities within pay between white British workers and ethnic minority groups in the UK, even after controlling for individual differences such as education level (Brynin & Güveli, 2012).

While the 'ethnic pay gap' may be the result of many factors, two main explanations have been identified; ethnic minorities enter lower paid occupations, or they are paid less than their white British counterparts for the same work (Brynin & Güveli, 2012). For example, within pharmacy, the ethnicity pay gap is smallest in primary care at 1.2%, with an annual salary of £53,248 for white British pharmacists, compared to £52,624 for racialised minority pharmacists (Kam, 2019). An overall 16% pay gap was calculated based on estimated median pro rata salaries of £50,960 for white pharmacists, and £43,056 for ethnic minority pharmacists based on a 40-hour working week (Kam, 2018).

Additionally, the 2017 McGregor-Smith review found that ethnic minority employees in business sectors, may experience difficulty with achieving the same career progression opportunities as their white counterparts. One in 16 ethnic minority employees hold higher management positions (Business in the Community, 2015), with many feeling overlooked for promotion due to their ethnicity (Business in the Community, 2014).

While this may be due to several reasons, ethnic minority groups state they have a lack of clear information on training opportunities or progression routes within the workplace. Thus, they feel they

struggle to achieve the same progression as their white counterparts. It is likely that this specifically affects ethnic minority groups, as there is a lack of ethnic minority role models and mentors in higher positions within the workplace, who could provide guidance and support. Mentors from ethnic minority backgrounds are likely to help in this context, as they may be aware or have first-hand experience, of the challenges and barriers 'race' can present in career development and progression.

2.1.2 Ethnic minority professionals in healthcare

A culturally diverse healthcare workforce is more likely to meet the needs of diverse populations (Keshet & Popper-Giveon, 2016). However, it is only recently that the job experiences of ethnic minority healthcare professionals are being understood. In England, a higher proportion of National Health Service (NHS) staff identify as being from a minority ethnic group, compared to the population as a whole (Appleby, 2018). In the 2011 Census, there were 15% ethnic minority NHS staff, compared to 20% in December 2017 (NHS Digital supplementary information files, 2018), demonstrating the rise in ethnic diversity within the healthcare sector. However, internationally recruited nurses in the UK have commonly referred to experiencing racism and harassment whilst working in NHS hospitals and the private sector (Likupe & Archibong, 2013), despite the long history of recruiting nurses from overseas (Cabanda, 2020).

Similar notions are found in physiotherapy, traditionally perceived as a white middle-class profession (Greenwood & Bithell, 2005). Ethnic minority physiotherapists have reported feeling disadvantaged, marginalised and isolated within the profession (Frumkin & Koutsoubou, 2013). This raises questions concerning the management of diversity, equal opportunities within the healthcare system, and more importantly the experiences of those racialised minority staff within the healthcare workforce.

2.2 Rationale for systematic review

A qualitative systematic review is needed to uncover common themes by synthesising relevant evidence. Qualitative systematic reviews enable findings to be summarised by comparing and analysing research whilst searching for rich and insightful meaning. Within the healthcare sector, qualitative methods are commonly used to generate knowledge for practice (Miller, 2010). Despite the available research surrounding racialised minority healthcare employees', no systematic reviews have synthesised the voices of ethnic minority healthcare professionals. The factors that influence their experiences were identified in the scoping searches conducted in April 2020. The Campbell collaboration and the Cochrane were searched for previous systematic reviews. This was supplemented by library and web searches. It was found during this process that many studies focused specifically on the experiences of ethnic minority nurses. While this was a key search term, it was also considered important to ascertain whether there has been research on other healthcare professions.

Additionally, given that the research was undertaken during the Covid-19 pandemic, the systematic review became more significant. Published reports highlighted the position of racialised minority professionals working on the frontline during the pandemic. Those from South Asian and African Caribbean heritages were described as disproportionately affected by the virus (Khunti, Singh, Pareek & Hanif, 2020) (see section 1.4.2). The current systematic review provided a timely synthesis in this area. It also informed and served as a rationale for the primary research study in this thesis, which explored this topic further from a forensic perspective.

2.3 Aims and objectives

This review aimed to examine qualitative studies that explored racialised minority professional's views of working in the healthcare system, including unfavourable perceptions and experiences.

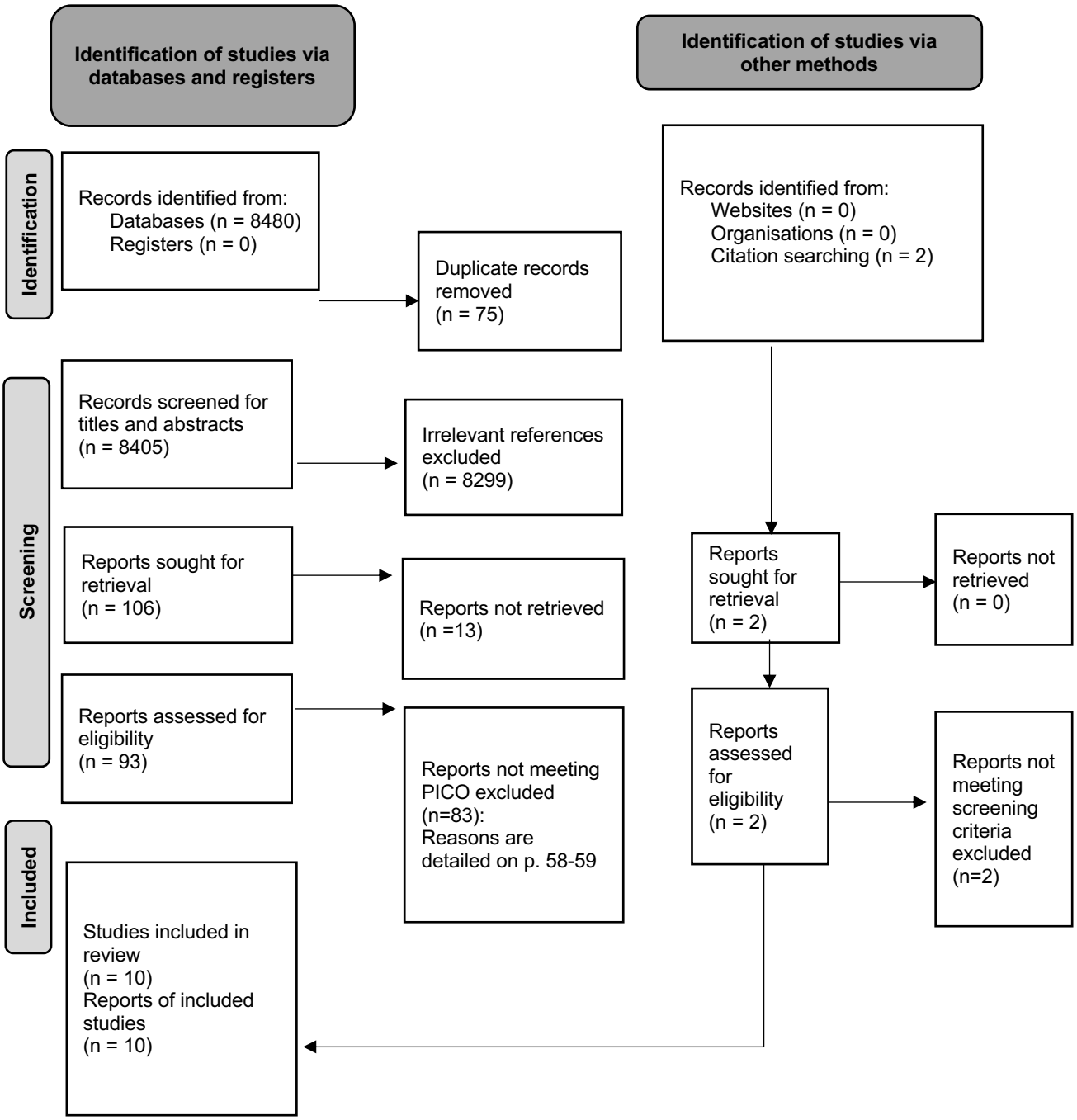
2.4 Methods

2.4.1 Search Strategy: Sources of Literature

Two electronic database searches were carried out on 27th and 28th July 2020. Grey literature was searched on 9th September 2020. Please see figure 2.1 for a flow diagram overview of the search process.

Figure 2.1

Search and selection and process



Databases searched were Scopus (1989 to July 2020), PsycINFO (1949 to July 2020), MEDLINE (1971 to July 2020), EMBASE (1975 to July 2020) and CINAHL (1987 to July 2020). The hits of the searches were merged and duplicates were removed first. Then, grey literature was searched in ProQuest and OpenGrey.

2.4.2 Study selection

A total of 8482 hits were returned [8480 database hits; 2 from citation searches]. 75 duplicate references were removed from all searches, leaving 8,407 overall hits [6,021 database hits; 2,386 grey literature hits]. The records were then screened in two steps: inclusion criteria and quality assessment.

2.4.3 Inclusion/Exclusion

Firstly, the researcher examined the studies using the predefined inclusion criteria (see Table 2.1 below). This approach minimised personal bias (Aromataris & Pearson, 2014).

Table 2.1 Inclusion and Exclusion Criteria

	Inclusion Criteria	**Exclusion Criteria**
Population	• Racialised minority employees • Adults (18 years or above) of all genders. • If studies have both racialised minority and white majority participants where the data for each group is clearly identifiable, only the data from the racialised minority participants will be synthesised.	• Any data from the racialised minority group that is not clearly identifiable. • Data on majority and minority white ethnic groups.
Exposure	• Current and past voluntary or paid employment in healthcare system	• Current and past voluntary or paid employment in non-healthcare system

Phenomena of interest	• Experiences, perspectives and perceptions surrounding working in healthcare settings as a primary aim of each study AND • Studies that include the negative experiences (perceptions of discrimination, unfair treatment and inequality) specifically mentioned as a primary aim of research.	• Studies that do not include negative experiences (discrimination, unfair, treatment and inequality) as a primary aim for staff in healthcare settings. • Studies that include both positive and unfavourable experiences, where the unfavourable experiences have been omitted will not be included.
Type of Data/Studies	• Original qualitative data with studies using qualitative designs. • Studies that include first person quotes and must be identifiable as quotes from the racialised minority staff member. • Grey literature	• Commentaries, discussions, book reviews or opinion pieces. • Studies where the information on the style of analysis or study design is not included or available. • Qualitative data from mixed methods studies where the focus is on the quantitative method.
Language of studies	• English	

No restrictions were placed on the publication date and country of origin, as international perspectives were welcome.

2.4.4 Search Terms

The main search terms were derived from the review question and inclusion criteria. Synonyms, word variations and alternative spellings were considered (see Table 2.2). Consideration was also given to differences in terminology and spelling (see Appendix A for database search syntax). Boolean operators and Medical Subject Heading terms (MeSH) were used. MEDLINE, EMBASE and PsycInfo used the same controlled vocabulary database, thus had similar index terms. CINAHL index terms were different from the previously mentioned databases. Therefore, the search terms were altered to suit the database. For databases that do not use MeSH terms such as Scopus, ProQuest and OpenGrey, word variations and free text words were based on the search terms in Table 2.2.

Table 2.2 Key Search Terms- Main terms and synonyms based on PICO

	Main Terms	**Synonyms**	
Population	Ethnic Minority	Minority Ethnic Racial Minority Minority Group Ethnic Group Multi-ethnic group Ethnic Community Black Minority Ethnic Black Brown Caribbean	African Asian Indian Hispanic Latino Chinese BME BAME Non-white community(ties) Non-white People of Colour/Color Person of Colour/Color
		Employee(s) Worker(s) Staff member(s)	Labourer/Labourer Staffing Team

	Staff	Colleague(s) Personnel Workforce Staff team Employed individual(s)	Job Holder Salaried Worker Professional(s)
	Healthcare Professionals	Nurse(s) Medical staff Nursing personnel Healthcare staff Paramedical staff Clinical staff Healthcare worker(s) Health worker(s), Caregiver(s) Healthcare professional(s) Clinician(s) Doctor(s) Physician(s)	Healthcare practitioner(s) Medic(s) Hospital staff Community health worker(s) Specific professions were also used, for example: Occupational Therapist(s) Physical therapist(s) Physician(s) Psychologist(s) Anesthesiologist(s) Cardiologist(s)
Exposure	Healthcare	Medical care Nursing Healthcare service(s) Health service(s) Medical service(s) Health-related service(s) Public health Public health service(s)	Healthcare delivery Healthcare provider Medical field Healthcare system In the area of health In the field of health National Health Service NHS
	Employment	Job The workplace Occupation Place of employment Profession	
Outcome	Experience	Encounter Occurrence Lived experience(s) Perception	

Based on this screening system, 108 studies were regarded as meeting the criteria. The primary researcher then examined the full texts of these studies. To minimise the potential for error, 25% of the full texts (27 texts) were independently reviewed for accuracy by a secondary reviewer (Trainee Forensic Psychologist at the University of Nottingham). The reason for exclusion was recorded for all excluded studies, and a final decision regarding the inclusion of a study was based on a review of the full study by the researcher and second reviewer. Any discrepancies between the researcher and the reviewer on the full text review, were resolved through discussion and consensus. The number of studies to quality assess were narrowed down to 13.

The 95 studies rejected after the full text review were excluded for the following reasons:

1) Mixed methods studies with the focus on quantitative data.
2) Participants had not worked in the healthcare system historically and at the time of the study.
3) The ethnicity of the participants was not described, or the data set included white participants which was not separated from racialised minority participants.
4) Studies did not include the original participants quotes.

5) Studies focused on the experiences of student nurses in nursing education, rather than their experiences in employment.
6) The perceptions/experiences of discrimination/inequality were not mentioned.
7) Studies were not written in English.

2.4.5 Quality Assessment

The quality of the 13 studies was assessed. The Critical Appraisal Skills Programme (CASP International Network, 2013) checklist for qualitative evidence was used (see Appendix B for the CASP checklist form). The CASP tool has 10 items, with each emphasising a specific methodological aspect of qualitative study. The items prompt the researcher to consider whether the research methods in the study were appropriate, and whether the findings are relevant and meaningful. The CASP checklist has also been endorsed by Cochrane and the World Health Organisation for qualitative evidence synthesis (Noyes et al., 2018).

A second reviewer from a white majority background also quality assessed the 13 studies, and was able to review the data. The reviewer was selected at random, and therefore it was not a planned decision to use a reviewer from a white majority background. However, the researcher was mindful that someone from a different background might interpret the studies from a different perspective. Any discrepancies that arose between the researcher and reviewer

were discussed and resolved. Three studies were excluded from the review for poor quality, mainly due to inadequate ethical declaration.

Across the three studies there was a gap in the reporting of ethical statements. This raised concerns relating to the integrity of the research, particularly considering the participants recruitment process and informed consent. As the research is qualitative and concerned with discussing sensitive matters, a lack of information regarding ethical considerations, researcher bias and methodology, was considered to hinder the quality and credibility of the research studies. After excluding the three studies, this resulted in a final 10 studies being selected for inclusion in the review. Please refer to Table 2.3 for reference to the quality assessment, and see Appendix C for reasons for exclusion at quality assessment stage.

Scoring system for each CASP questionnaire item:

Relevant: Y=Yes, N=No, U=Unclear

Addressed: Y=Yes, N=No, U=Unclear

For example, a score of 'Y,N' would indicate that the question was relevant and had not be addressed. Whereas a score of 'Y,Y' would indicate that the question was relevant and addressed in the research paper.

Table 2.3 Breakdown of the performance of quality assessed studies based on the CASP checklist form

		Study Number												
	Question	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Q1.	Was there a clear statement of the aims of the research?	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y
Q2.	Is qualitative methodology appropriate?	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y
Q3.	Was the research design appropriate to address the aims of the research?	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,U	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y
Q4.	Was the recruitment strategy appropriate to the aims of the research?	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,U	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y
Q5.	Was the data collected in a way that addressed the research issue?	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,N	Y,U	Y,Y
Q6.	Has the relationship between researcher and participants been adequately considered?	Y,U	Y,Y	Y,U	Y,N	Y,N	Y,Y	Y,N	Y,Y	Y,N	Y,Y	Y,N	Y,U	Y,N
Q7.	Have ethical issues been taken into consideration?	Y,Y	Y,Y	Y,Y	Y,U	Y,U	Y,Y	Y,Y	Y,Y	Y,Y	Y,U	Y,N	Y,U	Y,N
Q8.	Was the data analysis sufficiently rigorous?	Y,Y	Y,Y	Y,U	Y,Y	Y,Y	Y,U	Y,Y	Y,Y	Y,Y	Y,U	Y,U	Y,Y	Y,U
Q9.	Is there a clear statement of findings?	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,U
Q10.	How valuable is the research?	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,Y	Y,U

Table 2.4 Characteristics and findings of reviewed studies, in order of year of publication

Study number, Author, year Location	**Topical focus/ purpose/ aims**	**Methodology**	**Sample Description**	**Data Analysis**	**Main Emergent themes**	**Quality** (High/ Moderate / Low)
[1]Alexis, Vydelingum, & Robbins (2006) England	To explore the experiences of overseas black and minority ethnic nurses in the National Health Service (NHS) in the south of England.	**Thematic analysis** This methodology was chosen as there was limited in-depth evidence on equal opportunity and skill development of overseas black and minority ethnic nurses. This methodology is appropriate for the research aims	*Sample size:* N=12 *Gender split*: N=5 Males N=7 Females *Age:* Not provided *Ethnic minority group(s):* Philippines, South Africa, Caribbean, and Sub-Sahara Africa *Healthcare profession:* Nurses *Average number of years in healthcare*: 1-20 years	Semi-structured individual interviews scripts *Average length of interviews:* 60-90 minutes *Mode of interview:* In-person in participant's home *Declaration of Positionality:* Not disclosed *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* Not disclosed	Two key themes: 1) Unequal opportunity for career advancement 2) Unequal opportunities for skill development and training	Moderate
[2]Etowa (2005)	To discover the nature of work life experiences	**Grounded theory** This methodology was chosen as it enabled	*Sample size:* N=20	1) Semi-structured individual interviews scripts	Three key themes:	High

Canada	of Black nurses in the health care system in Nova Scotia.	the processes embedded in the experiences of black nurses emerge from the data conceptualised rich descriptions focusing on process analysis This methodology is appropriate for the research aims as it aimed to illuminate the processes embedded in the experiences	*Gender split*: N=3 Males N=17 Females *Age:* 27-72 years *Ethnic minority group(s):* African and Caribbean *Healthcare profession:* Nurses *Average number of years in healthcare:* 20 years	2) Field notes from participant observation in their natural settings *Average length of interviews: 30-120 minutes* *Mode of interview: In-person in the homes and offices of the participants and the researcher* *Declaration of Positionality:* "Insider-researcher" the researcher was a black nurse *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* Black	1) Realising- the process of going through a circumstance and finding one's location and response in that situation 2) Surviving- the interconnected problem-solving strategies black nurses engage in to help them withstand the challenges encountered 3) Thriving- moving beyond surviving. Participants who have the ability to survive and thrive in spite of a social culture that condemns them

[3]Alexis, Vydelingum, & Robbins (2007) England	To explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses who are working in the NHS in the south of England.	**Phenomenological Approach** This methodology was chosen as rather than a rigid method in understanding participants experiences, the analytic process involved the researcher moving back and forth within the data until an awareness and understanding of participants stories was reached This methodology is appropriate for the research aims as it enabled the researcher to make sense of participants experiences through a process of coding, reflection and balancing each descriptive statement by considering its context	*Sample size:* N=24 *Gender split*: Not provided *Age:* Not provided *Ethnic minority group(s):* Africa, Asia, and the Caribbean (8 countries were represented) *Healthcare profession:* Nurses *Average number of years in healthcare:* 3 years	Semi-structured focus group interview scripts *Average length of interviews:* 90 minutes *Mode of interview: In-person in a place convenient for all participants* *Declaration of Positionality:* Not disclosed *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* Not disclosed	Six key themes: 1) Devaluation process 2) Concept of self-blame 3) Discrimination/lack of equal opportunity 4) Concept of invisibility 5) Experiencing fear 6) Benefits of being here	Moderate
[4]Nunez-Smith et al. (2007)	To characterise how physicians of African descent	**Constant comparative method (Grounded qualitative research)**	*Sample size:* N=25 *Gender split*: N=11 Males N=14 Females	In-depth racially concordant interview scripts *Average length of interviews:* 40 minutes	Five key themes: 1) Awareness of race permeates the experience of	Moderate

USA	experience race in the workplace.	This methodology was chosen as the researcher aimed to generate hypotheses from data as opposed to testing prespecified hypotheses This methodology is appropriate for the research aims as it identified the unifying and recurring themes amongst participants	*Age:* 35-79 years *Ethnic minority group(s):* Africans, African Americans, and those from other regions of the African diaspora *Healthcare profession:* Physicians *Average number of years in healthcare:* Not provided	*Mode of interview:* In-person, location not specified *Declaration of Positionality:* Not disclosed *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* This information was not disclosed but were racially concordant with participants who were African/African diaspora	physicians of African de- scent in the health care workplace 2) Race-related experiences shape interpersonal interactions and define the institutional climate 3) Responses to perceived racism at work vary along a spectrum from minimisation to confrontation 4) The health care workplace is often silent on issues of race 5) These experiences can result in what we term "racial fatigue," with personal and professional consequences for physicians.

[5]Nunez-Smith, Curry, Berg, Krumholz, & Bradley (2008) USA	To identify the range of perspectives that might contribute to workplace silence on race and affect participation in race-related conversations within healthcare settings.	**Constant comparative method** This methodology was chosen to compare coded segments of text to expand existing themes and identify new themes. It also aimed to generate hypotheses from data as opposed to testing prespecified This methodology is appropriate for the research aims as it identified the unifying and recurring themes amongst participants	*Sample size:* N=25 *Gender split*: N=11 Males N=14 Females *Age:* 35-79 years *Ethnic minority group(s):* African descent *Healthcare profession:* Physicians *Average number of years in healthcare:* Not provided	In-depth racially concordant interview scripts *Average length of interviews:* 40 minutes *Mode of interview:* In-person, location not specified *Declaration of Positionality:* Not disclosed *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* This information was not disclosed but were racially concordant with participants who were of African descent	Five key themes: 1) Perceived race-related healthcare experiences 2) Protecting racial/ ethnic minority patients from healthcare discrimination 3) Physician participants often rely on external support systems for race-related issues 4) Physician participants perceive differences between their interpretations of potentially offensive race-related work experiences and their non-minority colleagues' interpretations of the same experiences	Moderate

					5) Physician participants are uncomfortable voicing race-related concerns at work.	
[6]Mapedzahama, Rudge, West, & Perron (2012) Australia	To examine how skilled African migrant nurses working in Australia forge social and professional identities within their transnational, cross-cultural existences. To explore how this group of migrant nurses interprets their own cross-cultural nursing experiences and how such negotiations inform how they construct	**Thematic Analysis** This methodology was chosen as it aimed to centre migrant nurses own voices about their subjective experiences. This methodology is appropriate for the research aims as it explored experiences from participants specific vantage point whilst producing a narrative among all participants	*Sample size:* N=14 *Gender split*: N=1 Males N=13 Females *Age:* 30-47 years *Ethnic minority group(s):* Black African *Healthcare profession:* Nurses *Average number of years in healthcare*: Not provided	Unstructured individual interviews scripts *Average length of interviews:* 90- 180 minutes *Mode of interview:* In-person in participant's home *Declaration of Positionality:* Researcher shared a similar ethnic background with some participants and had "insider/outsider" status within the research *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer: The interviewer was a black African migrant. One of the authors (Australian) conducted the data analysis. This researcher*	Four key themes: 1) The salience of skin colour: Becoming the Black Nurse 2) How Black nurses experience everyday racism 3) The white gaze and surveillance of the black nursing body 4) Contesting Racial Stereotypes	High

	themselves as nurses.			*was not involved in the interviews*		
[7]Wheeler, Foster, & Hepburn (2014) USA	To explore the experiences of Internationally Educated Nurses in their workplace compared with USA-educated registered nurses (US RNs).	**Constant comparative method (Structuration theory)** This methodology was chosen as structuration theory was the lens through which nurses experiences were noted. It poses that individuals are agents whose interactions form structures This methodology is appropriate for the research aims as it aimed to explore nurses' perceptions of agency within the workplace. It was also part of a larger study that employed an explorative qualitative approach to understand participants experiences, by comparing their	*Sample size:* N=62 (The original sample size is N=83, however 20 white participants were included in this study. These participants have not been included for the purpose of this review) *Gender split*: N=0 Males N=62 Females *Age:* 24-70 years *Ethnic minority group(s):* Caribbean, Sub-Saharan Africa, Southwest Asia, European Union East Asia, Pacific, Oceania, African American *Healthcare profession:* Nurses	Semi-structured individual interviews scripts *Average length of interviews:* Not disclosed *Mode of interview:* Not disclosed *Declaration of Positionality:* Not disclosed *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* Not disclosed	Four key themes: 1) Discrimination by patients 2) Discrimination by supervisory hospital personnel 3) Discrimination by fellow nurses 4) Coping	High

		perspectives with USA registered nurses	*Average number of years in healthcare*: 23.5 years			
[8]Dunkley (2018) USA	To explore the lived experience of being Black and female when becoming a nurse executive and to understand the lived experiences to increase the representation of Black female nurse executives and other minorities in positions of leadership.	**Phenomenological Approach** This methodology was chosen as the research aimed to understand lived experiences of a population who have experienced a similar phenomenon This methodology is appropriate for the research aims, as few black women are advancing to the nurse executive level and the lived experience of being black and female when becoming a nurse executive is not well understood. Thus, the research adopted an explorative approach using a phenomenological approach as it is	*Sample size:* N=10 *Gender split*: N=0 Males N=10 Females *Age:* Not provided *Ethnic minority group(s):* Self-identified as Black, N=7 foreign born *Healthcare profession:* Nurse Executives *Average number of years in healthcare:* 38 years	Semi-structured individual interviews scripts *Average length of interviews:* 60 minutes *Mode of interview:* Audiotaped telephone interview *Declaration of Positionality:* The researcher is a black female nurse working in a position of leadership- this was reflected upon throughout the research *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* Black	Three key themes: 1) Living in a constant state of readiness 2) Embracing the responsibility beyond the job description 3) Overcoming	High

		interpretive rather than descriptive				
[9]Keshet & Popper-Giveon (2018) Israel	To study the experiences, manifestations and interpretations of everyday racism and discrimination experienced by Arab physicians and nurses during their work in Israeli hospitals.	**Phenomenological Approach** This methodology was chosen as it reflects on the essential themes that characterise and describe the phenomenon This methodology is appropriate for the research aims as it aimed to identify a particular phenomenon by determining how it is perceived by participants from their perceptions	*Sample size:* N=23 *Gender split*: N=16 Males N=7 Females *Age:* 23-60 years *Ethnic minority group(s):* Arab and Mixed Jewish and Arab *Healthcare profession:* Physicians: N=10 Nurses: N=13 *Number of years in healthcare:* Not provided	Semi-structured individual interviews scripts *Average length of interviews:* 30-60 minutes *Mode of interview:* In-person at the hospitals, and in two cases in the interviewees' homes *Declaration of Positionality:* Not disclosed *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* Not disclosed- although the researcher and interviewee spoke fluent Hebrew. Therefore the interviews were conducted in Hebrew	Seven key themes: 1) Micro-level patients and families 2) Coping with manifestations of racism at the micro-level (patients and family members), 3) Micro-level colleagues 4) Coping with manifestations of racism at the micro-level (colleagues), 5) Meso-level medical institutions 6) Coping with manifestations of racism at the meso-level 7) Macro-level policies and legislation	High

[10]Iheduru-Anderson (2020) USA	To describe Black African born nurses' perceptions of their non-native accents and the effect this had on career advancement to managerial roles within nursing.	**Thematic analysis (focused ethnographic design)** This methodology was chosen as focused ethnography is appropriate when the study involves a limited number of participants, is context specific and when participants hold specific knowledge on common experiences This methodology is appropriate for the research aims as no previous study examined accent bias effects on nursing opportunities. Therefore, the study explored in detail the experiences of Black African-born nurses and the perceived effect of their accents on career advancement	*Sample size:* N=15 *Gender split*: N=2 Males N=13 Females *Age:* 32-65 years *Ethnic minority group(s):* Ghanaian, Kenyan, Nigerian *Healthcare profession*: Nurses *Average number of years in healthcare:* 5-27 years	Semi-structured individual interviews scripts *Average length of interviews:* 45-60 minutes *Mode of interview: Not disclosed* *Declaration of Positionality:* Not disclosed *Relationship between researcher and participants:* Not disclosed *Ethnicity of interviewer:* The researcher was a 'foreign-educated nurse with an accent working in the United States'	Six key themes: 1) Perceived low level of intelligence (accents make you unintelligent) 2) Prejudging without evidence 3) Not suitable to lead 4) Making fun of and belittling 5) Downgrading 6) Accent modification	Moderate

2.4.6 Search Strategy: Data Extraction

The extracted data from the studies included first and second order constructs. First order constructs include participants quotes and statements and second order constructs consist of the researcher's interpretation, assumptions and ideas based on the first order constructs (Toye et al., 2014). This enables the researcher to work with the raw data (quotes), as well as the original researcher's interpretations. The review findings can then be grounded in the original experiences of the participants, whilst providing context to the raw data for a more substantiated review of the findings.

As there are few qualitative research extraction tools available, a data extraction tool was developed from Robertson et al.'s (2014) systematic review. The tool was piloted on two studies prior to use. It was then modified as required, to include a section focusing on the theoretical perspective of the qualitative research, and emergent themes (see Appendix D for the data extraction tool).

2.5 Findings

2.5.1 Characteristics of included studies

The characteristics and main findings of the included qualitative studies are documented in Table 2.4. The 10 studies included were published between 2001 and 2020. They were conducted in the USA[4,5,7,8,10], Australia[6], the UK[1,3], Israel[9] and Canada[2]. Across the 10 studies, the overall number of participants was 230, with 49 males and 157 females, excluding study 3 which did not specify the gender

of participants. Seven studies included both male and female participants [1,2,4,5,6,9,10] and two studies[7,8] only included female nurses.

All studies included participants from racialised minority backgrounds. Four studies [1,7,9,10] specified the ethnicity of participants including: Zimbabwean, Nigerian, sub-Sahara African, South African, Southwest Asian, East Asian, Oceanian, Filipino, Arabian, Ghanaian, Kenyan, Arabic and mixed Jewish and Arabic. Five studies labelled participants as Black[8], Black African[6], African[2,3,4], Caribbean[2,3], Asian[3], African Caribbean and African American[4]. In study 7, the original participant sample included 20 participants from white ethnic backgrounds. These participants were excluded in the synthesis. In three studies[2,4,5], researchers commented on the notion that being 'Black' was defined as any individual of African descent in the diaspora, given that diversity exists within the Black population (Etowa, 2005). In study 3, researchers referred to the view that colour does not describe the 'actual colour' of people, and attention must be given to those who belong to minority groups with distinct cultural and historical identity (Alexis, Vydelingum, & Robbins, 2007). Nevertheless, all studies included participants who were classified as an ethnic minority, most commonly from Africa, the Caribbean and Asia. Participants held similar occupations within healthcare settings, as 70% of the studies focused solely on nurses and two studies[4,5] focused on physicians' experiences. One study[9] focused both on nurses and physicians' experiences.

Participants worked in a wide range of settings: NHS acute hospital[1], tertiary care[2], community settings[2,4,5], long term care[2], administration[2,5], clinical nursing practice[2], hospital-based practice [4,5], private practice[4,5], public health[4,5], inpatient healthcare organisations[8] and acute care[10]. One study[9] included specialist physicians in endocrinology, anesthetisation, internal medicine, paediatrics and trauma. Four studies [3,6,7,8] did not specify the setting, but stated that participants worked in a hospital or 'nursing workplace'.

In relation to length of time as a healthcare professional, four studies[4,5,6,9] did not specify the length of time participants had been employed in their respective healthcare professions. Across the 10 studies participants had a range of 1-40 years' experience working within healthcare, with a mean of 20.5 years. All the studies collected data through individual interviews. Study 3 was the only study to incorporate the use of a focus group, though they used a semi-structured interview technique and phenomenological analysis, as part of their method. Each study used a different approach for analysing data. Three studies[1,6,10] used thematic analysis whereas one study[2] used grounded theory. Another two studies[8,9] also used phenomenological analysis and researchers in studies four, five and seven adopted the Constant Comparative method.

Overall, participants in the 10 studies reported predominantly negative experiences. This was attributable to the review having a clear focus on experiences where discrimination, unfair treatment and

inequality is clearly addressed or mentioned in the research as a primary aim. Although participants in seven studies [2,3,4,5,7,8,9] also addressed the positive elements of their employment experiences in the healthcare sector.

2.5.2 Data Synthesis of included studies

The researcher read the 10 studies several times to become familiar with the dataset. Following this, the researcher synthesised the data and displayed the findings through themes which represent and explain the phenomena (Munn, Tufanaru, & Aromataris, 2014). The researcher was mindful of ensuring the review findings remained grounded in the original data, to reflect the original participants experiences. Thomas and Harden's (2008) three-stage thematic analysis process was used to interpret and synthesise the data:

Step 1: Coding of findings of primary studies- For each included study, the verbatim findings were written up and entered into the NVivo software. The researcher then independently coded each line of the text, to capture the meaning and content of each line or sentence. Engaging in line-by-line coding translated the concepts from one study to the next, and for each study. The codes will be added to the database of codes. At the end of this process, each study where codes were applied were checked for consistency of interpretation and to ascertain whether extra codes were needed. The second reviewer then checked the coding. Disparities or discrepancies

in coding were resolved through discussion, and if necessary, the codes were adjusted.

Step 2: Constructing descriptive themes- The researcher then searched for similarities and differences between each of the codes and during this process. Codes were examined and analysed for their meaning and organised into relevant categories that describe patterns in the data across studies. Each category was analysed and if necessary, new codes were then generated, to understand the meaning of each category of codes. At this stage, the synthesis reflected the original findings of the studies. Each theme was entered as columns into a table, and coded data from each study illustrated the themes in rows to facilitate comparison within and between studies as part of the analytic process. The aim of the table was to demonstrate and capture themes and illustrative data.

Step 3: Generating analytical themes- Each category was then examined and compared to other categories developed. The researcher looked for differences and similarities. Similar categories were merged into higher constructs and themes. This went beyond the findings of the original studies to understand the phenomena. As the themes and concepts were translated from one study to another, each theme was checked for validity when transferred across different study contexts.

The overall themes across the 10 studies were formed (for example '*seeking support'* and '*benefits of the profession'*) (see Appendix E for the identified themes from evidence synthesis). Each theme and how they relate to the lived experiences of racialised minority healthcare staff are as follows.

1- *Unequal opportunities and being disregarded*

This theme was prominent in seven studies[1,2,3,5,7,8,10]. Participants spoke of experiences where they perceived a lack of equal opportunities, leaving them feeling undervalued, invisible and overlooked. In study 1, a participant stated that: "*opportunities are not given to us equally*"[1] (p.133). This comment was made after having undertaken the appropriate training courses and being promised by their manager that they should apply for the next available vacancy. However, the job was given to someone in a junior position to the participant. Another participant shared "*they should…treat us as equals not as second-class citizens*"[1] (p.133). This participant felt that their chances of promotion was due to their ethnic differences. They highlight disadvantage where it pertains to lack of opportunities to progress, and feelings of powerlessness where they were not afforded the prospect of being promoted despite a wealth of experience.

The participants in study 10 believed that speaking with a foreign accent influenced their managements perception of them: "*you are…passed over for opportunities because of the accent*" (p.10).

They suggested that having a foreign accent in nursing reinforced negative stereotypes and prevented them from accessing career advancement opportunities. This could explain why some participants with foreign accents felt as though they lacked opportunities. There were also issues relating to feeling overlooked and disregarded because of their accents. One participant attempted to modify her accent: "*I took a speech and communications course…to reduce my accent…attempting to learn to speak like them…has not increased my opportunities*"[10] (p.10). Participants experienced accent bias where they were evaluated by how they sounded, rather than the content of their speech, and as result they were perceived as having lower intelligence and thus, not granted opportunities.

Being disregarded was apparent in seven studies[1,2,3,5,7,8,10] where participants spoke about occasions where colleagues and patients would ignore them by speaking to more senior staff members: *"some relatives would bypass me and look for a white nurse to enquire about their family member although I am the one caring for that patient"*[3] (p.2225). Participants in study 8 discussed their experiences of advancing to leadership positions and shared similar sentiments in that they felt overlooked by other healthcare colleagues. Though, it is noted that participants in this study were based in the USA, where historically, there are societal issues of racial discrimination and oppression towards black individuals (Battle, 2016; Collins, 2015).

2- Manifestations of discrimination from patients and families

This theme appeared in six studies[2,3,4,6,7,9]. Ethnic minority individuals can often experience discrimination from patients and their families[7], including disengagement, rejection, mockery and disrespect during interactions with them. Despite being required to provide care, patients have been described to create hostile work environments through their derogatory comments:" *I'll lay in my urine before I'll let a coloured folk see me*"[7] (p.354). Similar comments were noted in study 6: "*get away from me you, you black filthy thing*"[6] (p.159). While discrimination can be overt, participants in study 7 shared that the strongest form of discriminatory behaviour was the refusal of their care.

Likewise, participants in study 2 share similar experiences: "*I have five patients who refused to have me treat them*"[2] (p.140). This was also echoed in study 3: "*some relatives would by-pass me and look for a white nurse…although I am the one caring for that patient*"[3] (p.2225). These examples where discrimination is apparent can be described as acts of 'intentional racism', because at the core of these interactions, it could be inferred that patient's do not trust the ability of healthcare professionals based on their skin colour or ethnicity.

Interestingly, in study 9 the societal and political climate added a further layer to the discrimination healthcare workers received from patients and their families. Their study was conducted in Israel, during the regional and ethnic conflict between Jews and Arabs. Participants shared that many patients were discriminatory stating

"*you're an Arab and we do not want you to treat us*", "*dirty Arab, go away*"[9] (p.9). One participant in study 4 described being punched by a patient. While the pretext for discrimination towards healthcare professionals in this study may be closely associated with the national and political climate, the manifestation of discrimination from patients is experienced across multiple studies through various discriminatory attacks and interactions.

3- <u>Manifestations of discrimination from colleagues</u>

Participants across nine studies[1,2,3,4,5,6,7,8,10] also shared that colleagues and peers in healthcare settings fuelled discrimination, through a plethora of subtle and covert behaviours. Study 7 describes instances of discrimination through their immigration status being queried, their skills being questioned, and being undermined by other professionals despite their experience and qualifications.

Study 10 also found that African-born nurses described experiences of not being trusted by their colleagues, their colleagues refusing to work with them, and their accent being used by others to discriminate them. A participant shared: "*my peers refused to work with me…they did not think I was smart enough*"[10] (p.6). Most worryingly, these experiences caused participants to feel socially withdrawn from their colleagues due to fear of being ridiculed.

The feeling of being humiliated is purported in study 3, with participants feeling degraded by colleagues: "*you are watched so much and you are put down, you are not allowed to do anything*"

(p.2225) and "*white nurses have treated me as stupid and they will not include me as part of the nursing team*"[3] (p.2225). While these participants described their experiences as open discrimination, it could be argued that these behaviours were also disguised or invisible in nature, as they may only be obvious to its recipients. Participants in study 6 were of a similar belief stating that: "*implicit or subtle racism is evident…the members of that culture...don't even recognise them making decisions based in a racialised history*"[6] (p.159). These examples demonstrate that racial discrimination in healthcare may only be obvious through critical examination, where only its effect on the victim is noticeable (Alvarez & Juang, 2010), facilitating the 'normalisation' of racial acts (Henry & Tator, 2005).

4- *<u>Being prejudged and stereotyped</u>*

Eight studies[1,2,3,4,5,7,9,10] cited negative race-related experiences in the form of being unfairly judged and labelled by others in healthcare settings: "*I was always mistaken for the person who brought the trays or the janitor person*"[5] (p.48). Labelling ethnic minority individuals as being from lower paid professions was a common experience amongst other participants: "*people would say 'could you come clean the room?'…even though I didn't have a cleaning cart next to me*"[8] (p.156). The bias through which others perceived racialised minority professionals suggested that they were incapable of professional roles in healthcare. This can be understood further by a surgeon who believed that "*race permeates every aspect of my job…so when I walk onto a ward…I am a black guy before I'm the*

doctor"[4] (p.46). These accounts highlight the direct and unconscious presumptions made by their white majority counterparts, which at times led to racialised minority professionals being involuntarily placed into race-based positions in their workplaces.

Participants in study 4 referred to situations in which they were assigned to specific tasks because of their race. For example, helping with diversity committees and intervening in difficult situations with racialised minority colleagues. Other participants also shared that some made assumptions about their career goals based on their race. For example, some assumed the participants wanted to work directly in underrepresented communities of colour, rather than pursue academic careers: "*My mentor wanted me to be medical director of a community health centre…. that has never been my career goal. He said 'well you relate to the community'*"[4] (p.48). While some individuals may be content with being asked to support with race-related activities, others may view this as an example of being prejudiced and feeling such requests are offensive: "*whenever they want to diversify something, they call me*"[4] (p.48). While on the surface, it may appear as though the opportunity is being given as the participants have expertise, they felt as though they were 'involuntarily' placed into race-based roles. This could lead to individuals feeling isolated or this being viewed as a role that is unrewarding.

Participants in studies 6 and 10 share similar views in relation to being judged. They were assumed to lack the skills to practice as a

healthcare professional due to being from overseas or having an accent. In study 6, a participant stated, "*I feel just because of my colour that's why they always think that I don't know*"[6] (p.157). Due to racial stereotypes their accents were also associated with lower levels of intelligence: "*when you are Black, with a foreign accent, it is very hard for you to be considered smart enough to be a nurse manager or educator*"[10] (p.6).

5- *<u>Responding to discrimination from avoidance to confrontation</u>*

This theme appeared across four studies[2,7,8,9]. In study 5, the participants used a combination of techniques to manage and address discrimination in the workplace. Some participants believed that correcting their white counterparts was a necessary response to discrimination, where they felt empowered in doing so: "*I had the pleasure of correcting a white resident once who was upset about my not establishing a policy with patients*"[5] (p.1473). However, other participants felt that by choosing to address race-related concerns, they would be labelled for voicing their grievances. For this reason, they chose to suppress their responses: "*you know when something happens at work, I can feel myself getting annoyed or irritated…I have to keep my cool… I'll be dismissed as another 'angry black woman'*"[5] (p.1475). Participants expressed fears of potentially damaging their work relationships and receiving negative labels if they openly confronted discrimination in the workplace.

Likewise, participants in study 7 also reported to ignore and excuse discriminatory behaviour: "*many nurses ignore discrimination, saying*

they just 'don't take it personally'"[7] (p.335). When being discriminated against some nurses tended to justify the behaviour: "*they were born in the days when….black and white were separated… so it's hard for them to change…I don't hold anything against them because that's the only thing they know"*[7] (p.335). This nurse believed that because some patients have not had the opportunity to travel, their experiences and understanding of diversity and equality is limited. In this vein, participants decided not to internalise the discrimination from others, and instead chose to respond to discrimination by justifying and explaining the patients' behaviours through a different way. It is likely that this enabled them to dissociate from race-related experiences, to focus on serving effectively in their roles and protecting their wellbeing.

Dismissing discriminatory behaviour was a response adopted by participants in study 4. One participant reported:" we *gotta have a thick skin…you cannot let these things at work get to you… you've gotta brush it off*"[4] (p.48). Alternatively, other participants disagreed and shared that race-related encounters provided them with a chance to educate others: "*I make a point…of interjecting the importance of race and culture and cultural competence…and I try to break down the biases*"[4] (p.48). On the other end of the spectrum, participants have also been described to leave the institution if the discrimination is persistent: "*if...I'm meeting with difficulty in patient care as a result of racism, I leave*"[7] (p.356).

The variation in responding to discrimination demonstrates the individual differences amongst racialised minority healthcare professionals, where the response depends on the incident. Here the challenge lies in the individual making a conscious assessment of the most appropriate reaction in the moment.

6- *Going above and beyond*

Seven studies highlighted this theme[2,4,5,6,7,8,10]. Some of the approaches used by racialised minority healthcare professionals to cope with discrimination in healthcare settings are excellently described in study 2. Participants refer to performing above their expected level to prove their capability in the role: "*I'm always on the go to prove myself that this is what I'm capable of doing*"[2] (p.98), "*made sure to cross all my T's and dot all my I's very carefully…you want to prove to everybody that you are…more than capable*"[2] (p.104). While it was not expected by senior management for them to perform at a higher level, they felt pressure to be 'the best' and accomplish beyond their expected workload. This also related to nurses feeling responsible for representing their ethnic group. Participants in study 9, asserted that they needed to prove themselves in comparison to their counterparts: "*they worked harder, studied more diligently, and tried to stand out academically and professionally*"[9] (p.13).

While it may not be their desire to go beyond their role, participants in study 7 described how working harder was necessary for those who doubt their abilities: "*I'm used to working harder...to make sure I*

show people that I can do it"[7] (p.356). Although this has not been purported by participants as a negative response to discrimination, it has caused them to exhibit a higher level of proficiency to be considered in the same way as those in majority groups.

7- <u>*Healthcare institutions silent about discrimination*</u>

A total of six studies identified this theme[2,4,5,6,7,9.] In study 2, concerns were raised about how healthcare institutions support racialised minority employees with their experiences of racism and discrimination. They note that participants felt the healthcare organisation would avoid or ignore discussions about issues such as racism and equity: "*they don't want to face the idea that there is racism…nobody wants to discuss it…they just completely either ignore it or don't validate that something like this has happened*"[2] (p.142). But despite wanting to discuss this, some participants argued that they could not raise these matters: "*I didn't feel I had a cushion at work to talk about this*"[2] (p.90). Implying that the work environment itself did not feel supportive to address such sensitive issues.

In study 6, there was reference to the silence that can exist within healthcare organisations, when issues of discrimination are raised. They point out that it can be easy to dismiss race-based experiences despite their overt nature. One participant stated, "*we told our manager…and she just said 'oh okay then…don't worry about them'*"[6] (p.159). Individuals could perceive there to be little benefit in addressing concerns with management, and it could be argued that

the failure to address reports of such experiences lead to feelings of neglect.

8- <u>Un-comfortability and reluctance to address race-related concerns</u>

Participants across three studies[2,3,4] highlighted un-comfortability and reluctance to address race-related concerns. Feelings of discomfort were reported when deciding whether to share experiences of discrimination that had occurred within the workplace. In study 2 a participant shared "*I didn't talk to them about…racist remark…there never was an outlet for that*"[2] (p.170). Another participant stated: "*I never let racism come to my lips, ever*"[2] (p.89). Participants refer to avoidance when wanting to address the source of race-related issues, due to fear of repercussions from those in senior positions.

Avoidance was also highlighted in study 3 where, some ethnic minority professionals were migrants or temporary residents. In this instance, their avoidance to address discrimination in the workplace was related to their fear of losing what they had gained: "*we are just temporarily here… for us we would be thrown out with our families and we would have to start all over again*" and "*we are just careful of what we have to say… if we say something that they don't like we could be thrown out of the country*"[3] (p.2226) (this study was undertaken in England). Their attitudes suggested that surviving whilst working in healthcare was more important than addressing discrimination, given the repercussion it could have on themselves and others in their lives.

9- <u>The emotional and psychological responses to race-related experiences</u>

Six studies[1,2,3,4,8,10] commented on the impact of discrimination and other race-related experiences as a central theme. This included the accumulation of encountering emotional and race-related stress: "*it can be... very stressful…and you're carrying that baggage on you the whole time*"[2] (p.98), "*it is a drain to carry this burden…it is a daily stress at work.*"[4] (p.49). Feeling humiliated and degraded was also common amongst participants in study 10. They spoke of their fear of being mocked by others which they described as causing them distress in the workplace: "*you know when people make fun of you because of how you speak…they take away your sense of self*"[10] (p.8).

Study 3 notes that participants who had been subject to discrimination in the workplace, had a loss of self-esteem and confidence, which made them feel uncomfortable: "*It's difficult…to be comfortable here. I think if you are a softie and don't have enough strength to survive it can be quite difficult here*"[3] (p.2225).

Some participants disclosed that in their experience, they felt the responsibility of 'representation' was a burden: "*I have to do well…I have to let my community look good*"[8] (p.141). Though they appeared to willingly accept this duty and the responsibility that occurred with the role.

10- Seeking support

Support as a construct was a key consideration[2,4,5,7,8] identified in in five studies. In study 2, they described building support networks as a way of managing challenges in the healthcare environment. For the nurses in study 2, group solidarity and friendships were described as 'survival strategies', which often derived because of discrimination. Support for most of the black nurses in this study provided them with interpersonal relationships, which were vital in their day-to-day difficulties. Interestingly, some black nurses also became friends with their racialised minority colleagues, to form allies to combat the isolation and loneliness they may experience, as 'the only' racialised minority healthcare professional.

Alternatively, participants in study 5 emphasised that they tended to rely on external support outside of the healthcare organisation (friends and family), particularly with issues concerning their ethnicity or professionalism. They used this support to confirm their capabilities and competencies as a healthcare professional. It was also identified that participants need for finding external support derived from past experiences, in which their organisation failed to support them: "*few people reach out to physicians of colour…you can't rely on them to support you*"[5] (p.1474).

11- Benefits of being an ethnic minority professional in healthcare

Participants identified this theme in seven studies[2,3,4,5,7,8,9]. The participants in study 2 were positive when sharing their perspective on the benefits they have experienced whilst working in healthcare. Increasing diversity was reiterated by most of the nurses in study 2, as they found pleasure in working with others from minority backgrounds:*" I was really happy to see that there was another black nurse working there…just knowing that she was there was good"*[2] (p.167). Some participants in this study also felt a strong sense of pride in both their heritage and professionalism. They described feeling they have something unique to bring to the role which empowers them.

While feeling empowered and proud is generally viewed as an intrinsic benefit, participants in study 4 emphasised that their benefits were more extrinsically motivated. They viewed their race as a characteristic that facilitated the development of trust and communication amongst ethnic minority patients: *"just by having people see me as more than a doctor or professional, but they see me as a human being"*[4] (p.47). A similar rhetoric was discussed in study 8 where participants felt that being an ethnic minority professional in a healthcare organisation helped represent those who are marginalised. They verbalised that their race meant that they

were ‘tokens’ within the institution, which they viewed as beneficial towards a more diverse and inclusive culture.

2.6 Chapter two discussion

The objective of this systematic review was to explore the employment experiences of ethnic minority healthcare professionals. Ten studies were reviewed which provided significant insights from interviews explored across 11 themes. The results suggest ethnic minority healthcare professionals encounter several conditions and contexts related to discrimination, which places them at a disadvantage. This includes unequal opportunities, denial of professional growth and feeling invisible (Alexis, Vydelingum & Robbins, 2006; Iheduru-Anderson, 2020; Dunkley, 2018), being discriminated against by patients, family and colleagues (Wheeler, Foster and Hepburn, 2014; Etowa, 2005; Keshet & Popper-Giveon, 2018; Mapedzahama, Rudge, West and Perron, 2012) and having others stereotype and prejudge them (Nunez-Smith et al., 2007; Iheduru-Anderson, 2020).

Across many studies, participants note that they were not afforded the same, or fewer opportunities as their white counterparts or non-accented peers. It is possible that the speech style of non-native speakers (minority groups), is evaluated more closely by those in dominant groups. Dominant group members may assess the intellectual or professional ability of ethnic minority individuals solely

based on language or fluency. This draws on perspectives of racialisation, where inequity may operate through systems in which dominant groups racialise ethnic minority groups based on specific characteristics (Inwood & Yarbrough, 2010). As such, ethnic minority staff may deem it necessary to negotiate elements of their cultural identity within the work environment. As described in chapter one, there is a possibility that if ethnic minority individuals bring their entire cultural identity into the workplace, they will be stigmatised or treated differently (Slay & Smith, 2011). However, as accents cannot be easily concealed, ethnic minority staff members may be unable to assimilate to the dominant culture, causing them to struggle to be accepted as professionals and be afforded career development opportunities.

Several participants described instances in which they were not given opportunities for training and skill development, leading them to perceive their work environment as a place that does not support the career growth of ethnic minority staff. Taking a CRT perspective may enable wider understanding to be applied to how race and discrimination operate within power structures, to affect minority groups though systemic processes. This would provide some explanation for the inequities that exist to prevent ethnic minority individuals from having the same opportunities as their white counterparts. While this was not suggested by participants in the review, CRT suggests that racism and discrimination are the routine ways society conducts itself (Delgado & Stefancic, 2001). This would

include the workplace and the processes that exist within this environment. Such inequities could be labelled as 'everyday racism' (Essed, 1991), in which its recipients find these behaviours harder to substantiate and evidence, in comparison to overt acts of racism.

A cause for concern arising from the research were the different methods through which prejudice, racism and discrimination were communicated from patients and families. This is an important issue which not only impacts the patients experience of care, but also their wellbeing and equally the welfare of ethnic minority professionals. The understanding of how participants experienced discrimination and racialisation was important to take forward into later research and analyses (see chapters 3-6), to explore further in FMH settings given the aims of the research in chapters 4 and 5.

While some staff expected to be supported by senior management and their peers, the level of support was not present. In fact, prejudice and discrimination from colleagues was pervasive in their work experiences. Participants in multiple studies described, being treated as 'stupid', not being included as part of the team and having their skills questioned. Here could lie the risk ethnic minority professionals experience when they do not assimilate to the dominant culture, or when they present their professional identity in the workplace. As suggested by Major et al. (2016) professionals from ethnic minority backgrounds attribute being unfairly evaluated as prejudicial behaviour. As such, the balance between their cultural and professional identities could become skewed, as described in Dickens

and Chavez (2018) study, where participants connected less to their culture within the workplace, and more toward their professional identities to be accepted as professionals.

Minority ethnic professionals tended to rely on their personal support networks (e.g. family and friends outside of work), and were unwilling to address race-related experiences within the workplace, due to it feeling burdensome and taxing. Literature reports how for individuals who experience racial discrimination, they tend to use support seeking strategies and their existing social support networks to receive guidance and encouragement (Brown, Phillips, Abdullah, Vinson & Robertson, 2011). Furthermore, racialised minority healthcare staff may no longer see the value in 'speaking up', because their loyalty to the institution has reduced over time. With this attitude, while they may experience acts of racialisation daily, it is likely these interactions are normalised and rooted in the structure of the environment (Nunez-Smith et al., 2007).

The responses to discrimination in the workplace are a key component in how ethnic minority professionals navigate their race-related experiences. Some staff members showed 'exaggerated commitment' (Etowa, 2005), fulfilling their role above what was expected of them. This response to discrimination could be an attempt to counteract their negative experiences, by portraying themselves as the 'perfect' healthcare worker to appease others. It is also worth noting that participants responded to discrimination through using various coping mechanisms such as avoidance and

suppression. They discuss the value in avoidance, particularly if they have not yet developed more coping responses, or do not feel comfortable to address discrimination directly. Research shows that people experience avoidance-related responses regarding interracial interactions, and will actively avoid interactions as they expect them to be unpleasant (Plant & Butz, 2006). As avoidance was identified as common response to discrimination in this review, it is of interest to explore whether this is a similar finding in chapter four of the research relating to racialised minority staff in FMH settings.

There is clear inter-relatedness between the factors, and themes identified amongst participants across different studies. This demonstrates the complexity and challenge of race-related experiences within healthcare settings. The current findings are undoubtedly useful, as they contextualise the experiences of racialised minority professionals, and highlight the importance for healthy conversations to be held about race in healthcare settings. It must be reaffirmed that the evidence presented in these findings are not used to stereotype racialised groups. Instead, this review is a springboard to integrate understanding between the theories and perspectives presented in chapter one, and the findings and analyses from the current chapter for later research and analyses into FMH settings.

2.7 Evaluation of the systematic review

The strength of this systematic review is that there appears to be no previous reviews exploring the employment experiences of racialised minority healthcare professionals. As such, this review is unique in its aims, thus its findings could have considerable impact on the development of future research. Although it should be noted that while the review strategy attempted to include as many relevant studies as possible, within the confines of the inclusion and exclusion parameters, there will inevitably have been some studies that would have been eligible for inclusion, that the researcher did not manage to successfully identify. The review also includes a significant amount of American literature. In most cases, discrimination and race-relations differ enormously across various countries given the diversity in ethnic minority groups. While the review included Canadian, British and Israeli perspectives, the experiences of those included in each of the studies were similar across multiple areas.

This systematic review explored experiences in healthcare settings. The broader focus of this review was necessary, as it contextualised the thesis and highlighted the shortage of literature in FMH settings. Therefore, it was deemed that the review could inform research in the field of forensic mental health.

2.8 Conclusion

The review yielded a total of 11 themes, indicating that the concepts and views developed into themes by the researcher were relevant and applicable to the experiences of the targeted population. The review revealed that every participant included in the qualitative research experienced comparable forms of discrimination, and responded similarly to these behaviours. At the heart of their experiences, there are significant implications, not only for themselves, but also healthcare organisations, and more widely when considering the integration of these findings for research in FMH settings.

Additional research into this topic may provide information that is beneficial to staff and organisations as a starting point. The views and experiences shared by participants in the studies, reveal the daily challenges they encounter, and the tensions that healthcare organisations may face, as they attempt to engage in discourse to unsettle the silence in healthcare settings, where it pertains to race relations.

CHAPTER 3 - Methodology

3.1 Research questions and overview

The systematic review showed a lack of research in relation to FMH settings. Therefore, this chapter describes the methods to explore how racialised minority staff in FMH settings conceptualise their experiences, how this impacts them, and the implications this has on their ability to serve. The research question was acquired from the systematic review and gaps in literature, which highlight findings in relation to racial disparities in various workplace settings. Although, given the complexity of FMH settings and the diversity amongst staff and client groups, little is known about the experiences of racialised minority staff. This chapter presents and critically discusses the methods used for the qualitative research.

The research addressed the following questions:

1. What are the individual experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

2. What are the individual lived experiences of processing and managing cultural identity within FMH settings?

3. What are the systemic level experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

4. What psychological impact does the experiences of racialisation and discrimination of racialised minority staff have on them and their ability to serve within this setting?

This chapter describes the fundamental components of qualitative research and Interpretative Phenomenological Analysis (IPA), including its theoretical approaches. The chapter then provides information concerning the quality of IPA research and critically examines its approach while providing justification for the use of this method for the current research. The epistemological standpoint of the research is clarified, as well as the role of reflexivity. The chapter ends by explaining the data collection and analysis process, to highlight how the results in this study were produced.

3.2 Qualitative research

Qualitative research is an interpretative, naturalistic, and contextual mode of enquiry (Henwood & Pidgeon, 1996). It uncovers questions about life experiences and perspectives, focusing on concepts such as beliefs and attitudes. It provides individuals with the opportunity to disclose their perspectives, and the researcher the opportunity to establish a unique depth of understanding. In some cases, it can highlight marginalisation and identify contexts where individuals have been misunderstood or misinterpreted (Larkin, Shaw & Flowers, 2019). Researchers may often use qualitative methods to explore novel or under researched subject matters.

3.3 Interpretative Phenomenological Analysis

3.3.1 What is Interpretative Phenomenological Analysis (IPA)?

Interpretative Phenomenological Analysis (IPA) is a qualitative thematic approach grounded in the philosophies of idiography, phenomenology and hermeneutics (Noon, 2018). It explores the lived experiences of individuals who have been exposed to a particular phenomenon (Tomkins, 2017). In the current study, it aimed to discover how individuals from racialised minority backgrounds, explore their experiences of working in FMH settings, and the significance, and meaning they attach to their experiences (Smith & Osborn, 2003). As IPA is committed to both 'giving voice' and 'making sense' (Noon, 2018), the researcher attempted to comprehend how participants understood their experiences in FMH settings (double hermeneutic) (Smith & Osborn, 2003). This was done by situating participants descriptions in wider social, cultural, and theoretical contexts (Larkin, Watts & Clifton, 2006).

In adopting a comprehensive step by step guide, the researcher is supported through the analysis process (Smith, Flowers & Larkin, 2009), which enables complexity to be reduced, and the analysis and development of group-level themes (Smith, Flowers & Larkin, 2009).

IPA is also influenced by the researcher's biases, subjectivity, and interpretations (Brocki & Wearden, 2006). Therefore, the researcher identifies their own orientation and preconceptions before immersing themselves into the research and data analysis (Love, Vetere & Davis,

2020) (see section 3.4.2). After doing so, an account which closely describes the respondent's perspectives is provided (Larkin, Watts & Clifton, 2006).

3.3.2 Theoretical Underpinnings and Philosophical Assumptions of IPA

3.3.2.1 Phenomenology

Phenomenology relates to perception and how the world appears to the person experiencing it (Moran, 2000). It also seeks to explore meaning and interpret experiences. In the current study, the researcher sought to gain insight into the experiences of individuals from marginalised groups (racialised minority staff) (Orbe, 2000), by attentively reflecting on their lived experiences. The researcher engaged in phenomenological inquiry to explore subjective thoughts, feelings and memories through an interview process. This was with the aim of making sense and revealing meaning within and between participants (Nelson, 1989).

3.3.2.2 Idiography

Individuality and uniqueness are important aspects of IPA, and idiography is concerned with subjectivity in relation to respondents experiences (Moses & Knutsen, 2012). In the current study, the researcher was committed to understanding each individual case, and how the participant made sense of their experiences prior to analysing the next case (Cassidy, Reynolds, Naylor & De Souza, 2011). In this way, the researcher engaged in deep individualised

analysis, and confronted the data from a single case study perspective. During the exploration of themes, the researcher remained cognisant of individual accounts by providing quotes from their interviews. This enabled them to remain grounded in individual experiences, whilst considering how they align with more general themes (Eatough & Smith, 2008).

3.3.2.3 Hermeneutics

Hermeneutics recognise that analysis always involves interpretation linked closely to the researcher's analysis (Noon, 2018). In IPA there is an emphasis on 'double hermeneutics' where the "participant is trying to make sense of their personal and social world, and the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (Smith, 2004, p.40). In the current research, interpretations were relative to the participants ability to share their experiences, and the researcher's capacity to analyse them. This process was complicated by the researcher's own preconceptions, which could limit how accurate interpretations are. However, the researcher took a critical and reflexive approach to the current research (Shinebourne, 2011), to achieve an explanation closely aligned to participants views and experiences (see sections 3.4.2 and 3.6).

3.3.3 Judging the Quality of IPA Research

Qualitative data tends to be centered on its credibility, verification of findings and the authenticity of the phenomenon studied. When

qualitative data is gathered, it is important that real and accurate experiences are captured. This also includes the significance of meaning, which is likely to be context specific. Yardley (2000) produced a framework that includes four main areas that can be used to assess the quality of qualitative research, including IPA. The framework includes the following:

1. **Sensitivity to context:** This relates to the choice of method and the justification for choosing said methodology. The socio-cultural context of the current research was sensitively considered when developing a conceptual framework, formulating the research questions and implementing the design. The context included concepts of ethnicity, identity, race relations and other key constructs associated with the study area.

2. **Transparency and coherence:** Transparency refers to the clarity, presentation and explicitness of the stages by which the research process occurs. In the current study, the researcher aimed to justify decisions made to preserve transparency.

3. **Commitment and trustworthiness:** This can be shown by the researcher's intentional engagement and immersion in the study and subject area.

4. **Impact and importance:** Impact and importance are concerned with the objectives of the study, and the applicability of the research to the population for which the findings are relevant for.

The four areas will be discussed and considered throughout the data collection and analysis sections (see sections 3.5 and 3.6). This will highlight how the researcher made and executed research decisions whilst upholding the quality and integrity of the research (Leininger, 1994).

3.3.4 Critique of IPA

While IPA and other qualitative methods are being adopted more in psychological research, it has been criticised by those who propose concerns with its methods. It is worth reflecting on this to understand the strengths and limitations of IPA from multiple perspectives.

3.3.4.1 Science

The scientific status of qualitative methods has been questioned when researching matters in psychology. One of the reasons for this is the lack of clear method, as the steps in IPA are suggestive rather than fixed (Giorgi, 2011). The method allows for flexibility and variances in implementation, and therefore it is not prescriptive (Giorgi, 2011). Although, Smith (2010, p.189) holds a different view stating "…there are a set of research steps that need to be made and these do need to be made in the appropriate order… the point is that there is flexibility in how each of these steps is taken…". It is unclear whether

IPA is advised or prescriptive. Nevertheless, Smith (2010) shared that rather than adhering to fixed steps, it is the interpretative, ideological processes that are inherent to IPA.

Another area that has been considered is repeatability, which can be difficult in qualitative studies as findings describe individual cases. Although, repeatability could be redefined for qualitative research (Sukumar & Metoyer, 2019), where some aspects of the study design could be repeated. For example, the research question, context, methods, participants, and an interpretive comparison which could corroborate, contrast, or elaborate on earlier studies (Sukumar & Metoyer, 2019).

However, even if two qualitative researchers interview the same participant about the same topic, both following the same interview schedule and guidance for good practice, both interviews could not be repeated identically (Smith, 2010), and both researchers would likely conclude with different results. Qualitative research tends not to be generalisable (Polit & Beck, 2010), and therefore, repeatability criteria is different to quantitative studies. This being said, highly rigid methods could produce lower quality research (Smith, 2010; Parker, 2004).

3.3.4.2 Idiography and Phenomenology

While critiques of IPA suggest that the method lacks objectivity, IPA is designed to understand personal lived experiences (Smith, 2011),

as a basis for further dialogue and exploration (Shinebourne, 2011). IPA could inadvertently complement traditional methodologies which have their basis in objectivity and 'quantitative' variables (Murray & Holmes, 2013).

3.3.4.3 Language

IPA may not be appropriate for those who are unfamiliar or unable to provide in-depth and rich responses (Noon, 2018). As such, it may exclude respondents who are not proficient in their language skills, leading to their experiences being unaccounted for (Noon, 2018).

The above highlighted a variety of strengths and limitations for using IPA as an adaptable methodology with various theoretical frameworks (Pringle, Drummond, McLafferty & Hendry, 2011). The researcher was aware of the limitations and criticisms and aimed to address these in the research.

3.3.5 Rationale for IPA

Currently, the evidence base for research in this area is limited, and to date, there are no studies investigating racialised minority staff experiences in FMH settings. Research relating to the employment experiences of racialised minority individuals more broadly, have been explored using qualitative methods. However, the current research recognises the need for an idiographic interpretative approach. It calls for detailed exploration, to make sense of the participant making sense of their subjective experiences, and how they apply personal meaning.

3.4 Approaches to the data

3.4.1 Epistemological Standpoint

Epistemology is concerned with knowledge and how we 'know' what we know (Ormston, Spencer, Barnard & Snape, 2003). When conducting research, it frames the researcher's position and guides how research is conducted to investigate the topic area. Researchers should align with a stance they relate with (Finlay, 2006), considering their personal values and motivations for carrying out the research. The epistemological position underpinning this research thesis was critical realism (Bhaskar, 1989). This is concerned with the idea that "reality exists independent of our knowledge of it" (Danermark, Ekstrom, Jakobson & Karlsson, 2002, p.25). It claims that to understand the social world, the underlying structures that generate life events must first be understood (Bhaskar, 1989).

During the conceptualisation of the current study, the researcher was committed to establishing epistemological consistency across the research question, aims and chosen methodological approach. It was important that the research question addressed phenomena that occurred in its natural setting (the lived experiences of racialised minority staff members within a FMH setting). Therefore, aims were generated to explore this in line with the epistemological approach.

3.4.2 Researcher Positionality and Reflexivity

As qualitative research implies a "degree of bias" (McMillan & Weyers, 2007, p.125), it is important to consider the tensions that surface

between objectivity and bias, and the position of the researcher. Positionality refers to an individual's world view, and the position they assume during research (Rowe, 2014). In the current study, the researcher considered the different lenses and potential influences through which they view the research. Values and beliefs shaped by culture, ethnicity, race, social class and status, were viewed as factors that influenced the area of study and how the research was conducted.

As a black British Caribbean woman with work experience in FMH settings, the researcher acknowledged that this predisposed and influenced the conceptualisation of the research. It also impacted the lens from which the researcher viewed the study area from and the data collection and analysis process. It provided a level of knowledge and understanding from personal experiences that encouraged a desire to explore the research topic in depth. The researcher wanted to provide a voice for ethnic minority individuals to be adequately represented in this thesis.

As such, when considering participants, the researcher would be considered an 'insider' to the group being studied, given similarities in their cultural identity, shared racial status and experiences. This gives the researcher a 'lived familiarity' of the population (Holmes, 2020). In the current research, there were some advantages of being an 'insider', such as having the ability to ask meaningful and informed questions, having a better understanding of the context, language

and colloquial terms used in the interview, and potentially being trusted by participants. This could have resulted in more rich and honest answers. It also likely enabled the researcher to notice codes and themes that an 'outsider' may not have noticed. Despite the benefits, being too close to the population could have prevented the researcher from being able to analyse the data from an external perspective. The researcher may have been overfamiliar with participants' experiences and could have struggled remain inquisitive and explorative during the interview.

Taking this into account, the researcher located themselves as an 'outsider-insider' during the research process. Their positionality continuously shifted, as the researcher had awareness of potential bias, and engaged in constant self-reflection and reflexivity, to assess how their position contributes to the analysis and interpretation of raw data. The researcher also acknowledged that they would have been more sensitive to the matters that arose when analysing interview transcripts, as the researcher has witnessed racialised minority staff in FMH settings being discriminated against.

To manage this, the researcher preserved transparency throughout the research process by continuously reflecting on their personal views (Parahoo, 2006) and its impact on the research process. A reflective journal was used to record these thoughts (Mruck & Breuer, 2003), and acknowledge that some elements of the research could not be separated from their life experiences or background (Grbich,

2012). Extracts from the researcher's reflective journal are presented in Appendix G. The researcher also engaged in shared analysis of the data to manage interpretative bias and to encourage reflexivity (see section 3.6.2).

3.5 The data collection process

3.5.1 Sampling and Selection

Participants were recruited through a combination of sampling strategies; opportunistic and criterion sampling (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015). Opportunistic sampling is based on convenience and relies on naturally occurring groups (Brady, 2006). Criterion sampling involves selecting individuals that are experienced with the phenomenon of interest, where there are some predetermined criteria of importance (Patton, 2002). As the researcher intended to target racialised minority staff members who currently or previously worked in FMH settings, detailed inclusion criteria were developed, with a clear description of what characteristics were needed to be selected for the study. This ensured the sensitivity towards the context of the study was upheld, as only those who met the criteria and responded to the initial advertisement were recruited. The inclusion criteria were as follows:

1. Participants will be from the United Kingdom. The decision to recruit from this country is to increase the homogeneity of the sample. Racialised minority professionals employed in the

same country may share experiences that differ from those in other countries.

2. As defined by the Office of National Statistics, participants must identify as coming from a 'Black and Minority Ethnic' group, with the visible difference being their skin colour'. This is due to participants in the current study being referred to as racialised minority individuals, in line with the CRT perspective that race and ethnicity are a central part of society. Participants need to be hyperaware of their ethnicity to understand dialogues about race/ethnicity and racialisation.
3. Recruited staff members will be required to have worked in or currently work in a FMH setting. This includes; low, medium or high secure settings, community forensic mental health teams and forensic Learning Disability services, to capture a breadth of experiences.
4. Participants must have worked in the FMH setting for a minimum of 2 years. This is important as participants will be asked about their experiences. Therefore they will need to have had sufficient experience to take part.
5. The study will purposely select staff from a range of roles and positions within the FMH setting, as this may provide variety within the experiences of those interviewed.
6. The study will include staff who work in both private and NHS trust settings.

7. Both male and female participants from age 21 years and above will be welcomed to take part in the study, providing they meet the criteria.

3.5.2 Procedure

Participants were invited through social media networking sites (i.e., LinkedIn, Facebook and Twitter). A research poster (see Appendix H) was used to advertise the study to ensure participation was voluntary. Potential participants were asked to contact the researcher via email expressing their interest in taking part in the study. They were then sent a Participant Information Sheet (PIS) (see Appendix I) via their email address, and given 10 days to ask any questions and consider whether they wish to take part. The researcher followed up with participants, by contacting them via email to confirm their involvement. Participants who agreed to take part were asked to read and sign an informed consent form (see Appendix J), if they understood the PIS. An email was then sent to participants to organise an interview date and time.

As the interviews were conducted during Covid-19 restrictions, all interviews took place online via Microsoft Teams in a location of the participants choice. Most participants engaged from their homes, which helped them feel comfortable in their environment (Jankowicz, 2005). To minimise technological issues, the researcher asked participants to ensure they had a strong and viable internet connection, and to test their audio and camera before the interview. Measures taken to uphold confidentiality included ensuring both the

researcher and participant were in a quiet and private space, where others could not overhear the interview. The researcher displayed a 'do not disturb' sign throughout the interview on the door, and the participant was recommended to do the same.

Before the interview, an email was sent to the participant with a one-time use link and password to enable access to the secure interview space. Once entering the video interview, the researcher introduced themselves and provided a brief outline of the study. Confidentiality, risk, and their right to withdraw from the research at any point was discussed. The researcher explained that the participant could ask for clarification at any point and a break where necessary. Finally, the researcher checked that the participant had read and digitally signed the consent form. Providing participants with thorough information about the procedure, ensured every aspect of the study was explicit which helped maintain transparency.

Once the participant was content with the information provided, and after demographic information had been collected, the researcher pressed 'record' on Microsoft Teams. There were no interruptions or emergencies in any of the participants interviews. Though had this been the case, the interview would have been terminated and rescheduled. During the interview period, there were technical difficulties attributed to internet connection. The researcher encouraged the participant to try and resolve the issue, or where necessary, the interview was terminated periodically before reconnecting and resuming the interview.

Interviews lasted between 30-60 minutes. As the interview contained potentially sensitive questions relating to experiences of racism and discrimination, participants were advised that they could conclude the interview at any time. Distress was managed by guiding participants to seek support if necessary. Participants were asked if they wanted to receive feedback after completion of the research, and were reminded how to contact the researcher should they wish to. The recruitment process concluded after 10 interviews had taken place, as recommended by the suggested participant size for IPA (Smith & Osborn, 2003).

3.5.3 Participants

A total of 10 participants with experience working in different FMH settings took part in the study. This included: community forensic services, medium and low secure male units, a young offender's prison, a locked rehabilitation female unit, a medium secure male specialised personality disorder unit, medium and low secure male learning disability units, a Psychiatric Decisions Unit, a Forensic Child and Adolescent Mental Health Service (FCAMHS) and a medium secure male specialised acute ward.

Five males and five females took part in the research, and the age of participants ranged from 25-46 years old. Participants included: three healthcare assistants, one assistant psychologist, one programmes facilitator, two senior forensic psychologists, two occupational

therapists and one psychosocial therapist. Overall, participants were considered experienced FMH employees. The least experienced FMH employees had been employed for two and a half years, while the most experienced had 11 years of experience. At the time of the interview, all participants were working in a FMH setting. Participants came from a range of locations such as, Kent, Liverpool, Birmingham and London. The geographical locations of the FMH services were not included in Table 3.1 to prevent participants from being identified. Participants identified as: White and Pakistani, Black British African, British South Asian, Black British African and Caribbean, Black Caribbean, Black British Caribbean, Indian and British Pakistani (see Table 3.1 for participant demographic information). Recruiting participants from a variety of FMH settings, in various job roles and from diverse racialised minority backgrounds ensured that the research remained sensitive to the socio-cultural context of the study.

Table 3.1 Participant demographic information

No	Pseudonym	Gender	Ethnicity	Forensic Mental Health setting	Job Role	No of years in FMH settings
1	Nima	Female	White and Asian	Male Community Team	Trainee Forensic Psychologist	5
2	Slyvia	Female	Black British African	Male Medium Secure Unit	Health Care Assistant	3
3	Patrice	Female	Black British African	Male Young Offender Prison	Programmes Facilitator	3
4	Odell	Male	British South Asian	Male Low and Medium Secure Unit	Senior Forensic Psychologist	11
5	Justin	Male	Black British African and Caribbean	Male Low Secure Learning Disability Unit	Occupational Therapist	2.5
6	Destiny	Female	Black Caribbean	Male Acute Medium Secure Unit	Senior Forensic Psychologist	6
7	Iman	Male	British Pakistani	Male Medium Secure Unit	Health Care Assistant	7

8	Ricardo	Male	Black British Caribbean	Male Medium Secure Unit	Occupational Therapist Assistant	5
9	Alisha	Female	Indian	Male Medium Secure Personality Disorder Unit	Psychosocial Therapist	3
10	Raj	Male	British Pakistani	Male Medium Secure Unit	Occupational Therapist	3

3.5.4 Development of the Interview Schedule:

A set of topics to address in the interview were developed based on areas identified in previous research, those relevant to the current study and the conceptual framework. This included; cultural identity, discrimination and racialisation. The first interview was treated as a pilot interview carried out with a single participant, who met the criteria for the study. The final interview schedule used was the second amended version following adaptations from the pilot interview (see Appendix F). Facilitating a pilot interview enabled the researcher to identify any limitations within the interview design. This enabled the researcher to make necessary revisions, before implementing the final interview schedule to increase research quality, coherence and trustworthiness.

After completing the pilot interview, the researcher noticed that it lacked depth, mainly in relation to the section that discussed race-based experiences in FMH settings. To address this, two questions were added which focused on these areas specifically. It was also observed that some questions were too specific, and instead prompts and follow up questions could be used to encourage the participant to expand on their responses. Therefore, some questions were removed or merged with similar questions, and prompts were added to encourage depth and breadth to the responses. For example, "*Has your perception of your ethnicity changed while working in the FMH setting?" (Prompt: How has it changed? Why do you think it has changed?)* (see Appendix F for full interview schedule). Recording the

changes that occurred ensured the process remained transparent and demonstrated the researcher's commitment to the research development.

A semi structured interview format was adopted which allowed for flexibility and expansion of relevant areas of interest that emerged during the interview (Smith, 1995). The researcher was able to maintain the natural flow of questions, with consistency across interviews. This was ideal given the potentially sensitive nature of the research. Using a semi-structured approach encouraged the researcher to engage in a collaborative conversation and build rapport with participants. This was with the prospect that it would enhance familiarity and comfortability in discussing the role of race and identity in their experiences.

In remaining sensitive to the context of the study, the researcher understood the potentially difficult nature of sharing such experiences. With this in mind, understanding was shown during the interview by responding using non-verbal behaviour such as nodding, and positive verbal communication. This signified that their experiences were validated and understood. It also demonstrated the researcher's commitment to the research and participant's accounts.

The impact and importance of the research became evident, when participants decided that their experiences could be used as part of this research. The researcher surmises that because the area of study was important and engaging for participants, they were more inclined

to share their experiences. This enabled the researcher to communicate the influence of the research (Kacprzak, 2017).

Finally, to adhere to being transparent and coherent, the interview construction and facilitation were presented in detail, to provide an understanding of the methodological decisions and the conditions in which it took place (e.g. online interviews in participant's homes and other practical concerns).

3.5.5 Ethical Considerations

Ethical approval was granted from the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee (Reference no: 10-0420) (see Appendix K). Before involvement in the study, participants were provided with an informed consent form (see Appendix J) which included consenting to their interview being recorded for transcription, and their data being anonymised in the transcript and write up. If participants did not consent to the recording, this did not take place. They were also notified that the data would be secured in a password protected file for seven years, before being destroyed. In relation to the results of the study, participants were advised that they may be presented in an anonymised format at academic conferences and journals. Being explicit in explaining the ethical matters of the research enhanced the trustworthiness of the research process.

Another ethical challenge encountered was during the data collection stage. Merriam (2009) states that it is inevitable that the researcher

will influence the data collection. Therefore, given the researcher's positionality, there was difficulty remaining objective throughout the data collection process. The researcher noticed that they often had to refrain from engaging beyond their role as a researcher in the interviews. This was particularly challenging when a participant mentioned an experience that was closely connected to the researcher's own experiences. While this made the researcher more self-aware of their own assumptions, it also made taking a curious stance to the data more challenging. There were times when the researcher would instinctively understand something a participant mentioned, and this could have impacted the extent to which participant's responses were explored. As CRT states that racism is a part of everyday life that has become normalised and unnoticeable, using IPA alongside this theory encourages further investigation to uncover how it operates. However, this may have been difficult given the researcher's closeness and introspective understanding towards the topic area.

Additionally, this may have also been experienced by participants, as they became aware that the researcher was a black woman. Having a researcher from a similar cultural background when discussing sensitive topics such as a racialisation, could have provided them with a greater sense of security, that they could be open. During the interviews, the researcher felt that they were offered some insider status due to their intersectional identity as a black female who has worked in FMH settings. This likely afforded the researcher a position

of power and privilege that could have informed the extent to which participants shared in their interviews. They were likely more willing to share and describe their experiences to an 'insider', due to feeling that they would be validated. This could be viewed as an advantage, but this was also an ethical challenge that the researcher continuously reflected on.

Given the openness of participants, the researcher noticed that participants tended to describe their experiences in significant detail, often using specific information and personal identifiers. This became a challenge when analysing the data and choosing to use quotes, as it was important to uphold the participants anonymity and confidentiality without losing the context and integrity of the data. Therefore, participant's quotes were selected carefully, to ensure their identity was not compromised, whilst preserving the significance of their experiences.

3.6 Approaches to data analysis

3.6.1 Transcription

The full interview with each participant was transcribed verbatim by the researcher. An example of a transcribed interview is provided in Appendix L. In some cases, participants mentioned identifiable information in their interview. The researcher considered whether the specific quotations and examples presented could lead to participants

being identified. If so, the data was modified to maintain confidentiality and protect participants by changing distinguishable information, without altering the original meaning of the data.

3.6.2 Analysis of interview data

When analysing the data, the researcher worked closely with raw material from the interviews. This was to ensure the analysis was grounded accurately in participant's claims, to uphold sensitivity to the original context. The analysis of interviews was approached with the intention of understanding the data and how each participant applied meaning to their life experiences. The IPA six stage approach was used to organise, explore, and analyse the data, to draw out emergent themes, similarities, differences, and interrelationships (Smith, Flowers & Larkin, 2009). This was completed for each participant's account:

1. The researcher transcribed the data (see section 3.6.1 for more detail).

2. The transcript was read several times by the researcher, to become familiar with each account and perspective. Preliminary thoughts were noted while reading each transcript. This increased the trustworthiness of the data collection process and documented interesting, relevant, or significant observations for each individual interview to ensure the context of the study was upheld.

3. The researcher then read the transcript again, and any aspect of the dataset that was deemed to be relevant to the research question was coded. The emerging codes captured the quality of what was found in the data and the codes began to invoke more psychological terminology, and theoretical connections within and across participant's accounts. For example, 'solidarity in shared ethnicity and experiences' and 'lack of cultural sensitivity in FMH settings'. It was important to include verbatim quotes to stay committed to upholding the participant's perspective, and to remain sensitive and acknowledge statements being made by participants. This ensured the analysis was contextualised in participant's accounts (Shinebourne, 2011).

After the researcher had coded the data, it was presented to the researcher's supervisors who have lived experience as racialised minority individuals, and in qualitative research to increase the trustworthiness of the analysis process. The supervisors were an Associate Professor of Forensic Psychology and HCPC registered forensic psychologist, who understands the culture of this discipline and some associated work contexts. There was also an Assistant Professor in Pharmacy and researcher/academic. This was with the aim of multi-researcher triangulation and discussing general thoughts to agree codes. The discussion highlighted the

influence of each person's academic background, as well their personal beliefs and life experiences. During this process the researcher found that the content of the codes was more important than the name or label to describe the code. Engaging in this collaborative process mitigated the analysis from being too focused on the researcher's own perspectives. It enabled the researcher to be explicit about any initial assumptions, reflect on the analysis through more than one lens, and increase trustworthiness.

4. The emerging codes were listed, and the researcher looked for connections and clusters of related themes between them (superordinate themes) (see Appendix M for emerging codes).

5. A table of superordinate themes was produced by the researcher which identified clusters of themes (subordinate themes) to capture the strongest participants concerns on this topic. The subordinate themes were given a name which represented an overarching superordinate theme. During this process, themes were eliminated that did not 'fit in' with the emerging structure nor have much evidence. As the researcher was aware of their positionality during the research, the superordinate themes were discussed with the researcher's supervisors. This allowed assumptions to be questioned and a curious and reflexive attitude to be maintained, which increased trustworthy interpretations of participant's experiences. There are several processes as

identified by Smith, Flowers and Larkin (2009) through which subordinate and superordinate themes were created including:

Subsumption: This is where one theme links other related themes to it. For example: During the analysis process, two emerging codes '*being the only one'* and '*lack of support'*, were linked to create the subordinate theme '*being the* '*only one*'. A causal link was identified between both emerging codes which aligned closely with the superordinate theme, 'carrying the burden'. It was deemed that one would have to be perceived or feel as though they were the 'only one' and receive a lack of support, to sense the need to carry the invisible social burden of race related matters.

Contextualisation: This refers to identifying the context of the theme within the analysis. During the analysis process, the wider context was re-examined. This helped understand whether various themes held significance for individual participants, and its overall relevance to the research questions and aims. This enabled the researcher to decide if it should be included.

Numeration: This reflects how often the theme emerges in the data. For example: The theme '*questioning oneself'* was eliminated from the emerging themes, as the theme did not appear often in the data. Therefore there was limited evidence.

Function: This considers what purpose the theme demonstrates. The researcher explored the function of statements and quotes made by participants to understand their perspective and stance. For example, *'I've always felt like I've had to prove myself and jump through hoops'* (Raj). It is likely that he is using this language to convey some of the systemic and structural practices that reinforce inequity.

Abstraction: This refers to merging similar findings and creating a theme name for the cluster of themes. For example: The themes '*educating others about cultural differences'*, '*confronting and explaining cultural differences*' and '*different ways of responding to racism and discrimination*', were initially merged to create the subordinate theme '*hyperawareness can lead to a response'*. It was considered that to educate others about cultural differences and confront, explain or respond to any form of prejudicial interaction, hyperawareness towards racialisation, or race-related issues are required.

6. Finally, the researcher chose the main superordinate themes which were refined and reviewed to ensure they were coherent and distinct from each other. Themes were not selected based on their prevalence within the data. Other factors including the richness of the data, enabled the researcher to choose the main superordinate themes, supported with subordinate themes and quotes from participants. Reaching a consensus with the supervisors, encouraged the researcher to establish the

parameter of each theme with reflexivity throughout the analysis process.

This step-by-step approach shows the thoroughness of the study. It also demonstrates how data was analysed, decisions were made, and how validity was monitored. This demonstrates a level of coherence and highlights how interpretations were derived from the data.

The NVivo qualitative analysis software was used to analyse the data. The software supported the researcher to locate how often a theme was produced and referred to across each transcript. It also enabled the researcher to become immersed in the data by moving back and forth between the raw material, and looking beyond the text to find a deeper level interpretation and psychological analysis (Smith, 2004). This helped the researcher arrange the data and facilitate the understanding and clarity of how significant a theme was. The subsequent chapters will present the themes identified through the data analysis process.

CHAPTER 4 - The findings on the individual experiences of staff from racialised minority groups in Forensic Mental Health settings

Chapter four overview

Chapter three illustrated how IPA was applied, and some of the challenges that emerged during this phase of the research. The data produced from the interviews were analysed, and the key themes that emerged from the data will be presented in the next two chapters (see Appendix N for themes mind map). It is hoped this will provide insight into the lived experiences of racialised minority staff members from FMH settings.

Chapter four presents the analysis and results of the first part of the study. It explores the individual experiences of participants, as they encounter and respond to racialisation and prejudicial events. It highlights how they process and manage their cultural identity within FMH settings at the micro level. Chapter four responds to the following research questions:

1. What are the individual experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

2. What are the individual lived experiences of processing and managing cultural identity within FMH settings?

Participants provided extensive accounts of their experiences, however due to word limitations these cannot be presented in their

entirety. Therefore, the researcher attempted to provide a narrative that conveys the interpretation of participants experiences with verbatim quotes, to display the commonality, convergence, divergence and individuality in a systematic manner[1].

The findings on the individual experiences of staff from racialised minority groups in Forensic Mental Health settings

Five key superordinate themes form the basis of this chapter and respond to the research questions. Although the themes have been separated during the analysis, it is important to acknowledge each theme in relation to each other and the participants complete experiences:

- *Standing out as different*
- *Carrying the burden*
- *Navigating environmental and emotional mastery*
- *The challenge of staying true to myself*
- *Dismissal and minimisation of race-based experiences*

[1] Participants were given pseudonyms to protect their identity.

Table 4.1 superordinate themes and related subordinate themes for individual level experiences

Superordinate Theme	Subordinate Themes
1. STANDING OUT AS DIFFERENT	• Covert and overt discrimination
2. CARRYING THE BURDEN	• Hyperawareness can lead to a response • Being the 'only one'
3. NAVIGATING ENVIRONMENTAL AND EMOTIONAL MASTERY	• Learning and developing coping mechanisms • The emotional and psychological effects of discriminatory experiences
4. THE CHALLENGE OF STAYING TRUE TO MYSELF	• Personal cultural pride • The difficulty in expressing cultural matters in professional environments
5. DISMISSAL AND MINIMISATION OF RACE-BASED EXPERIENCES	• Minimising, dismissing or excusing discrimination in FMH settings

4.1 STANDING OUT AS DIFFERENT

This theme refers to participant's experiences associated with the visible difference of being from a racialised minority background. This was paramount in how they perceived to be viewed by others, and in turn how others interacted with them. It was felt that being a racialised minority individual was attached to multiple stereotypes and challenges. This theme was comprised of one subordinate theme:

'covert and overt discrimination'. There was a consistent thread throughout participant's accounts, where their experiences were those which included direct and indirect discrimination through prejudiced attitudes, discriminatory behaviours, and levels of exclusion and differential treatment. They also highlighted instances in which they were stereotyped based on specific racial group characteristics. Further to this, there were accounts of feeling frustrated towards the intentional and unintentional expressions of bias, often leaving participants feeling othered.

4.1.1 Covert and overt discrimination

Different forms of covert discrimination were deemed as an implication of standing out as different, whilst working in FMH settings.

> *If I, voice something and if someone who is white says the same thing as me in a similar way, I felt that they wouldn't get as much [….] I don't want to say backlash, but as much as what I would get (Nima- Female, Trainee Forensic Psychologist).*

> *I've had discrimination from professionals, even in supervision, they'll say, "you don't have to be aggressive" (Patrice- Female, Programmes Facilitator).*

Nima expressed how being from a Pakistani background meant that she experienced more scrutiny. This potentially led to feeling as though she is not operating on a 'level playing field', due to the disparities in what is expected between white and racialised minority groups. This view was shared by Odell who felt his professionalism has been challenged, and observed other racialised minority colleagues also being managed under a closer lens:

> *It sometimes might feel that you are under maybe scrutiny sometimes, or maybe some of your decisions might be questioned a bit more, compared to if the same kind of decision was made by a different psychologist from a different ethnicity […..] like when I recommended that a service user be referred for a particular psychological intervention, a senior psychologist called me into a meeting to question this decision. But in Multidisciplinary Team (MDT) meetings with my white colleagues, I've never seen that happen (Odell- Male, Senior Forensic Psychologist).*

> *I've had my reports and decisions be questioned by more senior psychologists, but I don't see that happening to other people (Odell).*

> *I have found that some supervisors are more critical perhaps, or seem to supervise, some BME assistant psychologists a lot closer than they would another white assistant psychologist for*

example. I have noticed that, so maybe the feedback is a bit more thorough (Odell).

Racial microaggressions were also experienced by Raj and Slyvia, where verbal communication from others subtly conveyed insensitivity and seemed to demean their racial heritage and identity. They could not 'turn off' or hide their ethnicity, and instead had to tolerate incorrect assumptions about their job role in the FMH setting. Individuals appeared to discredit their professional achievements and may have perceived them to be less qualified. These quotes highlights some of the differences between how white majority and racialised minority professionals can be treated in this environment, resulting in racialised minority individuals feeling as though they stand out as different:

…if they see me they might say 'oh who is the O.T?' and I'll tell them that it's me and they'll say, "Oh you're the O.T?" [.….] so I'm getting dirty looks from them, I'm getting indirect remarks, I'm getting them treat me as if I'm a little kid and not take my professional opinion seriously (Raj- Male, Occupational Therapist).

They'll be like, "oh really, so you actually went to university?" (Slyvia- Female, Health Care Assistant).

Slyvia presented an experience where she was met with an aversive response after sharing her professional opinion. While this response was likely rooted in negative racial stereotypes, this led her to be singled out:

> *If I didn't agree with something that was going on and I chose to voice my opinion, I'd get "you're being problematic, you're being challenging", rather than saying, okay, you've got a different opinion, let's explore it (Slyvia).*

Covert discrimination was a common occurrence for all participants. Though on some occasions, 'out grouping' and standing out as different manifested in more overt and deliberate acts of discrimination and racism. Nima and Ricardo reported being confronted with intentional and derogatory racial name calling by clients, which appeared to be used intentionally to hurt them. As the racist language was used by clients as opposed to staff members, its meaning, significance and intent may have been denied or minimised:

> *…this was when I was in a locked rehab and yeah, I think even then, I was called a 'Paki' there a few times (Nima).*

> *…I've been on the ward and heard service users call staff, "black bastard, the black n****r" and the service user, not even being supported to apologise to that person they were targeting (Ricardo- Male, Occupational Therapist Assistant).*

Slyvia also spoke of the visible expressions of racism where:

> *…they [clients] treated the majority of us black staff members really badly, you could tell the difference. When they were speaking to a black staff member then a white staff member. They were rude, they would humiliate us" (Slyvia).*

Standing out meant that participants were treated unfairly and had to decide whether to address discrimination or not. This can be a challenging dilemma, particularly where racial language and rhetoric has been used in a 'playful' manner, as recalled by Ricardo:

> *… I think there was a period where there seemed to be a lot of black staff working there and the white staff became the minority. I remember walking up to two people and they said [.….] "here comes the jam jar golliwog" to me (Ricardo).*

It was apparent across many participants accounts the challenges of being perceived as different. Although it is also important to acknowledge the impact of intersectionality. While participants were from racialised minority backgrounds, their experiences of covert and overt discrimination are also likely situated in positions that include, gender and class. Therefore, although participants did not highlight differences with reference to intersectionality, it is noted that discourses of discrimination cannot simply be explained by 'race' only.

4.2 CARRYING THE BURDEN

This superordinate theme describes working in a FMH setting as a racialised minority individual where there is limited ethnic representation. In such circumstances, race-based matters in discussions could be emphasised, ignored or excluded. With the accumulation of personal and professional race-based experiences, participants were more aware of 'race' and culture issues that may not be overtly evident, and as such they elicited different responses. Some directly addressed issues with the intention to educate and encourage accountability, while others were more dismissive. Being confronted with the decision to respond to issues appeared to leave participants feeling alienated, as they were the only individual present to represent and speak on behalf of those from racialised minority backgrounds. As such, they struggled with this responsibility and the challenges it resulted in.

4.2.1 Hyperawareness can lead to a response

With prejudiced attitudes, discriminatory behaviour and racism being a common experience for most racialised minority individuals, this can often be at the forefront of their collective thoughts. It can then become more difficult to live without thinking about 'race' in every situation. Carrying this burden may lead these individuals to have increased vigilance or hyperawareness for cues of mistreatment, and as such, some participants felt responsible to directly express their views on the matter:

I will speak up about it and let you guys know that this is an issue that I face every day. You know, particularly in the workplace. So I'm very pro-black and I let it be known (Patrice).

There was a service user who always referred to black people as being loud […..] he'd say "not them again, they're always so loud, I don't understand what they are saying" […..] I just tell them straight that what you're saying is wrong, it's offensive. I take offence, it hurts me (Justin- Male, Occupational Therapist).

I'm done trying to make everybody comfortable [……] we need to address certain things. So yeah, I think it's not more awareness, it's just you're not letting anybody get away with it anymore and call it out more (Destiny- Female, Senior Forensic Psychologist).

Raj commented on how his awareness has increased given his personal experiences of racism:

…my experiences of racism or discrimination has made me more aware of when it happens to other people, and when discrimination occurs in the forensic mental health setting (Raj).

The above excerpts depict how each participant shares similar sentiments with a strong sense of identity. This may have increased their assertiveness and ability to address race-based matters. Destiny had a similar approach and went a step further, as she provided educational resources such as books, research papers and documentaries to encourage meaningful dialogue about difference, whilst prompting accountability. It is possible that her perception of 'accountability' was through engaging in informal communication about how racism, discrimination or unfair treatment of individuals from racialised minority backgrounds is not acceptable:

> *So I'm just like holding people accountable and sharing resources [……] I sent him a whole bunch of things to read (Destiny).*

To have accountability in the workplace, it is important for it to be built into the culture, to prevent it from being one individual or a group of individuals responsibility. Instead, it should overtime become a cultural norm where accountability is rooted in open communication, and practices that prevent racial inequality.

For some participants, being hyperaware can lead to further thinking about how a response is given. Raj provided insight into the challenges of responding in a supportive and positive manner, when met with an unfavourable reaction:

I do believe that if someone responds negatively, you should try your best to respond positively. So I try to do this, but sometimes it does get to me, so I can be sarcastic back to them. Most of the time, I'm able to respond positively, but it is in my nature to respond emotionally at times (Raj).

…there has to be a mutual relationship where they understand and take my feedback on board. And I have to be willing not to become defensive and have an open conversation with them (Raj).

Therefore to manage the 'burden' and 'survive' these potentially negative circumstances, it appears as though Alisha minimised the encounters she experienced, downplaying them to navigate working in the FMH environment. While she does not deny everyday race-based experiences, choosing not to respond in some situations can be viewed as psychological protection against the effects of such experiences, or not feeling safe enough to challenge the behaviour:

because it's something that's been happening all throughout my life it's something that I just don't pay much attention to sometimes. Especially when, I think about microaggressions [……] I just laugh along with it [……] sometimes I just dismiss it (Alisha- Female, Psychosocial Therapist).

4.2.2 Being 'the only one'

Participants often felt as though they had to carry the burden of addressing issues related to 'race', culture and identity. Feeling responsible for such issues may be due to; others refusing to accept its existence, the emotional disconnect others display when racialised minority individuals articulate racial matters, or simply because nobody else wanted to. Odell and Destiny expressed a range of emotions such as loneliness and frustration in their position as the 'spokesperson':

> *…and its often people from BME backgrounds who have to raise these issues or bring these issues and awareness up [……] it's me that must raise the awareness about some of these cultural backgrounds (Odell).*

> *…sometimes I have to be the only voice, bringing out these matters and ensuring that I hold everybody accountable (Destiny).*

Acting as the 'cultural representative' within FMH settings could cause racialised minority professionals to feel as though they are serving in two roles. The possible implication of this could be be 'diversity fatigue', arising from exhaustion caused by discussions about race-based issues.

For Patrice and Raj, they highlighted a further difficulty of being the 'only one', where they felt that others were unable to relate to them

from a cultural perspective. This led to feeling isolated where they may be deprived of the psychological safety that enables them to be authentic. Racialised minority professionals could in turn struggle to feel a sense of belonging within the FMH environment because of this:

> *Sometimes I experience moments where I feel like I'm the only person in the room that understands or talks in a certain way (Raj).*

> *So there were times where it would feel a bit isolating. Because I was the only black girl. So I didn't really get to share my experiences with anyone else (Patrice).*

As highlighted by Nima, being the 'only one'; also creates distance between themselves and their cultural identity. Not working professionally alongside those with shared racial status, could significantly impact how 'close' and connected they feel to their culture. Some may unconsciously supress their personal values and views to align more with organisational ones:

> *…if you're the only one in kind of a majority white team and there is literally nobody else there you can kind of share that experience with, you can lose your culture from that point (Nima).*

Being the ‘only one’ was also met with a lack of support from others. Ricardo touched on an important issue where other people may choose not to support racialised minority individuals. For Ricardo, it appeared as though this was frustrating, where it highlighted others lack of cultural sensitivity and genuine desire to understand:

> *We had black history month, a few years ago and I needed some support with preparing some of the food. And I walked into a room of O.T's, and all of them looked down, not interested. And there was murmurings about them not wanting to participate in the event (Ricardo).*

> *If you are unfortunate to work on a ward where the service users are very quick to be racist, the negative side of it is, you don't feel supported or you don't feel there's enough work being done around awareness for these people (Ricardo).*

This subordinate theme highlights an experience that almost all participants had, of being situated as having specific knowledge solely based on their racial status. Though it also displays the shared view that this ‘burden’ is inherited, as a by-product of being a minority in a non-diverse workforce.

4.3 NAVIGATING ENVIRONMENTAL AND EMOTIONAL MASTERY

There were two subordinate themes comprising this category: 'learning and developing coping mechanisms' and 'the emotional and psychological effect of discriminatory experiences'. This superordinate theme describes the ongoing difficulties participants encounter working in a high-pressured environment. FMH settings encompass a myriad of challenges such as clinical, legal and ethical issues, whilst working daily with high-risk clients.

Amongst the contextual challenges, participants expressed further complexities through their experiences of discriminatory behaviour, and racially driven encounters. As such, navigating the environment and the emotions that arise because of this can be a complex process. This theme highlights how participants developed various mechanisms to cope and protect themselves in an environment where difficult emotions are persistent. Their accounts highlighted how having a sense of control over the environment produced some feelings of assurance and safety. This theme also acknowledges the emotional and psychological effect of discriminatory experiences within FMH environments. Participants expressed that despite developing coping methods to manage prejudicial events, their psychological and emotional wellbeing may still be adversely impacted.

4.3.1 Learning and developing coping mechanisms

By way of coping mechanisms, participants shared their preference for managing situations by avoiding interactions:

> *…you tend to like, avoid as much as you can with having casual conversations with service users (Alisha).*

> *…I think, if I know that a service user is racist or says racist things, I'm less inclined to work with them in a therapeutic sense, or I think that's probably how it's affected me. So I probably don't have as good a rapport with that service user (Destiny).*

Destiny and Alisha both focused on their relationships with clients and shared similar accounts, in that avoidance provided a physical and psychological barrier to reduce potentially negative encounters. Destiny shared that she would prefer not to develop a therapeutic relationship with clients who have displayed prejudicial views, to prevent further racial injury. This appeared to be an intentional response, to manage any difficult dynamics. In relation to colleagues, Odell shared that he is more conscious of the distance he places between himself and colleagues who are from white majority backgrounds:

I am a bit more mindful perhaps to keep more of a boundary [……] compared to other colleagues that are from BME backgrounds (Odell).

Similarly, Ricardo spoke of his interactions with clients, in that he is mindful of potentially favouring clients who are not racist or those who may share a similar cultural background:

Obviously, we are there to care for people, but you've got to stay within your boundaries. I think that's really, really important, a boundaried approach [……] because it's easy to start, favouring someone, or being lenient to someone, and that will have repercussions later on (Ricardo).

Setting boundaries with work colleagues and making it clear when a boundary has been crossed can be risky in some respects, due to the potential for offending people or becoming further isolated. Although as highlighted by participants, it can also demonstrate to others that autonomy is valued, and as such there may be less opportunity to be emotionally reactive.

Similarly, Slyvia talked about her reasons for setting boundaries with others. Her cautiousness was apparent, as she narrated her thought process when deciding whether to connect with others. For Slyvia, it seemed as though maintaining boundaries was an important coping

mechanism to protect herself, and manage the challenges of being a racialised minority in a FMH setting:

> *…it's just made me be more wary of who to open up to, ask questions to, and it made me observe people a lot more and weigh them out? Is this a person that I can trust? Or this is a person that I can go to if I need to in the future or not? If not, then that's it (Slyvia).*

In actively maintaining these boundaries, Slyvia appeared to have developed the ability to be less reactive to prejudicial treatment:

> *I had to be mindful of my words. Even if I'm having a bad day [……] it sounds like a lot of work, but that's how I had to do it in order to be able to survive unfortunately [……] it's something that I had to learn how to do as well, not to challenge everybody. Because if it's not going to be addressed, you're just going to end up frustrated. Unfortunately that was the attitude that a lot of us had to adapt so that we could safeguard ourselves and our mental health (Slyvia).*

Her decision not to respond may have developed following previous experiences of emotional reactivity. Patrice agreed with this view, and resigned an attitude which demonstrated that she is no longer taking responsibility for engaging with people on the topic of 'race':

I don't engage in conversations about racism with my colleagues, because I'm not here to educate you. And I'm not here to teach you about what racism means to me (Patrice).

Another coping mechanism that was developed to manage the encounters experienced in FMH settings, was making 'race' and culture issues and discussions more visible. This seemed important to some participants where they felt responsible for addressing dialogue around difference:

I'll feel more comfortable addressing it. But it's taken me years to be able to get to this point. To the point that yeah, I don't care in the sense of it doesn't bother me. It doesn't take my peace away knowing that you don't value me (Slyvia).

…it's just like I say what I say. You know I send emails to the lead psychologist and, you know, try to get people to be accountable. So yeah, I think from the beginning that was my stance, but it really intensified last year (Destiny).

Both Destiny and Slyvia appear to be comfortable with this position and valued the importance and power in speaking about race-based issues. However, many participants held the view that they no longer address these matters, as they have over time internalised discriminatory experiences, which have become normalised. It could

be suggested that this is a defence mechanism that has developed following several negative interactions:

> *I think, you know what, I am so used to it throughout my own life, to me it's become normal [……] people are always going to say and do it. So part of me kind of has a defeatist attitude, so I wouldn't really care what people say or do (Raj).*

> *I no longer have a desire to push for more. I no longer have a desire to kind of speak on topics such as these, simply because what is the point (Patrice).*

> *…it happens so often that you just kind of, you don't really pick up on it, or you just learn to kind of see that as the norm I kind of learned to just let it go. Use self-talk and just kind of end up making excuses for some of the behaviours from other people (Odell).*

Slyvia also spoke about an intentional coping mechanism which involved her deciding to detach herself from work related experiences:

> *…the way that I coped was literally leaving all work-related things at work. Once I'm out of my establishment, then it's a different chapter. I can be home and free [……] otherwise it*

would completely spill out into every single area of my life, unfortunately. Which was difficult to do (Slyvia).

She also shared the importance of having a sense of belonging by connecting with other racialised minority colleagues who have similar experiences. Seeking solidarity enabled Slyvia to feel safer. This coping mechanism likely provided her with support to process and move beyond the impact of prejudicial experiences, and challenges in the FMH environment, by engaging in a space where there is shared understanding and experiences:

…being able to have everyday chats, laugh about things that, you know, your colleagues would also find funny, we also understand. When it would be like our lunchtime, sharing food with each other. The staff room would be a safe space for us to relax, and enjoy each other's company (Slyvia).

While there are many coping mechanisms to protect against negative treatment in FMH settings, Odell and Slyvia spoke about how important resilience is, in being able to manage the impact of pervasive discriminatory experiences:

had to become very resilient [……] I had to learn to stand up for myself, but not in a defensive way [……] how to professionally stand up for myself [……] so yeah, it has changed me a lot (Slyvia).

…so your resilience has to be really built in forensic settings (Odell).

This subordinate theme highlights the many ways participants have intentionally or unintentionally developed successful coping mechanisms, to buffer and self-manage against perceived racism.

4.3.2 The emotional and psychological effects of discriminatory experiences

Participants reported workplace experiences whereby they struggled with their emotional and psychological health, due to racial discrimination. Two participants described the pervasive impact of race-based stressors, and spoke of the negative impacts on their mental health:

Over time, trying to do all that is very draining. You burnout because you're thinking about all of that plus the environment as well. You burnout so quickly, so quickly [……] it's highly stressful (Slyvia).

It would like affect me emotionally and affected my well-being. I wasn't sure what was happening (Ricardo).

This feeling was common amongst participants who also felt the harmful effects of racial discrimination at work. Nima described

feelings of hopelessness as a response to racism. Her sense of self seemed to have diminished, leaving her feeling powerless in an environment where prejudice and discrimination may be unavoidable and uncontrollable:

> *It was uncomfortable, it used to make me dread going into work and you kind of feel really hopeless and [……] burnout starts and compassion fatigue, because you're just like 'what am I even doing this for?' (Nima).*

> *Sometimes it can feel a bit hopeless, but I think that is largely down to systems rather than the kind of individual (Nima).*

This leads to thoughts about how Nima carries herself and functions in her role after experiencing an emotional injury. In an environment where racialised minority professionals face repeated acts of injustice, Slyvia also cited how she managed some the unexpected difficult race-related encounters:

> *…sometimes if the patient did something to us, we would take it, go to the back room cry, wipe your tears and go back into the ward again (Slyvia).*

From her account, it is likely that the negative interactions she experienced directly threatened her sense of safety and security. As such, it triggered a visceral emotional response. Though despite the

level of distress she felt, she maintained her professionalism. There may be a concern that if an act of racism is addressed, she could be ridiculed, disliked or looked at as being "too sensitive".

Alisha also talked about how being a racialised minority professional in an FMH environment, can cause her to feel inadequate due to the challenges she encounters:

> *I might feel a bit insecure because it's difficult to be a minority (Alisha).*

Ultimately, there was a sense for participants that their psychological and emotional health was impacted to varying degrees whilst working in this environment.

4.4 THE CHALLENGE OF STAYING TRUE TO MYSELF

This master theme captures the subordinate themes of having 'personal cultural pride' and 'experiencing difficulties expressing cultural matters in professional settings'. It emphasises how being a racialised minority professional in a FMH setting continues to be a challenge, as participants attempt to manage their professional and cultural identities. In the first subordinate theme, participants share how they maintain the pride and essence of their culture and its customs within the workplace. Though whilst displaying this cultural connection, it highlights the difficulties they encounter as they

grapple with addressing race-related or cultural matters in the work environment, particularly in a predominantly white profession.

4.4.1 Personal cultural pride

Participants shared the importance of unapologetically displaying their culture within the FMH environment. Slyvia, Patrice, Destiny and Nima talked about how they confidently bring their cultural identity into the workplace, and highlight its significance and value:

> *I proudly tell them my roots are a big part of who I am. I am proud of being you know, who I am [……] my ethnicity is a big part of me (Slyvia).*

> *…we are very much in support of our heritage, our culture, things like that. it's not changed…I will speak up about it and let you guys know that this is an issue that I face every day. You know, particularly in the workplace. So I'm very pro black and I let it be known… (Patrice).*

> *…And I think it's always important. So I'm always showing up fully as black Jamaican woman (Destiny).*

> *I really value it, more so now erm [……] and it's something I probably push on people a little bit more than I used to (Nima).*

Some participants found it easier than others to merge their cultural and professional identities. Raj spoke about how he used elements of his culture to develop a group for clients and cultivate an environment that is culturally competent:

> *We are doing a group called 'roots and culture' where we get service users of a certain culture. For example we get a Pakistani service user to cook food and do a small presentation. And on that day, I wore my Pakistani clothes and I was cooking food like curries and pakoras (Raj).*

For Patrice, she spoke of how proud she is of her heritage, by providing specific information about traditional practices, and other elements of her culture. She illustrated how sharing this information also enables her to educate others, and understand how people perceive and make sense of culture and other race-related matters:

> *I was always telling them about food that I cook, I love eating, and I love food. Or like my trips to Ghana [……] people knew I was from Ghana, they knew that I love my heritage (Patrice).*

> *You get to kind of teach people about your background, your heritage, your country, you show them to a different way of thinking [……] a lot of people in the Western countries think that in Africa, we all live in huts and villages and things like that. So you just get to educate them to say we are more than*

this. So it is an opportunity to have conversations, and [……] to kind of understand why they think the way they way they think (Patrice).

Other participants shared how they are becoming more comfortable with displaying their culture. Slyvia expressed how she takes a thoughtful approach when deciding how she brings elements of herself such as her hairstyle into the work environment:

…I'm more reflective about it. So for example, if I'm getting ready for work one day, and I think, okay, I have to do my hair this way. And then I think, actually, you don't, so go ahead and do it (Slyvia).

For some participants, they reflected on how they managed by not compromising their culture over their professional identity. They highlighted how they considered the cultural values that had been taught to them, as well as the values they deemed as important to withhold as a professional within this setting. Rather than being split between their cultural and professional identities, participants seemed to find value in accepting and merging both:

I wasn't ready to, sort of like change my belief, or, professionalism, or put the service users' needs before my culture and my belief if that makes sense (Alisha).

…so I embraced it, you know, I think I bring it into everything that I do [……] especially at work and in different meetings and you know I don't really shy away from it (Destiny).

Odell highlighted how he has been able to find a balance between both identities. He expressed how his culture influences his professionalism, as opposed to them being separate elements:

…in my work, I acknowledge where I'm from. And I acknowledge […..] I will be influenced by my cultural background (Odell).

Maintaining and displaying cultural pride was evidently important to participants. Most were able to integrate both their professional and cultural identities. Although, being proud of their cultural identity, likely exacerbates how they view and address cultural matters. This can be difficult to navigate in professional environments as indicated by the next subordinate theme.

4.4.2 The difficulty in expressing cultural matters in professional environments

As professionals in FMH settings, some participants struggled to bring issues about culture into discussions. Nima often referred to feeling 'uncomfortable' in making these matters more visible:

I always felt like I had to apologise or justify it because it would make other people, maybe white counterparts uncomfortable (Nima).

…you can just see they just get uncomfortable and they just don't want to talk about it [……] they don't want to 'go there' in a way [……] I just felt really uncomfortable with it (Nima).

But I think definitely when I've had white supervisors, they don't really get it and made me feel very uncomfortable talking about it [……] particularly with the last year and the aftermath of what happened with George Floyd. I'm very sceptical now of a lot of things (Nima).

Nima shared various thoughts about addressing race-based issues. She reflected on her own feelings, in that she found it challenging to discuss these topics, as she was mindful of how her white counterparts might respond to it. It appeared that her expectation about how others would consider these matters, in addition to them not being from racialised minority backgrounds, made her diminish or downplay its importance and meaning. She also communicated her frustration about her supervisor not understanding racial issues. This resulted in her feeling uneasy, perhaps due to the limited support she had from a senior staff member, who lacks 'first-hand' experience as a racialised minority individual. As a result of these experiences, Nima

appeared to consider whether she would attempt to have future meaningful discussions about culture.

A similar view was also shared by Alisha, who expressed the inherent challenge that comes with deciding whether to confront another individual about being racist. Alisha likely found this to be a difficult position, as to refrain from being perceived as someone who is 'overreacting' or adhering to racial stereotypes:

> *When someone is racist towards you, you might not even feel comfortable to challenge them about it (Alisha).*

Further to this, Destiny talked about how she would prefer to be perceived in professional environments. She held the view that she would rather remain as someone who is considered a professional. Thus, it could be implied that leaning into cultural identity, and addressing race-based matters is not seen as professional:

> *I just kind of, yeah. I mean I want people to think that I'm professional I want to operate you know within the boundaries of what is expected of me, you know my sorts of professional obligations (Destiny).*

The data in this subordinate theme has been selected as part of the individual level experiences, as it distinguishes how different participants feel towards addressing cultural matters within the work

environment. It highlights how participants made sense of this on an individual level, and their specific difficulties based on their encounters and perspectives. While it is recognised that the data in this subordinate theme leans towards systemic level experiences, the associated layers will be conceptualised in more detail in the next chapter.

4.5 DISMISSAL AND MINIMISATION OF RACE-BASED EXPERIENCES

This theme comprised of one subordinate theme: 'minimising, dismissing or excusing discrimination in FMH settings'. Although some participants attempted to address race-based experiences and issues, they seemed to encounter resistance and silence when raising such matters. Participants highlighted occasions where white majority individuals explicitly avoided discussing race-based experiences. This tended to create frustration amongst racialised minority professionals, who felt these important issues were being disregarded. On occasions where race-related issues were being discussed, participants felt that their white majority colleagues were 'sidestepping' discussions to talk about other issues. This could be deemed as a way of invalidating their views. Denying or minimising relevant racial subjects could deviate discussions, prevent self-development or maintain systemic racism.

4.5.1 Minimising, dismissing or excusing discrimination in FMH settings

When reflecting on their experiences, participants often referred to the silence that was observed when discussing race-based issues. Slyvia talked about the response she received from those in senior positions, when she shared her encounters with prejudice in the FMH setting:

> *…if that was ever brought up to the manager, who was not black, it was always dismissed or it was always, "was it something about your tone?" or "did you challenge the patient?" So it was never the patient's fault. It was always, "what did you do wrong, how did you approach situation wrong?" (Slyvia).*

> *I knew that if I took it to my supervisor or anybody, it wouldn't get addressed. Nothing would ever happen. So really, and truly a lot of the stuff that we went through there, we just have to keep our mouth shut (Slyvia).*

She referred to the manager not being black as significant, implying that she may not have expected her to understand 'race' issues. She also shared how her concerns were often viewed as less important, and as if it was her responsibility to address these matters. By telling a senior staff member, it is likely that she was hoping to receive support in managing the situation. However, Slyvia seemed let down

by the lack of meaningful consideration given to this issue. It is possible she may have felt disappointed and displeased at her supervisor's response. She believed that 'nothing would ever happen', which could suggest that she felt discouraged about raising these matters in future.

Both Odell and Raj found that other colleagues would create excuses for discrimination:

> *Oh, they didn't really mean that", or "I don't think that's what their intention was" to kind of make-up excuses (Odell).*

> *But sometimes I feel like people cover this up by saying "oh it's just PD[2]" (Raj).*

Within the FMH environment, working with clients with various challenges such as mental health and personality difficulties is expected. Therefore, others may justify their decision to minimise discrimination from clients, resulting in them not being held accountable for prejudicial behaviour. This could lead to the racialised minority individual feeling overlooked and invalidated, causing them to refrain from expressing concerns about race-based issues in the future.

[2] "PD" is an acronym for Personality Disorder. Personality disorders can impact how a person feels, behaves, thinks or relates to others. These inner experiences and behaviours often differ from the expectations of the culture in which someone lives.

Ricardo shared similar sentiments where clients were not being held accountable for discriminatory behaviour:

> *…that has been an issue in the past where service users were able to do that and weren't being made accountable for it [……] it just made things even worse. Imagine, staff working on there and being called those names and nothing's been done (Ricardo).*

Patrice gave her perspective as to why she felt others avoided conversations about culture:

> *Individuals kept quiet and never really spoke on it. It made me realise, you clearly don't want to learn or you don't want to understand. So I know with you, I'm going to tread very lightly (Patrice).*

Patrice suggested that part of the reason why others did not talk about racial matters is because they choose not to acknowledge or understand it. It is possible that because of their response, she lost the desire to raise these issues due to feelings of weariness and unfulfillment. It is also interesting to note that Patrice altered how she interacted with those who choose not to understand race-related matters.

4.6 Chapter four discussion

4.6.1 Overview of chapter four

Chapter four aimed to explore the individual level experiences of processing and managing cultural identity within FMH settings. It also looked at individual experiences of racialisation and discrimination for racialised minority staff members in FMH settings, and how they encounter and respond to these prejudicial events.

Where individual experiences are concerned, most participants highlighted the difference associated with being from a racialised minority background. This difference was visible due to the colour of their skin and other elements of their cultural identity, which led them to stand out in comparison to others within the environment. Similar to previous literature on cultural diversity in healthcare settings, participants shared that they were judged and discriminated against both overtly and subtly. The subtlety of racism may have led participants to analyse their experiences from a racial lens, to make sense of them. There may be the perception that all interactions have the potential to have racial undertones or connotations. From a CRT perspective, one might consider the possibility that racism is a normal part of everyday life where it manifests organically through personal exchanges (Delgado & Stefancic, 2012). Therefore, it may be unrecognisable, but it is crucial to reveal how it operates (Hylton, 2008).

In their narratives, participants shared the weight that comes with being from a racialised minority background within the FMH environment. They reflected on the difficulty of being hyperaware of mistreatment, prejudicial attitudes and discriminatory behaviour. This led to some participants speaking up about these experiences within the workplace, and holding others accountable through education and engaging in conversations about racism and its impact (similar narratives were also noted by participants in chapter two, section 2.5.2, theme 5). Though for some participants, this also came with the 'responsibility' to address such issues. This was occasionally followed by frustration due to lack of support and understanding.

It is already understood that FMH settings can be challenging due to the need for professionals to hold both risk and therapeutic approaches at the forefront of their practice (Sappänen, Törmänen, Shaw & Kennedy, 2018). Though amongst the complexity of the FMH environment, an additional challenge was managing the day-to-day encounters of discriminatory behaviour and practices. Participants developed various coping mechanisms to protect themselves against the impact of negative experiences, one of which was avoidance. This coping mechanism was highlighted by participants who shared that they preferred to avoid certain interactions, to reduce the likelihood of having a negative encounter. They also maintained a level of avoidance through the relationships they developed with clients and staff members, by keeping them at 'surface level' and ensuring professional boundaries were upheld. Similar experiences were found

in the systematic review (chapter two), where participants in other healthcare settings spoke of suppressing their responses to discrimination and ignoring prejudicial behaviour. This could also be viewed as a form of avoidance.

In considering identity development and more specifically, the negotiation between cultural and professional identity, participants were faced with the difficulty of maintaining the true essence of themselves. Some participants struggled to bring their cultural identity into the workplace and merge this with their professional identity. As discussed in chapter one, they may have felt that they would be stigmatised, racially stereotyped, viewed as 'non-professionals' (Slay & Smith, 2011) and further racialised.

Other participants were able to hold both their professional and cultural identities equally through their clinical practice and informal interactions with others. They addressed race-based matters with a sense of not wanting to compromise their cultural identity. For other participants, it seemed as though they did not feel comfortable enough to display their cultural identity, due to the minimisation and dismissal of race-based issues, and the lack of support and avoidance from colleagues to address these matters within the FMH environment. As such, it is likely that the dominant group (white majority), held more power in these situations which may have silenced the voices of racialised minority staff (Bamberg & Andrews, 2004).

Overall, participants provided rich and thought-provoking responses when considering their individual experiences as racialised minority professionals in FMH settings. Chapter five will continue to explore participants narratives focusing mainly on the institutional and systemic level experiences of racialisation and discrimination encountered within the FMH environment.

CHAPTER 5 - The findings on the systemic level experiences of racialisation and discrimination and their psychological impact from staff from racialised minority groups in Forensic Mental Health settings

Chapter five overview

Chapter five presents the second part of the findings which draws on the diverse experiences of racialisation, discrimination and prejudice that were perceived as deriving from systemic level experiences and observations. The results outline how participants made sense of the wider FMH environment as an individual from a racialised minority background. It also explores how their experience impacts their professional relationships, clinical practice and employment progression. This chapter answers the following research questions:

1. What are the systemic level experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

2. What psychological impact does the experiences of racialisation and discrimination of racialised minority staff have on them and their ability to serve within this setting?

The findings on the systemic level experiences of racialisation and discrimination and their psychological impact from staff from racialized minority groups in Forensic Mental Health settings

Five superordinate themes form the basis of this chapter and respond to the above research questions:

- *The complexity and contextual nature of FMH settings*
- *Culture prevents staff progression*
- *Reducing inequality by changing the narrative*
- *Interactions are impacted by cultural identity*
- *Buffering for psychological protection*

Table 5.1 Superordinate themes and related subordinate themes for systemic level experiences

Superordinate Theme	Subordinate Themes
1. THE COMPLEXITY AND CONTEXTUAL NATURE OF FMH SETTINGS	• Systemic racism and biases • The imbalance of racial representation • Whiteness in psychological services
2. CULTURE PREVENTS STAFF PROGRESSION	• Lack of cultural sensitivity in FMH settings • Working harder to overcome barriers to progression
3. REDUCING INEQUALITY BY CHANGING THE NARRATIVE	• Directly addressing discrimination and cultural identity • Acceptance towards cultural identity provides opportunities and support • Being positively represented
4. INTERACTIONS ARE IMPACTED BY CULTURAL IDENTITY	• Using shared cultural identity to relate, support and adapt • Racialisation impacts working relationships
5. BUFFERING FOR PSYCHOLOGICAL PROTECTION	• Supressing oneself and cultural identity • Solidarity in shared cultural experiences

5.1 THE COMPLEXITY AND CONTEXTUAL NATURE OF FMH SETTINGS

In this superordinate theme, there was a sense that participants believed that there is an inherent systemic challenge that comes with being a client, or staff member from a racialised minority background. Three subordinate themes arose: 'systemic racism and biases', 'the imbalance of racial representation' and 'whiteness in psychological services'. In the subordinate theme 'systemic racism and biases', participants share the nuances of being a racialised minority individual, particularly in their interactions with white majority clients and, the exchanges between white staff members and racialised minority clients. They reflect on the preconceptions and misconceptions that are perpetuated and share how they observe this through systemic processes.

The second subordinate theme 'the imbalance of racial representation', explores how participants observe disparity between the workforce and clients, but also within the staff population, between lower grade and managerial positions. They describe how this allows individuals to remain complicit in structures that uphold discrimination. Finally, participants emphasised the invisibility of racialised minority psychologists in FMH settings, and the 'white middle class' image that is the normative position within the profession. They reflect on the client population where it pertains to

those with specific diagnoses, and how this is likely to maintain structural racism.

5.1.1 Systemic racism and biases

Participants identified several accounts of systemic racism and bias when considering how racialised minority clients were treated and spoken about. Whilst working in an FMH setting, staff members are likely to be exposed to incidents of aggression and violence when providing care. However, the respondents identified that the perception of racialised minority clients are likely based on the challenging behaviour they display, and negative racial stereotypes. This was highlighted by Slyvia:

> *If there were problems within the patient's behaviour, or between the patients themselves, it was the minority person that would be ostracised, it's the minorities that would be the challenging ones. They're the ones that need to be put on increased observations, or have their daily needs taken from them. The others would get chance after chance after chance, and we couldn't say anything (Slyvia- Female, Health Care Assistant).*

> *…minorities would be labelled with schizophrenia, psychosis, things like that. […..] and for the black counterparts with schizophrenia and psychosis, it would be medication,*

medication, medication, restraints, medication, seclusion, medication (Slyvia).

Slylvia shared that racialised minority clients were responded to more harshly, and were more likely to be heavily restrained and medicated. Their psychiatric history and current behaviour could be framed in a way that creates racial bias, and Slyvia suggests that there is also systemic bias and cultural insensitivity at play. In considering the history of psychiatry and the institutional racism within the FMH setting, it is likely that structures of 'whiteness' within these services enable blame to be located in factors such as cultural beliefs and language barriers. This contributes to the complex interplay between racialised communities and FMH services, where system level practices perpetuate prejudicial attitudes and behaviours.

This is further supported by Patrice, who had an encounter with a white staff member in a meeting. She reflected on the use of stigmatising language, and how rather than combatting systemic problems that affect racialised minority individuals, there was a sense that the staff member was acting in a position of superiority or power:

…she would always call the black guys "gang members", because they were black. "Oh, you know, it's kind of like little boys finding themselves and you know, becoming men". And I was thinking, "they're not projects". And she said "no, I don't mean it like that". At first I'm like, she just wants to help. But

then I realised this is the 'white Saviour complex' that you are displaying amongst these guys, because you think that they come from a gang background (Patrice- Female, Programmes Facilitator).

Patrice seems to be pointing to the intersectionality between masculinity and race. Essed (1990) adopted the term 'gendered racism' sharing how the interaction between racism and sexism, produces experiences that are different from racism or sexism as separate entities. These experiences of racism are likely to be particularly salient to black men and are rooted in stereotypes. In her example, this type of microaggression conveys the assumption that black men are violent or dangerous, and thus she saw the importance of challenging this belief.

Odell reflected that systemic bias with racialised minority clients, can also be observed in how white majority individuals make sense of behaviour that is deemed natural to those from ethnic minority communities:

…particularly service users from a black, African Caribbean background, sometimes their communication style, can be interpreted as very aggressive. So I feel like I need to kind of question when people use the word 'aggression' to describe some of those behaviours, and I'm kind of more mindful to

think about, what exactly is aggressive about this? (Odell-Male, Senior Forensic Psychologist).

This highlights the visible and permanent difference of racialised minority clients, and how this can be associated with negative stereotypes that cause others to perpetuate stigma. Odell appears to highlight the dehumanisation that racialised minority individuals experience daily. He sheds light on the consequences of racialised minority individuals using their voice, and how this can lead to them being deemed as hyper visible and intimidating. It is possible that through his questioning of the word 'aggression', he is attempting to unpack the phenomenon of displaced blame (Jones & Norwood, 2016) and bias-filled interactions to capture evidence of micro-aggressive behaviour.

Systemic biases were also observed beyond the treatment of racialised minority clients, as they were noticed in management structures:

…if you look up the chain, and it's all white, it's not, it's not inclusive. I don't care if it's 70 or 80% women, it's still not inclusive. So when it comes to inclusiveness, there's a lot of work to be done (Patrice).

Destiny reflected on her own role and involvement in FMH settings. She places some of the responsibility on herself as a racialised

minority staff member, to be more vocal about systemic racism and to cultivate opportunities for action:

> *I'm thinking more about how I'm complicit in certain systems, because, you know there is an over representation of ethnic minority service users and different things have come up, and I'm just trying to be more responsible in some of those issues in terms of how our patients are seen and treated (Destiny-Female, Senior Forensic Psychologist).*

It was interesting to note how, Destiny also observed how racialised minority nurses have been complicit in contributing to possible prejudicial behaviour. While it is surprising that other racialised minority staff members contribute to the negative treatment of ethnic minority clients, in this case, it is likely that complicity was not exclusively related to unconscious negative beliefs and attitudes. It is possible that this was a by-product of the unjust systems and processes that already exist:

> *…the nurses are quite complicit you know even though they're, you know from ethnic minority groups. They sometimes don't treat the service users as well as they should. So yeah, and I think even just about our service users being "gang members" and how we stereotype them. That is perpetuated within the nursing team as well (Destiny).*

It is unclear as to whether the nurses believe the stereotype, or simply go along with majority behaviours without thinking. Perhaps there is an element of being able to justify this behaviour as acceptable, as they are also from racialised minority backgrounds and therefore, they may feel comfortable to use prejudicial language and behaviour consistent with those used by majority groups, without fear of repercussion. Alternatively, they may perpetuate the stereotypical beliefs and behaviour to be accepted within the majority group. While this has not been confirmed, by Destiny in her account. It is worth thinking about how racism operates across structural and interpersonal domains. She alludes to the idea that this should be considered across different domains in the work that is undertaken, to explore complicity and prejudice.

5.1.2 The imbalance of racial representation

Throughout participants narratives, they reflected on the extent to which different racial backgrounds are represented within the FMH environment. What was apparent in their accounts was the evidence of racial disparity between racialised minority frontline staff members and those in senior leadership positions:

> *So on the front line it is more diverse, but as you go up the ladder, you lose the diversity […..] I don't think we have any black consultants who are from black backgrounds (Alisha-Female, Psychosocial Therapist).*

Frontline staff are heavily based on BAME culture and background. But as you continue to look up, when we progress up the chain […..]it becomes very much white, and so the challenge in that is where do I fit in? (Patrice).

The above excerpts demonstrate the imbalance of racial representation between higher and lower grade positions. There was a real sense for all participants, that racialised minority individuals are significantly underrepresented at management levels. As this observation was noted by all participants, there could be a link between the negative experiences of racialised minority staff in FMH settings, and their organisation level or status; with lower paid racialised minority staff experiencing more challenges at work. While the reasons for systemic discrimination are complex, it could lead to disadvantages in being able to progress organisationally, or access key resources (see section 5.2.2). As such, inequity is likely to be perpetuated. Interestingly, Patrice appears to place the obligation on herself to 'fit in'. This could suggest that rather than desiring to expose structural racial disparities, she seeks to 'fit in' to it.

Participants identified that senior teams rarely represent the communities they serve and the staff they lead. Though it was also observed that the gap between lower grade racialised minority staff members, and clients was closer. This could encourage a more positive experience for racialised minority staff and clients, and

increase the likelihood that staff understand the needs of those being served. Ricardo identified that:

> *When I looked at the nursing teams on the ward, and I could see that it was a mixed bag, mixed bag of whites, Asian and people who are black, and other diverse ethnic backgrounds […..] I liked that, because I felt like that was like a true reflection of the clients that we have there (Ricardo- Male, Occupational Therapist Assistant).*

Although, some participants felt it important to highlight that disparity still exists between clients and staff members, where in some FMH services, the client population is predominantly white:

> *So I guess, when, when you've got a lot of staff who are from black and minority backgrounds, and then your patients are white so you can see quite a lot of racism going on […..] it's a bit difficult to pull them up on it, because most of the time it's quite subtle (Alisha).*

Racialised minority FMH staff members are uniquely positioned to understand and be able to work with challenging clients from majority white backgrounds, whilst enduring prejudicial treatment. When working with a majority white client population, it is possible that racialised minority staff members experience a higher level of racial discrimination. This is in comparison to their white counterparts, who

work with majority racialised minority clients, and may experience less discrimination.

5.1.3 Whiteness in psychological services

Participants shared that the demographic make-up of psychologists in FMH settings is disproportionately made up of white, middle-class females. Although racial inequalities in FMH are apparent, they described the dominance of eurocentrism in psychological services:

> *I think the main difficulty that I have probably found is working within the staff teams […..] particularly in psychology teams, which are overwhelmingly white (Nima- Female, Trainee Forensic Psychologist).*

> *I looked at the psychology team, and I just saw all white (Ricardo).*

Based on the above accounts, it appears as though being white is the normative position in psychological professions, and thus it is rarely challenged. Odell agreed and shared that he has noticed since becoming a qualified psychologist, there is less diversity in psychology teams:

> *I think that's very different to when you become qualified or enter the kind of psychology world where your colleagues are*

very different in terms of their ethnicity. A lot of times you work with white middle class women (Odell)

As a result of being one of the only racialised minority psychologists, and perhaps due to the historical context of the profession (see chapter one, section 1.5.3), Odell shared that he does not feel able to express his cultural identity. It may be that the dominance of white majority psychologists, causes him to feel more uncomfortable with expressing elements of his culture:

…in terms of the psychology environment, it sometimes feels like there aren't many opportunities to kind of express your cultural background or identity as much (Odell)

Nima and Slyvia considered the demographic make-up of clients who were under psychological services. They highlighted that those diagnosed with personality disorder, tended to be from white majority backgrounds, and suggested racialised minority clients are rarely diagnosed with personality disorder:

On the personality disorder ward, the service user population was very overwhelmingly white (Nima).

On the wards, which were mainly to […..] help support those with personality disorders they were mainly white (Slyvia).

According to research, personality disorder diagnoses tend to be more common among white clients. This is because many of the characteristics associated with personality disorder are contextualised and conceptualised in western norms (Najjarkakhaki & Ghane, 2021). Therefore, culture can be overlooked in the diagnosis process, causing those from racialised minority groups to be subject to other forms of diagnoses such as psychosis.

5.2 CULTURE PREVENTS STAFF PROGRESSION

The following theme refers to participants accounts of their career progression and the difficulties they experienced. Two subordinate themes were highlighted as part of this theme; 'lack of cultural sensitivity in FMH settings' and 'working harder to overcome barriers to progression'. Participants shared that in FMH settings, there is generally an inability to understand the nuances of different cultures, and a misunderstanding towards their dynamic values and beliefs. As such, participants reflect on how this can create an environment that lacks awareness, respect for cultures and has limited adaptability. They also report having to work harder than their white counterparts, as there are factors related to their culture that are likely to obstruct their career progression. Overall, their accounts highlight the interplay between cultural identity and structural barriers, which can create discrimination or other forms of inequity.

5.2.1 Lack of cultural sensitivity in FMH settings

This theme describes participants experiences of observing limited cultural sensitivity in their interactions with others in FMH settings. Some participants shared how in their exchanges and communication with their white majority peers, their cultural nuances were often misinterpreted or misunderstood:

> *…you know that was really stressful for me because from a cultural perspective, she didn't really understand me and how I operated so she thought that […..] I just came across as rude (Destiny).*

Although destiny did not explain how she operated and what she felt people did not see, it captures the assumption that participants feel as though they cannot bring part of their cultural identity into the workplace, without having to compromise. This is likely to make it difficult for participants to bring their cultural identity into the FMH environment, due to potential fear of being judged, or not being able to connect with other staff members. It may also create the expectation that elements of their cultural identity will be perceived negatively or misread.

On a system level, Nima and Ricardo reflected on the lack of cultural sensitivity where it pertains to psychological treatment, and general practice. They expressed how participants were likely disadvantaged in their ability to access elements of the service, due to their cultural

differences. It appears that culturally competent practice was not completely embedded within the FMH environments they worked in. This likely intensified the responsibility racialised minority professionals felt, to ensure racialised minority clients can access appropriate treatments and interventions:

> *I think a lot of treatments are not culturally sensitive, and there's no one there to adapt them, so it's not great […..] in the context of the South Asian community, there is such a stigma with mental health, they are less likely to talk to people or reach out to the family because the family are actually going to perpetuate the problem more so. It's almost like, they are imposed with these white standards of treatment. Then people from those backgrounds aren't really going to meet it and then they are kind of penalised for it (Nima).*

Nima highlights the nature of systemic racism in relation to treatments, which she states tend to be Eurocentric or infused with Western norms. In her example, it demonstrates how 'majority thinking' inadvertently puts those from racialised minority backgrounds at a disadvantage. It may be that this exacerbates anxiety around help-seeking for clients who feel their culture is not understood. As such, systems of care may not be as effective, as they are not culturally relevant or informed. With the lack of cultural adaptation, ethnic disparities, stigma and inequity are likely to be maintained.

5.2.2 Working harder to overcome barriers to progression

This theme describes participants accounts of the systemic obstacles that hinder them from advancing in their careers. Through their narratives, they recount the conflict they experienced which limited their access to further opportunities to progress. Raj expressed how racialised minority professionals are given unequal opportunities. He highlights the challenge of not being viewed as someone who is deserving of opportunities:

> *There needs to be more opportunities for minorities to climb up that ladder and feel supported […..] sometimes I don't get opportunities because other staff might be in a clique, so they get seconded to higher positions quicker whereas I have to go through the whole process. I feel like I'm jumping through hoops that are on fire […..] when I first came I had to try really hard. It took me over a year to become ok with service users and staff (Raj- Male, Occupational Therapist).*

Patrice shared similar sentiments in that like Raj, her perception of how she views her career development, is rooted in how much discrimination exists, and how this can be an obstacle. She explores the idea that needing to work harder is inevitable because of her ethnicity:

> *because of the colour of my skin, there's already a certain limit, or bias that's been placed on me in comparison to my white colleagues. So I always made sure that when I did the work, I did it 20 out of 10. So you cannot fault me […..] It comes with me having to work twice or three times as hard as my colleagues simply because I know the odds are against me already (Patrice).*

Patrice shares that she is automatically at a disadvantage compared to her white colleagues. This is supported by the CRT which exposes how racialised minority individuals are economically, educationally and socially excluded from opportunities to advance. Her awareness means that for her skills to be recognised she must work harder, although she was not explicit in what she had to do. This may be due to the expectation that she will be scrutinised more than her white colleagues, as mentioned by participants in chapter four. Inherent in her ethnicity was the feeling that there was a lack of transparent objective selection. The subtlety of the discriminatory behaviour or situation likely makes it more challenging to pinpoint specific race-related or prejudicial associations. This could leave Patrice and other staff feeling powerless and less likely to respond to their observations. Furthermore, as a black female, she may enter certain experiences in the workplace with some racial anxiety and hostility, based on her perceived loss of social power.

For Odell, he shared that he had to prove himself beyond what is typically expected of employees. He links cultural identity to professional competency, sharing that there is an expectation that he must prove his intellectual value:

> *I feel like sometimes […..] you might feel like you have to prove your point a bit more or work a bit harder […..] you might feel like you're being judged in a way, or needing to prove yourself a bit more because you're from a certain background […..] It's like, if I was white, for example, I don't think somebody may question some of the decisions or kind of the key points that I do make. Which is fine for people to ask questions, I have no issues with people asking questions in that sense. But it is quite interesting that if came from a different person, a white person, then it would be viewed very differently (Odell).*

It is possible that racialised minority FMH staff could feel unable to freely voice any criticism of their management or employer, as they are expected to show gratitude for the opportunities afforded to them, rather than being recognised for their work and readiness for more opportunities. Destiny demonstrates this as she describes the process of obtaining a leadership position:

> *…we had to do a presentation for the CEO of the trust, and different members of the board and I'm like, we are the ethnic minority people performing to prove our worth, you know to*

prove that we're good enough to have leadership positions. Even though it's a good thing in theory, we just have to work hard all the time (Destiny).

'Working harder', proving oneself or high effort could be a form of stereotype management, as a response to the ongoing interplay between everyday discrimination and systemic racism in FMH environments. This could foster success and a constant state of awareness that being from a racialised minority background is marked with inferiority, thus cultivating a drive to prove stereotypes wrong. It is important to note that from the data, participants did not unpack what made them feel as though they had to work harder, this could be an area for future research.

5.3 REDUCING INEQUALITY BY CHANGING THE NARRATIVE

This superordinate theme describes how participants considered ways in which equal opportunity can be obtained, by altering how racialised minority individuals are understood and perceived in FMH settings. This theme comprised of three subordinate themes; 'directly addressing discrimination and cultural identity', 'acceptance towards cultural identity provides opportunities and support' and 'being positively represented'. The first subordinate theme signifies how participants respond to discrimination by being straightforward and explicit in their methods of challenging, addressing and educating others on prejudicial matters. The second subordinate theme

highlights how after addressing issues relating to their cultural identity or culture more broadly, they feel listened to, supported and respected, both at an individual and system level. In the final subordinate theme, the importance of the positive portrayal of racialised minority individuals is shared. Participants highlight the significance of this for specific cultural communities, and emphasise the importance of positive representation where it pertains to removing stereotypes within the FMH field.

5.3.1 Directly addressing discrimination and cultural identity

Working in FMH settings exposes staff members to individuals who are mentally unwell, and those who have various challenges. Some with their interpersonal relationships. While participants understood that they have a duty of care to clients, Raj and Alisha shared that they were able to respond to racialised statements and discrimination, by confronting this matter in an assertive but kind manner:

> *I respond positively. I feel like some of the lads here […..] overplay on their mental health because they don't have it easy. But I also respond to them by saying 'look that's not on, if it [being racist] offends me, it's going to offend someone else'. We might also discuss it in MDT meetings (Raj).*

> *I challenged the patient in that moment, it [racist remark] didn't sit well with him though […..] I think because of how the*

patient is, it took him about a year to talk to me because challenged him, he was avoiding me (Alisha).

It appears there was an understanding that by addressing racism, this might impact their therapeutic relationship with the client, but this did not discourage them from doing so. It is also possible that the racial attitudes expressed by clients are illustrative of wider structural racism that is reinforced by attitudes and other practices.

For Destiny, she felt that it was important to professionally educate her employees, and remind them of what constitutes to discrimination. There was a sense that she was committed to her cultural values and views on equity, diversity and inclusion, by communicating this with those in senior positions:

I care less about making other people comfortable […..] I still try to speak in a way that people can understand me. But I think more and more now, I say what I say. I send emails to the lead psychologist and, try to get people to be accountable […..] I'm trying to be vocal and hold everybody accountable […..]to call it out, when I hear it, when I see it (Destiny).

Holding people accountable seemed to be important to Destiny, as a means of supporting others to recognise and address discrimination and prejudice towards racialised minority FMH staff. What may be uncovered here is how participants try and hold the balance between

their cultural and professional identities. These intersecting identities likely guide how they respond to discrimination within the FMH setting.

Ricardo also believed that people should be held accountable and educated:

> *I'm a person who will correct someone if they're saying the wrong thing, or if you start talking about black people, and you have no idea of what you are talking about, especially if you're if you're conducting this in an open space, someone like me is gonna pull you up. I probably won't do it in a rude way, but I'll do it in an educated way (Ricardo).*

Interestingly, the term 'being vocal' was evident in different participants narratives. Odell shared:

> *I don't allow that to happen anymore. So if I do feel disrespected, I will raise it, I will say something, I'll bring it to supervision, or I'll just talk to that person directly and say, "I feel disrespected", or "I don't think that was okay […..] I will make sure that people are aware of it […..] so I think I'm a lot more vocal now […..] it's about having that on the agenda and people being open to the idea of discussing issues that affect BMEs (Odell).*

There is a sense that participants feel responsible to challenge and publicly call out inequity and discrimination. This is particularly noteworthy given that in chapter four, participants shared how they were silenced, encountered resistance or discouraged when speaking up against these matters. Despite the potential negative outcomes of being vocal, participants did not seem to internalise these experiences, or be adversely affected by these barriers, to the extent that it prevented them from addressing discrimination.

5.3.2 Acceptance towards cultural identity provides opportunities and support

Participants shared that despite systemic prejudice and discrimination, FMH settings have gradually become more inclusive and open to understanding and learning about cultural differences. Becoming more culturally competent in FMH services was clearly important to participants. Iman commented on how he appreciated his culture being recognised more widely within the environment, with acknowledgement being given to cultural traditions and practices:

> *…every week, they have this thing called 'culture and roots'. There was a day they did a session on my country, because the patient on the ward wanted to talk about Iran and stuff. So they made Iranian food, put Iranian videos on, historical stuff, so it was quite good […..] they're trying their best trying to*

[…..] meet our understanding and try and help us have a better environment (Iman- Male, Health Care Assistant).

Destiny reflected on the inclusivity of the FMH setting she works in. She highlights the importance of needing to raise cultural-related matters, to educate and increase understanding, and the positive impact this has had within the service:

…I think more and more the service is trying to be more inclusive […..] I think, the more I say or the more I get involved, is the more people want to do anti-racist work and understand other cultures more (Destiny).

Although discussions around 'race' and culture have the potential to be sensitive moments, it indicated that some progress is being made, and the opportunities to discuss these matters are becoming more frequent. There is a sense from Destiny, that being vocal about discrimination and inclusivity helps to dismantle the scaffolding of systemic racism. Her account also captures the view that becoming anti-racist is a lifelong journey that is difficult within the context of structural inequalities. However, Justin highlights how in his FMH service, there is openness and acceptance towards addressing cultural difference:

we're quite open to change, open to discussions. I feel that everyone has the opportunity to raise their voice for change to

happen […..] everyone is listened to and all ideas are taken on board and taken seriously (Justin- Male, Occupational Therapist).

While FMH settings are open to discussions about culture, Ricardo shared that to do so, seeking support with other racialised minority individuals was important. The assumption is that those who share similar cultural identities, would be better able to understand and validate shared experiences:

I'm part of the BAME network within the trust. So that's helped a lot because I was able to be around people who have had similar experiences, or I shared the same vision, or the same principles of the best way forward for everyone (Ricardo).

5.3.3 Being positively represented

Accounts from participants highlighted that positive representation of racialised minority FMH professionals was significant to their experiences within the workplace. There are likely various reasons as to why this is important to racialised minority staff. It may be because they aim to deconstruct negative stereotypes of those from ethnic minority communities, or create opportunities for those from underrepresented communities. Raj indicated that having a diverse team of professionals provides him with encouragement:

For example, in my MDT, we have people of Caribbean backgrounds and this is quite good. It provides me with support and has provided other people with support where we can use our collective experiences (Raj).

Ricardo supported this view by sharing that he has noticed his team gradually become more diverse, and well represented with those from different ethnic minority groups:

…the assistant psychologists are dominated by people of colour now. And then when I look in O.T, I see two Asian band five O.T's, and then I see me and another black colleague. So it's a vast improvement […..] you can see that there's been an effort to have a wider range of ethnicity in the teams (Ricardo).

For others, while positive representation was important, there was also an emphasis on the sense of responsibility held individually, to positively represent their cultural communities, with the view that it could influence others. The desire to be a positive representation was important to Patrice and other participants. This may be rooted in wanting to manage negative stereotypes and biases:

I want to represent the black community well, every time a black offender sees me (Patrice).

Patrice continued to point out the need for others to observe racialised minority individuals in a positive light. In her account, she implies that the aim is for both her community and others who are from white majority backgrounds, to observe the value and importance she places on her cultural heritage and identity. In her narrative, she also explores the desire to understand other perspectives towards culture, and equally the need to educate others:

> *So if I'm walking in, I want you to know that we are very pro black, we are very much in support of our heritage, our culture, things like that. it's not changed […..] You get to kind of teach people about your background, your heritage, your country, you show them to a different way of thinking. A lot of people in the Western countries think that in Africa, we all live in huts and villages […..] so you just get to educate them to say we are more than this. So it is an opportunity to have conversations, and it's also an opportunity to understand why they think the way they way they think (Patrice).*

It is possible that the accounts of wanting to be positively represented, also derive from seeking to regain feelings of confidence, which may have been lost from experiencing racial discrimination, and other prejudicial encounters within the FMH environment.

5.4 INTERACTIONS ARE IMPACTED BY CULTURAL IDENTITY

This superordinate theme reflects the resources, strengths and skills racialised minority FMH staff draw on in their professional roles. Many of the participants were able to use their shared racial status to connect relationally with clients, by bringing elements of their ethnicity into the professional space. They explored how this aids culturally attuned practice and interactions with clients, whilst holding onto both their cultural and professional identities. They reflected on the importance and value in this resource, and how it enables them to bring different perspectives to educate the wider workforce. Although, while they identified how cultural identity is used to connect with clients, they shared how white majority clients used racialised minority staff members ethnicity to assign negative racial connotations, and stereotype different cultural communities. As such, they referred to being singled out and experiencing racism based on their ethnicity. They suggest how this impacts their professional relationships with clients.

5.4.1 Using shared cultural identity to relate, support and adapt

Within the FMH environment, the likelihood of there being cultural barriers while providing and receiving care is possible. There are many hurdles that can affect the provision of culturally competent care. However, participants shared how they have been able to relate and support clients through shared cultural identity:

…when it comes to planning interventions, I find things like colouring and writing very tedious, if I'm a 25-year-old British Pakistani, why do I want to colour an easter egg? With all due respect, it's not me. I'm into cars, trainers and relating it to the service users. I said "let's do a group called crep check" where we check in on the new trainers, discuss what trainers they have and just have banter (Raj).

…I will speak the same language as the service user. So it could be that I talk a bit of street talk, a bit of slang, patois. Or I might make references to words in different languages. Like, I could greet someone by saying 'hello' in Zimbabwean. I keep it real with the service users and I try to be streetwise around them (Ricardo).

Both Ricardo and Raj spoke about the methods they use to be relatable and adapt service provision based on the client's cultural needs. In Ricardo's account, he drew on his ability to speak different languages, and shared the importance of language concordant communication. As Ricardo and the client were able to communicate with each other in a similar language, it may have improved the clients experience, increased their wellbeing and helped them feel listened to. There is a parallel here between how racialised minority clients and staff both view and value connecting with others using their shared cultural identity. It could be that Ricardo sees it important to relate with clients culturally, given the significance of

this in his own experiences. As this is fundamental to his interpersonal relationships with others, he may subconsciously seek to replicate this.

As well as through language, Ricardo also shared the versatility that comes with being a racialised minority FMH staff member. In his commentary he explores how he connects with the client through cooking cultural foods:

> *I was working with someone who is of an ethnic minority background. He said he wants to cook food that his mum used to make. When we started cooking the Ackee and Saltfish and rice, the guy just started opening up. I was thinking, I didn't even think that you could talk like this. So it's those small differences that we can make that can change, or have an effect on someone's life (Ricardo).*

Ricardo's experience demonstrates the effectiveness of cultural relatedness, and how this can enhance the clients experience of care within the FMH setting. Other participants agreed that they were able to use their culture as a resource in their therapeutic relationships. Some participants spoke about the idea that by simply being a professional that looks like them, it can encourage them to feel safe and supported:

…he was like, 'Oh my gosh, I've never worked with black psychologists before'. And I worked with one young person […..] who was half Jamaican. And he was so happy he was basically bouncing off the walls when he found out that he was working with a Jamaican psychologist. So in that way it's really nice to see how patients react, especially because they're overrepresented. And they don't really interact with senior professionals, who look like them so that's nice and yeah so I embraced it, you know, I think I bring it into everything that I do. (Destiny).

…being from a BME background can sometimes help some of the relationships and build the therapeutic rapport with service users […..] sometimes service users may feel that I may be able to understand them a bit better, if they think that I'm from a similar background (Odell).

Destiny and Odell seemed to feel at ease with connecting based on visible similarities. They reflected on the impact and personal value of this positive relationship for the client.

Other participants considered the idea of having an 'unspoken understanding' with other people from racialised minority backgrounds. In particular, Nima shared that she valued having a supervisor from a racialised minority background as she can be more culturally attuned in her interactions:

I've definitely found a difference when I had a supervisor from a minority background, erm… I felt like I was more able to talk comfortably about that, because they had their own understanding of it. But I think definitely when I've had white supervisors, they kind of, they don't really get it (Nima).

The above excerpts demonstrate how staff were confident in using their shared cultural identity in an environment that may not be culturally responsive. Participants appeared to subconsciously and naturally connect with racialised minority clients given their shared racial status, and this had positive outcomes for the client.

5.4.2 Racialisation impacts working relationships

While cultural identity can positively influence the interactions racialised minority staff have with others within the environment, the negative effects of everyday discriminatory experiences are also likely to impact their relationships. Destiny shared her thoughts on how building a relationship with a client who has been discriminatory can be difficult:

…for somebody from a minority background […..] you feel like you can't build any sort of trusting relationship with that service user, or you just don't want to help them, you're like well you stay here in your misery […..] In that sense, it did affect some of the relationships that I have (Destiny).

Her experience of interacting with clients from white majority backgrounds, invokes a sense of how hard this was for her. She describes there almost being a barrier to connecting with those who have displayed prejudicial behaviour. Other accounts echo this view and reference how uncomfortable they were with having to work with, and provide care for clients who can be discriminatory:

> *I think mainly it's because of the client group really. Because I know that it's not going to be pleasant, they're not going to make it easy for me (Alisha).*

> *It's just not nice you have to sit with someone who has said all of this horrible stuff to you, and most of the time as well, because of the nature of it, you know you're not gonna get an apology really (Nima).*

Alisha and Nima seemed to share the belief that as a staff member, they have a responsibility to work with clients who display this behaviour, despite the possibility that this will not be challenged by others in the environment. There is the view that culturally discriminatory behaviour is accepted or overlooked by other staff. This acceptance might be linked to attributing their behaviour to their psychological difficulties, as opposed to impact of systemic racism:

But I've been on the ward and heard service users call staff, "black bastard, the black nigger" and the service user, not even being supported to apologise to that person they were targeting (Ricardo).

Working in FMH environments exposes racialised minority staff members to clients who have various difficulties. However, there appears to be a lack of expectation around other colleagues supporting them when they experience negative racially motivated interactions. This could be a source of stress for racialised minority FMH professionals, and it is likely to have a strong impact on various areas of their lives and wellbeing.

5.5 BUFFERING FOR PSYCHOLOGICAL PROTECTION

The final superordinate theme uncovered participants experiences of protective buffering. In their narratives they described the methods they use to protect themselves from the negative experiences they endure. This theme captures the subordinate themes of 'supressing oneself and cultural identity', and 'finding solidarity in shared cultural experiences'. The first subordinate theme highlights how racialised minority FMH staff dampen down and reduce elements of their cultural identity. This was with the aim of protecting themselves from racial stereotyping and the negative treatment that may come with being a racialised minority staff member. The second subordinate theme focuses on how participants describe feeling safe, supported and more comfortable when they share experiences with other

racialised minority individuals. They reflect on the value of this, as they have meaningful conversations about their cultural identity, and feel a sense of belonging with those who have a similar background. This may buffer against the adverse effects of negative events that occur in FMH settings.

5.5.1 Supressing oneself and cultural identity

Although participants have expressed the challenges of negotiating between their professional and cultural identities, they also reflect on the need to supress their cultural identity, as a form of psychological protection against the difficulties of working in the FMH environment:

> *I supress that part of me and downplay it, in order to not get a lot of grief […..] I probably held back more […..] I think there is still an element of holding back a little bit (Nima).*

> *I would either get asked a lot of questions. Like "why are you doing this? Is that professional? Should you be speaking like that?" I think it would be either that, or I would be just immediately written off as being unprofessional. So I would say that I definitely have to tame things down in order to fit in or seen as being accepted so to speak (Slyvia).*

From the above accounts it is possible that supressing their identity is with the aim of reducing the frequency and severity of racialised comments. Withholding elements of their cultural identity may draw

less attention to themselves, which could prevent being exposed to discrimination and thus becoming too emotionally overwhelmed and impacted by negative experiences.

In Raj's explanation it appears that he somewhat related being 'overly professional' to the conscious effort to blend in with other professionals, by supressing elements of his culture. Although Raj did not define what it means to be 'professional', he referred to being 'quite formal' and 'using jargon terms'. It could be that this forms part of his perception of 'professionalism', which may be determined by the behaviour of majority white individuals:

> *I felt like I negated away from my cultural identity as a Pakistani. So, I'd be quite formal and professional, but overly professional, using jargon terms because that's what I was seeing other members of the O.T team doing […..] For example when a service user first fist bumped me, I remember I just said 'are you alright?'. But now if they fist bump me, I do fist bump them back (Raj).*

It is unclear as to whether Raj consciously made attempts to wipe away any trace of his cultural identity, by being 'too professional'. He implies that he felt less of himself if he had to be professional. Raj may have been attempting to 'fit in' with his work peers, and as such could have felt as though he had to supress his cultural identity to be a 'professional'. What is interesting here is that from Raj's

perspective, it seems as though professionalism and cultural identity cannot coexist.

Slyvia, Odell and Patrice also shared their views on concealing parts of their cultural identity. They explore the perspective that dimming the expression of their culture tends to be subconscious:

> *…unconsciously, I'd make more of an effort of […..] sadly subduing it at times, just so that […..] it's not in their faces too much. So I'm conscious about that, do I need to sort of subdue myself in a way or form? Even if it's something so little, like, my accent or my hair? And I unconsciously do that, unfortunately (Slyvia).*

> *I feel like sometimes I might need to change my behaviour or the way I talk in order to fit in […..] I do find I feel the need to talk differently […..] in a way that […..] people would kind of respond better to me. I'm mindful of that and I need to kind of be aware of when that happens, and not to do that (Odell).*

> *…it's about learning how to bite your tongue. Keeping certain opinions to yourself, or maybe restructuring the opinion, so it doesn't sound as aggressive as they would like to say (Patrice).*

Although Slyvia attributed the changes she made as 'little', it highlights the extent to which participants feel they need to dim

elements of their culture to reduce how much they stand out. It could be inferred that by making 'race' and culture less visible, this could help participants navigate the environment more easily, by only having to align with their professional identity. It also ensures that their work and personal worlds do not intersect. Odell mentioned the idea that other professionals may respond better to him if he changes how he behaves, although he did not provide any examples of the type of behaviour.

Other participants shared that they supress their identity because they do not want to make others feel uncomfortable, nor do they want to feel uncomfortable themselves:

> *We don't want to make white people uncomfortable, so we just kind of go with the times and also it's exhausting […..] I have to speak a certain way so that people understand me (Destiny).*

> *I might not be comfortable. I'm probably more inclined to behave in a way that is much more westernised when I'm at work (Alisha).*

Alisha also makes an interesting point, in that she is mindful of how she presents herself in the FMH environment, as this prevents further judgement. She may be concerned with ensuring she does not live up to negative racial stereotypes. Thus, by suppressing elements of her cultural identity, she has some control over how racialised

minority individuals are perceived, whilst also protecting herself from negative encounters:

> *…we need to put more thought into how we present ourself. I think this is because we are worried that because of the colour of our skin, they might not see us for who we truly are […..] so we put in that extra effort, more than our white counterparts (Alisha).*

5.5.2 Solidarity in shared cultural experiences

By way of buffering for protection, participants identified that connecting with their colleagues from similar ethnic backgrounds, was important in being able to manage the everyday challenges of the FMH environment.

In Nima's response, she suggested that she felt uncomfortable when speaking to her colleagues from white majority backgrounds, as there is an assumption that they may lack understanding. She shared how she seeks connections with racialised minority colleagues as a source of support:

> *…there's just something about the differences and the challenges when you come from a minority background that others just won't get […..] you're more comfortable talking about that experience with people from minorities rather than from white backgrounds […..] I think we all somehow banded*

together, and it was a nice bit of support in the workplace […..] will talk to me about things that are unique to our experience (Nima).

Talking to racialised minority colleagues enabled her to share her experiences more freely. There was a sense of camaraderie that led to recognition among her peers about the uniqueness of being a racialised minority in an FMH setting. This sense of 'togetherness' and being able to relate, was a significant aspect of their daily work lives. This was also encountered by Justin and Raj:

…there's some sort of connected, feeling, which I can't explain […..] it's a comfort feeling (Justin).

There are some people from minority backgrounds in psychology and on the wards. There is some level of belonging and relatability there where we have banter and that mutual understanding. Even just having a space to vent to others from minority group is helpful (Raj).

Raj mentioned the importance of having a space to offload, with the idea that 'venting' or expressing feelings about negative experiences, is an important part of being able to manage, or buffer against day-to-day negative encounters. It is also likely that the collective experience of discrimination, also helps share emotions whilst vicariously relating with others:

I think there's a lot of shared experiences. I think that's really important, the shared experiences of discrimination, prejudice in the environment […..] discrimination occurs at every level, every professional, different seniority grades, I think you have a sense of belonging or there's some sort of shared experience (Odell).

For Slyvia, there were moments where she did not feel as though she had to 'switch off' her ethnicity, and thus there was a sense of freedom and ease in being her true self:

…if I am around others, who I relate to more in terms of my culture […..] it's as though there isn't any need of consciously thinking, 'do I have to behave a certain way?' […..] that was like the only saving grace of those jobs. You know, you'd always be looking forward to having shifts with certain people, because your shifts would be easier (Slyvia).

While solidary and support created openness and buffering against difficulties in the workplace, Raj commented on the importance of racial connectedness for work related discussions and understanding:

…in my MDT, we have people from Caribbean backgrounds […..] it provides me with support and has provided other people with support where we can use our collective

experiences […..] sometimes if we're talking about service users, we don't have to explain in as much detail because most times we're understanding of each other […..] (Raj).

Given the challenges of working in an FMH setting and the desire to connect with other staff members in the work environment, Raj reflects on the decision he made to have a supervisor from a racialised minority background:

That's why I changed one of my supervisors to someone who is from an ethnic minority background so that we can have these conversations […..] I feel by doing that, it has been a lot more comforting because we have shared experiences (Raj).

It is likely that there is natural willingness to discuss racial similarities, and initiate dialogues on racial diversity and the various dynamics and challenges of working in the FMH environment. Therefore, while it provides a level of comfort, it may also result in more effective supervision of racialised minority individuals.

As mentioned previously, the feeling of being 'othered' can be heightened in FMH settings. Therefore, it would appear there is a limit to what racialised minority staff can discuss with their colleagues, perhaps fostering a level of exclusion or feeling uncomfortable. For instance, racialised minority staff may be able to have work related conversations, but culturally bound topics may only be broached with

their racialised minority colleagues. This was reflected in Slyvia and Odell's quotes:

> *A similar sense of humour helps a lot, having things in common, being able to have everyday chats, laugh about things that, you know, your colleagues would also find funny, we also understand. When it would be like our lunchtime, sharing food with each other. The staff room would be a safe space for us to relax and enjoy each other's company […..] So for us minorities, we have to stick together and support each other (Slyvia).*

> *in terms of kind of making jokes or kind of having banter with somebody, or just being a bit more...I think I can have a bit more of a joke, and I feel more comfortable […..] I think possibly, it's a mutual understanding. I think, a lot of the time […..] in terms of BME background […..] the humours quite similar (Odell).*

For racialised minority professionals, feeling relaxed, understood and being able to communicate through cultural nuances and linguistic similarities, are an important aspect of their work lives. It is possible that racialised minority staff members would not have a safe space to feel validated and seen, if not for the opportunity to connect with their colleagues from ethnic minority backgrounds. Moreover, from participants narratives, it appears as there is little protection for those

who are discriminated against in FMH settings. Therefore, through their own approaches, they buffered against the psycho-emotional effects of working in FMH environments.

5.6 Chapter five discussion

5.6.1 Overview of chapter five

Entwined in their individual encounters of working in FMH settings, chapter five aimed to explore the systemic level experiences of racialised minority staff in FMH settings, focusing mainly on racialisation, discrimination and prejudice. It also aimed to discover what psychological impact their experiences of racialisation and discrimination had on them, and their ability to serve in this setting.

Participants shared both their own and client's experiences of systemic racism. These experiences included: being labelled as challenging or aggressive, lack of racial diversity and representation in senior positions, needing to work harder to progress and the Eurocentrism of psychological services. Many of the examples provided by participants could appear less obvious to those who rarely experience marginalisation (white majority groups).

From a CRT perspective, it is acknowledged that systemic racism goes beyond the explicit, surface level expressions of discrimination, and is deeply rooted in the social structures and networks of institutions (Singer, Weems & Garner, 2017). As such, participants insinuate that the structure of FMH settings are designed to disadvantage

marginalised groups. Although interestingly, it was observed that some racialised minority nurses became complicit in contributing to possible prejudicial behaviour in their interactions and treatment of racialised minority clients. While this behaviour may be unconscious, it demonstrates how structural racism can be influential, and permeate individuals causing them to behave similarly to the majority group. Participants also noticed a lack of racial representation between higher and lower grade positions, emphasising how these structures could allow the expression of discriminatory tendencies, which may reinforce a feeling of inadequacy among racialised minority staff.

In relation to the psychological impact this had on racialised minority staff members, some participants stated that working within the environment became stressful as they felt culturally misunderstood and this led them to struggle to develop professional relationships with both clients and other staff members. Some participants felt uncomfortable by this, and as a by-product, they worked harder to prove themselves and their intellectual ability. They had a desire to seek support from those who share similar cultural identities, as there was an assumption that someone from a racialised minority background would be better able to understand, by virtue of shared racial status. This seemed to protect them from negative experiences and provided them with a safe space in which to have meaningful dialogue whilst feeling validated.

5.6.2 Interconnection between individual and systemic factors

Individual and systemic level experiences of racialisation and discrimination cannot be viewed without acknowledging the relationship between the two. Although it is acknowledged that individuals are responsible for their own behaviours, thoughts, and actions, the structures, policies and practices of institutions and systems can also have an influence on how individuals are likely to interact with others (Banaji, Fiske & Massey, 2021).

It is often that individual and interpersonal interactions, bridge the gap between systemic level demonstrations of racialisation. Implicit bias or prejudicial behaviour towards individuals, can result from existing in an environment that is immersed in systemic racism (Payne & Hannay, 2021). Therefore, how individuals interact with each other, can be linked to cultural habits and social norms, many of which are shaped by societal structures and procedures. According to CRT, these structures are inherently discriminative and entrenched in deep rooted systemic oppression. As such, the institutional and societal systems can create bias in individuals and racialised interactions, resulting in systemic racism (Banaji, Fiske & Massey, 2021). Therefore, it can be difficult to distinguish, what is systemic and what is an individual level experience, given that the two are so closely intertwined.

This was observed throughout chapters four and five, where some participants experiences could be viewed through both an individual

and systemic lens. For example, in chapter four, section 4.1.1, in the subtheme 'covert and overt discrimination', a participant stated she experienced more scrutiny. This led her to feeling as though she was not operating on a 'level playing field'. While this impacted her at an individual level, this could also be interpreted through a systemic lens. As CRT states that racism is part of the structure of society and the everyday interactions. This would suggest that racialised minorities have not been afforded the opportunity to be viewed as equal, or be placed on a 'level playing field', due to the inequity in the structures and systems that exist. Another example can be found in chapter four, section 4.5.1, in the subtheme 'minimising, dismissing or excusing discrimination in FMH settings'. Participants shared experiencing 'silence' when discussing race-based issues, particularly from individuals in senior positions. While participants encountered this 'silence' through their interpersonal interactions with colleagues, the 'silence' could also reflect the perspective of the wider system in that it did not acknowledge race-based matters.

The following examples, demonstrate how discrimination and racialisation are perpetuated and reinforced at both systemic and individual levels, and how at both levels there is an interplay between the two. For racialised minority groups, any perceived individual level discrimination could link to the systems and structures that exist which perpetuate inequity (see CRT), making it more likely for individuals to be racialised. The intwined nature of individual and

systemic level experiences can be seen throughout participants accounts in chapters four and five.

5.6.3 Discussion of findings links to theoretical framework

As established from the identified themes in both chapters four and five, participants described several individual related and systemic-level issues when exploring their experiences as racialised minority professionals working in FMH settings.

Most participants shared in their individual experiences of race-based issues and awareness towards the natural dominance of white majority groups, a responsibility to represent those from similar cultural backgrounds. This meant that some participants spoke out about matters relating to discrimination or difference, despite often being the only representative of the marginalised group. This aligns with CRT perspective which suggests that those who have been racially oppressed, have the experiential knowledge needed to communicate the challenges they have faced. This is because racial issues are a normal part of their thinking (Masko, 2005). However, speaking about 'race' and culture came with its own challenges. Participants encountered resistance, minimisation and avoidance from others due to exposing negative race-related experiences, thus exacerbating and perpetuating the permanence of their difference. As a result of these challenges, participants shared how they developed strategies to cope, such as avoidance of interactions, maintaining boundaries and detachment from the work environment. Although,

despite having developed strategies, their experiences still took an emotional toll on their wellbeing, with feelings of powerless and hopelessness.

In considering cultural identity, almost all participants talked about the importance of their cultural identity and how they display this in FMH settings. The salience of their cultural identity was experienced as being more fluid and contextual, depending on who they were with, and how comfortable they felt about emphasising aspects of their identity. For example, participants tended to express different elements of themselves, including more of their cultural identity, when in the presence of those from similar cultures, compared to their white peers. Other participants felt they had to sacrifice their cultural identity to assimilate to the majority group, be perceived as more 'professional', and protect themselves from further racialisation and stereotyping.

This highlights the intersectionality of identities from a CRT perspective (Arriola, 1994). For some participants, combining both their cultural and professional identity was a continual process linked to deciding what would be deemed 'acceptable'. This concept suggests that 'professionalism' and cultural identity are viewed as mutually exclusive. Therefore, participants may experience a fragmented self of self as they navigate this dilemma, resulting in a fusion of identities to relate with both minority and majority groups (Abbey & Falmagne, 2008).

From a systemic perspective, the CRT and literature on systemic racism explore how it is possible that Eurocentric organisations, are structured and designed to privilege white majority groups, at the expense of ethnic minority groups (Singer, Weems & Garner, 2017). According to the CRT, 'whiteness' as an ideology underpins organisations and institutions, which can strongly influence how white majority groups think and behave in such organisations (Singer, Weems & Garner, 2017). If this is true for FMH settings, it is likely that the environment is based on western orientations. Therefore, as cited by participants, there is a lack of cultural sensitivity. Their accounts described how cultural nuances were misunderstood, and psychological treatment for clients was not culturally informed, as they typically promoted European values and interests.

The findings in chapters four and five highlight the importance for FMH settings to consider the impact of the experiences on racialised minority professionals. The next chapter will discuss the findings and their implications in more depth.

CHAPTER 6 – General Discussion

Chapter six overview

This chapter begins by considering the findings of the qualitative research, specifically the main aim which explored racialised minority participants experiences of working in FMH settings. The findings are examined in relation to the systematic review results (see Chapter 2), the qualitative study research questions and findings (see Chapters 4 and 5), previous literature and relevant theories to highlight contributions made by the research. The chapter then explores recommendations for future research, policy and research implications, and the final section highlights the strengths and limitations of the research.

6.1 The findings in relation to the research questions and existing literature

Four main research questions were posed as part of the qualitative research study. Each question will be considered in the discussion:

1. What are the individual experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

2. What are the individual lived experiences of processing and managing cultural identity within FMH settings?

3. What are the systemic level experiences of racialisation and discrimination for racialised minority staff members within FMH settings?

4. What psychological impact does the experiences of racialisation and discrimination of racialised minority staff have on them and their ability to serve within this setting?

6.1.1 The individual experiences of racialisation and discrimination for racialised minority staff members within FMH settings

To explore and make sense of the individual level experiences of racialisation and discrimination in FMH settings, the CRT perspective must first be understood. CRT suggests that racism is the usual way society operates (Delgado & Stefancic, 2001). For this reason, racism aside from when it is deemed to be extreme, is so ordinary that its existence is usually refuted (Warmington, 2020). The denial of racism can include colour-blindness, where individuals do not recognise how they perpetuate and reinforce racialised relationships and practices, through individual interactions and systems. Instead they appear to present as meritocratic and race-neutral (Warmington, 2020). Adopting a CRT lens sets the framework for which racialised minority FMH professionals experiences can be described and understood. It enables the presence of racism in FMH settings to be explored from a race-conscious perspective, whilst being mindful of the context in which it exists.

While CRT helps to make sense of how society operates in relation to racism, the historical and contextual systems of FMH services must also be held in mind. It is understood that there are complex racial and ethnic disparities, and biases observed in systems of justice (Riggs Romaine & Kavanaugh, 2019). Racialised minority individuals are over-represented across different stages of the justice system (Epp, Maynard-Moody & Haider-Markel, 2017), and sentencing often varies depending on the race of the individual, with racialised minority individuals receiving harsher sentences (Demuth & Steffensmeier, 2004). This demonstrates how racialisation occurs within justice systems such as FMH settings, as it does within the wider society, and sets the scene for racialised minority participants experiences of racialisation and discrimination in FMH settings. It is important to highlight the context of FMH settings as a key factor, as this somewhat differs from the historical context of general healthcare settings as explored in the systematic review (see Chapter 2). Therefore, while there may be some similarities between healthcare and FMH professionals' experiences, this needs to be considered in relation to the systems in which they operate.

For the majority of racialised minority professionals in the current research, they expressed several challenges relating to both the subtlety and overtness of discrimination and racialisation. Being a racialised minority professional in a FMH setting, was acutely experienced by participants, as indicated by the theme 'standing out as different'. Participants referred to being perceived negatively due

to their race, cultural identity and ethnicity. Negative perceptions linked to cultural identity were also encountered by participants in the systematic review findings. Several participants recalled that their foreign accents led them to experience negative treatment by others in healthcare settings such as; limited or less opportunities for development, and being perceived as less intelligent. While it is unclear as to whether this was actual or perceived discrimination, participants felt that this perception of them subtly reinforced negative racial stereotypes, for racialised minority professionals in healthcare settings. In the qualitative research findings, many participants also spoke about their interactions with others in the FMH environment, where racism was subtle. They shared that their professional perspectives were dismissed, they were scrutinised more than their white majority colleagues and their decisions were questioned or disagreed with.

Sue et al. (2007) shares how these types of racial microaggressions are possibly present when individuals from different race and cultural backgrounds interact. The interactions they encounter could be further explained by research which suggests that implicit prejudice or racial bias operates unconsciously, influencing behaviour (Schimmack, 2021). Culturally embedded stereotypes about racial differences are reflected in how individuals make their conscious or unconscious evaluations about others. This provides a foundation for how different types of discriminatory treatment can be maintained within the FMH environment (Bertrand & Duflo, 2017). However, the

elusiveness of participants experiences could have led to confusion, with participants feeling that their professional identity was devalued, as they could not confidently attribute their encounters to discrimination. The systematic review findings offer similar insights. Participants described experiencing subtle forms of racism, which they felt were disguised and only visible to those who were recipients of it. This aligns with the CRT perspective in that racialisation is normal part of everyday life. In this way, both the systematic review and qualitative research findings highlight how those from racialised minority backgrounds, encounter overt and subtle forms of discrimination and racialisation.

With the CRT perspective in mind, participants in the qualitative research seemed to view most interactions with others from a racialised lens, despite discrimination being unproven. To determine whether an encounter was racist or not, some participants compared their experiences with their white counterparts. For example, Odell (British South Asian) noticed that his reports and decisions were questioned by senior staff, but he did not observe this happening to others. Likewise, when Nima (White and Pakistani) shared her perspective, she experienced criticism but noticed that her white majority colleagues did not receive the same response. This could result in racialised minority staff being cautious in their interactions, as they are constantly aware that any encounter they experience could be loaded with racial undertones. Herein lies a difficulty for racialised minority FMH staff, as they constantly attempt to decipher

whether they are being racialised. It is likely that this results in psychological and emotional effects for racialised minority individuals, due to the difficulty associated with trying to process and make sense of whether an encounter was racist or not (see section 6.1.4). This emotional work could encourage participants to display less of their cultural identity, and present their professional identity as a buffer against potential difficult emotions.

As racialised minority participants were challenged with whether to view encounters as racially driven, it likely led them to hold responsibility for speaking out or 'carrying the burden' (see chapter 4, section 4.2). Participants felt discouraged and frustrated that they were not supported in raising racial issues, as they were typically the only individuals cognisant of such matters. This could indicate how the racialised responses of those in FMH services are maintained. The CRT perspective would argue that if individuals were able to comprehend when discrimination is displayed and what sustains it, this could be undone (Tanemura Morelli & Spencer, 2000). However, while overt discrimination was also present in healthcare settings as described by professionals in the systematic review, it was dismissed by senior staff members. Participants deemed that the dismissal of racism was due to healthcare organisations choosing not to acknowledge the existence of racial discrimination, causing it to be maintained.

This was also evident in FMH participants, who conveyed that racist language and racial slurs were used towards them by clients. Though these deliberate acts of racism also went unchallenged by others in the FMH environment (see section 4.5 for superordinate theme 'dismissal and minimisation of race-based experiences'). Part of the reason for this may be due to the presentation and challenges FMH clients present with. Unlike clients in healthcare settings, FMH clients are likely to be high risk, diagnosed with mental health difficulties, present with challenging behaviours and have a forensic history. Therefore, FMH staff may avoid challenging clients about their racism, to minimise distress, prevent the client becoming difficult to manage, or damaging the client-staff relationship if not handled carefully. In this vein, part of the decision not to address race-related matters, could include the concern towards the contextual and environmental nature of FMH settings and its clients, which significantly differs from healthcare settings. However, avoiding the subject of race equally carries an element of risk, as it dismisses the emotional concerns of racialised minority staff (Park et al., 2020). This is likely to be more destructive as it reinforces the ordinariness of racism, at a time when silence towards racial discrimination and prejudicial behaviour is equated with complicity (Saha & Cooper, 2021).

6.1.2 The individual lived experiences of processing and managing cultural identity within FMH settings

Despite there being some ethnic diversity in FMH staff teams, the narratives of individual racialised minority staff reflect that they 'stand out' in forensic settings. 'Standing out' may be related to visible ethnic differences (e.g. skin colour, accent or hair texture), causing them to be racialised by others, as discussed in section 6.1.1, and as described by CRT researchers (Hernández, 2016). Although, acknowledgement also needs to be given towards the non-visible aspects of their cultural identities, which may impact how they manage in this setting.

Patrice (Black British African) shared how she experienced discrimination from professionals who described her as 'aggressive', in supervision spaces. It is possible that Patrice's display of her cultural identity was misinterpreted by her white majority colleagues, causing her to be stigmatised and stereotyped. Similar experiences could cause racialised minority professionals to be more conscious of which elements of their cultural identity they deem to be congruent with their professional identity. Pinel (1999) describes this as 'stigma consciousness', where there is apprehension about being negatively labelled, which could influence how one's cultural identity is processed and managed.

Explorations into how professional and cultural identities are negotiated, was a new finding in the qualitative research that had not been uncovered in the systematic review. While healthcare professionals shared that they enjoyed working with other racialised minority staff members, they did not examine further how they contend with both their professional and cultural identities. However, in the FMH setting, participants described how they struggled to negotiate different discourses when navigating how to position themselves in relation to their identity. Raj (British Pakistani) balanced both his cultural and professional identities equally, where he displayed an ability to merge aspects of his culture with his clinical practice, by working in a culturally sensitive and informed way. Being able to hold both his cultural and professional identities, suggests that he could negotiate his identity without feeling his sense of self was compromised or fragmented (Abbey & Falmagne, 2008). This highlights the ability to create a hybrid identity which can effectively shift between both dominant and minority groups.

In this vein, some racialised minority professionals in FMH settings may possess an intrinsic understanding of why cultural identity is important, and how knowledge of this might influence their clinical work. Racialised minority individuals have the capacity to adapt and attune to elements of their culture, when interacting with clients from marginalised and majority groups. It is possible that negotiating professional and cultural identities is more significant for FMH professionals, due to the nature of their roles. Working

therapeutically with FMH clients requires professionals to prioritise relational security, and develop therapeutic relationships due to their challenging mental and psychological difficulties. This is in comparison to professionals in healthcare settings, who as part of their role are not expected to prioritise relational working and dynamics between themselves and the client. Therefore, they may be more able to separate their professional and cultural identities.

The process of managing cultural identity within the FMH environment must also be considered in relation to the CRT, and other social processes. Unlike participants encounters in the systematic review, racialised minority FMH professionals referred to the different social forces such as racism and power, which impacted whether they expressed their cultural identity in the work environment or not, and if so, how they expressed it. For example, Slyvia (Black British African), reflected on how she thinks about her physical presentation when getting ready for work, particularly when exploring how to style her hair, and what message this might communicate about her cultural identity. This demonstrates how social forces can influence whether cultural identity is displayed, and how individuals filter out external influences that impact how they manage it (Abes, Jones & McEwen, 2007). This finding was not uncovered in the systematic review. It is possible that this is partly due to differences in FMH and healthcare roles, where there could be less autonomy in how healthcare professionals are able present themselves at work. As healthcare professionals tend to wear a uniform, it could be argued

that their individuality and elements of their cultural identity are deflected. Whereas, some FMH professionals can wear their own clothes, which permits them to present their uniqueness and possibly their cultural identity.

Taking this into account, there is likely to be a level of complexity for racialised minority professionals when expressing cultural identity in the FMH environment. CRT provides a perspective on how those from minority groups, including the racialised minority participants in the qualitative study, might manage this. One of the aims of the CRT is to reveal how racism is perpetuated both visibly and invisibly. As explored in section 6.1.1, participants were subject to various forms of racialisation and prejudicial treatment. These experiences are likely to play a significant part in how racialised minority professionals perceive and manage their cultural identity within the FMH environment.

Narratives about their individual experiences of racism, or others comfortability around race related matters, illustrated the difficult process of deciding how to hold their cultural identity in the FMH environment. For example, Nima (White Pakistani) noticed how uncomfortable others became when attempting to talk about race or cultural issues. This was emphasised by other participants in the subordinate theme 'the difficulty in expressing cultural matters in professional environments' (see section 4.4.2). It is possible that others discomfort towards speaking about racial matters could

influence how racialised minority professionals chose to manage their cultural identity. This could result in transference occurring, where feelings from white majority staff such as discomfort, are directed towards racialised minority professionals. In this case, the social environment, racialisation and negative interactions they encounter from others could impact how they view themselves, possibly making them less inclined to express their cultural identity. Interestingly, in the systematic review, racialised minority healthcare professionals shared that rather than others feeling uncomfortable, they held feelings of discomfort when deciding whether to address discrimination that occurred within the healthcare environment or not. Their discomfort led to avoidance, which prevented them from addressing discrimination due to being apprehensive of the outcome. Or, fearing that their decision to address discrimination could negatively impact their citizenship or job security.

However, participants in the qualitative study recognised that they managed their cultural identity differently depending on the context they were in. Slyvia (Black British African) observed that identifying as Black British African and displaying elements of her culture in certain contexts, created companionship and solidarity with others who also identified as a racialised minority individual. This could indicate that she recognises a difference between how she processes and manages her internal and public cultural identity (Hernández, 2012), which appears to be constantly negotiated. Internal cultural identity is likely to remain consistent, as it is how the individual

personally makes sense of their cultural identity, and connects to their ethnicity without being racialised. However, public cultural identity is likely to fluctuate in different contexts such as the FMH environment, due to racialisation being perpetuated by individuals and as part of wider structures and systems, as highlighted by the CRT.

A salient part of Slyvia's response is the idea that for her to display her cultural identity, the space in which she does so needs to be 'safe'. This is an insightful contribution to the field which was not discovered in the systematic review findings. Several studies on FMH settings describe the benefits of safe spaces for clients and professionals. Feerick, Doyle & Keogh (2021) found that creating safe spaces for forensic nurses to be supported was necessary, given the challenges of working in a forensic environment, and the tension between therapeutic and custodial practices. Equally, research also recommends safe spaces for FMH clients experiencing distress (Jubb, 2017). Given the research on the positive impact and effectiveness of safe spaces, it is important for FMH services to consider similar safe environments for racialised minority professionals. These safe environments may include support groups or supervision spaces, and could provide them with space to process and express the effects of racialisation, social injustice or discuss the experience of being a racialised minority in FMH settings.

As some racialised minority professionals work in predominantly white FMH services, their ethnicity is likely to become the dominant identity, central to the way they are identified in this setting. Thus, given the negative experiences in section 6.1.1, along with the complexities of working in forensic services, this may provide racialised minority staff with a need to process and manage their cultural identity in a positive and safe way.

6.1.3 The systemic level experiences of racialisation and discrimination for racialised minority staff members within FMH settings

Systemic level experiences seemed be significant in all participants narratives. In the qualitative study, they discussed their everyday encounters and interactions with others as part of the wider system. As well as the processes and biases they deemed to be part of institutional structures which perpetuated racism. Systemic racism occurs when racially unequal opportunities and outcomes are built into the fabric of societies structures (Banaji, Fiske & Massey, 2021). It operates both consciously and unconsciously, and with and without intention (Banaji, Fiske & Massey, 2021). Research suggests that systemic responses are based on racialisation, which is maintained and perpetuated by organisations (Gee & Hicken, 2021).

Systemic discrimination is such that, if individual level racism was eradicated, racialisation and discrimination would still be maintained

and persist at a systemic level (Jones, 2000). This is because those with no explicit expressions of racism, contribute to decisions that result in pervasive and unconscious bias, which results in systemic racism (Banaji & Greenwald, 2016). Therefore, while white majority groups in FMH settings may be supportive of racialised minority groups, some continue to hold negative racial stereotypes. This limits their tolerance to becoming less racially biased or discriminatory in practice (Banaji, Fiske & Massey, 2021). With this perspective in mind, participants experiences of systemic level discrimination in the FMH environment are explored.

Every participant expressed their experiences and observations of systemic racism and biases whilst working in the FMH environment. In many of their narratives, they discussed how racial injustices are entrenched in the wider system. This was reflected in the theme 'the complexity and contextual nature of FMH' (see section 5.1). The findings show that participants observed the apparent disparities in the FMH workforce. They shared that those on the frontline (e.g. FMH nurses and healthcare assistants), were more ethnically diverse, in comparison to staff in higher managerial positions, who were mostly from white majority groups. It is possible that racial biases embedded into the FMH system, significantly influence decision making in recruitment and staffing. This likely produces disadvantages for racialised minority professionals, as it restricts their opportunities, limiting the likelihood that they will be considered for higher grade positions. With these challenges, participants in both the systematic

review and qualitative research spoke about needing to 'work harder' in their roles to progress, access better opportunities and 'prove that they are good enough'. It is viewed that this was an inherent difficulty of being from a racialised minority background in both FMH and healthcare settings (see section 2.5.2).

Racial biases in workforce structures and systemic obstacles that impact career advancement, can serve to exacerbate racial disparities in FMH staff teams. While the reasons for this are multi-layered, Tilly (1998) proposed the idea of 'durable inequality', which accentuates how dynamics in organisations create and maintain group boundaries. His analysis describes how structures and systems within organisations, exacerbate the use of categorical distinctions, to create inequality. Through this, those who are categorised into specific groups, are more likely to experience discrimination (Vallas, 2003).

Racialised minority professionals in FMH settings are likely to be doubly disadvantaged and experience durable inequality. Given that they have membership in two visible categories; ethnicity and job grade, this could make them susceptible to experiencing significantly more prejudice and inequity. The disparities in the workforce seem to allow individuals in the FMH environment to remain complicit in structures that uphold discrimination. As seen in section 6.1.1, participants experienced direct discrimination, some of which were from clients and others from their colleagues. With the systems that exist, and the racialised rules that are embedded into everyday

practice to maintain racial hierarchy (Gee & Hicken, 2021), clients and staff may deem it suitable to be discriminatory towards FMH professionals. The idea of maintaining racial hierarchy was also found in the systematic review. Racialised minority participants with senior roles were mislabelled as being from a lower paid role (e.g. cleaner). These unconscious presumptions demonstrate the lens through which some majority groups view racialised minority individuals, reinforcing the pervasiveness of the CRT. The Equality Act (2010) states that anti-discriminatory practice is essential to the ethics of care provision and protecting people's dignity.

Thus, those who are receiving care, including the workers that provide it, should be protected from being treated unfairly under the legislation. Where this is not the case, it could be deemed as a breach of the Equality Act. Furthermore, while participants in the qualitative study did not discuss intersectionality, there is a need to consider the simultaneous experience of social categories such as ethnicity, gender, religion and sexuality. CRT suggests that the way in which these categories interact can cause inequality to be perpetuated through various systems and processes.

Systemic level racialisation and discrimination is also apparent when considering the interactions and treatment of ethnic minority clients in FMH settings. The findings demonstrate how participants observed staff members use negative racial stereotypes towards racialised minority clients. They were labelled as 'challenging', 'schizophrenic',

'gang members' and 'aggressive', and were also met with differential treatment which served to restrict and dehumanise them. Examples of this include practices such as frequent restraints, periods in seclusion and high dose medication to manage their behaviour. Under these circumstances, such practices are likely to keep racialised minority FMH clients marginalised. These findings stand out compared to those found in the systematic review, as healthcare professionals did not seem to experience such overt encounters of racialised language and differential treatment from other staff members.

It is possible that the use of racialised language and prejudicial treatment towards racialised minority clients in FMH settings are underpinned by power, which is central to CRT, as it can sustain racial imbalance (Kolivoski, Weaver & Constance-Huggins, 2014). FMH settings are those in which power is exercised daily by professionals and by the system itself (Goulet, Pariseau-Legault, Côté, Klein & Crocker, 2020). Thus, given the role of power in systems of justice and the historical context of FMH settings (see section 1.5.3), this finding is novel in comparison to those found in the systematic review. While the operation of power is being considered more in forensic settings (see the Power Threat Meaning Framework, Johnstone & Boyle 2018), power dynamics are not always recognised by FMH professionals in their interactions with clients. Disparities in power exist for all FMH clients as a product of being detained, though the addition of being from a racialised minority background, is likely to

have further implications when considering the pervasiveness of systemic racialisation. In this vein, racialised minority participants may struggle with the idea of being part of a system that uses power with racialised minority clients through unequitable processes.

6.1.4 The psychological impact of racialisation and discrimination of racialised minority staff and how this affects their ability to serve within the FMH setting

The previous subsections discuss the individual and systemic level experiences of racialisation and discrimination, and how racialised minority professionals process and manage their identity. The final research question explores the psychological impact of their experiences, and how this affects their ability to serve in the FMH environment. Racialised minority participants highlighted their experiences of racialisation and discrimination at different levels through different practices. While some everyday discrimination through individual and systemic processes may be viewed as 'minor', these incidents can be perceived as important when considering their impact on racialised minority professionals.

Often, the everyday incidents can result in more significant consequences, despite them being perceived as 'less severe', as they are likely to be more frequent (Deitch et al., 2003). The pervasive nature of racialisation and discrimination can psychologically impact those who are recipients of it. The findings of the qualitative research

revealed several distinct occupational stressors. Those who were subject to prejudicial treatment shared that they struggled emotionally, resulting in psychological stress responses. This included feeling drained and burnt out. For participants in the qualitative study, it could be inferred that their overall mental health and job satisfaction was low, characterised by feelings of emotional exhaustion and reduced personal accomplishment (Kahill, 1988). This could be partially accounted for by the discriminatory encounters, which white majority professionals do not experience as discussed in sections 6.1.1 and 6.1.2, but also given the stressful conditions of working in a FMH environment. Although, healthcare professionals in the systematic review also referred to the 'stress' associated with being racially discriminated against (see section 2.5.2). This highlights that in both healthcare and FMH settings, the impact of being racialised was significant.

Research by Schneider, Hitlan & Radhakrishnan (2000) found that individuals who experienced race-based harassment, including being excluded from interactions due to their ethnicity, displayed more negative outcomes. Similarly, in the current study, a participant stated that she felt hopeless while working in the FMH environment. She attributed her hopelessness to the systems that exist which negatively impact racialised minority individuals. As opposed to the individuals that hold negative stereotypical beliefs or behave in a way that maintains racial inequity. For FMH professionals, the systemic level experiences of racialisation and discrimination may be more

pertinent than individual level experiences. It is possible that this is due to how discrimination is systemically reinforced in this setting. Racialised minority individuals are more likely to be arrested and detained as a starting point, experience bias in psychiatric diagnoses, and be perceived as more dangerous where they are exposed to excessive use of seclusion, and higher levels of medication (Fernando, 2017). Therefore, systemic racialisation can be reinforced daily in FMH settings through such encounters and observations. In this vein, racialised minority FMH staff may feel as though the system is reinforcing discriminatory behaviour. In healthcare settings, this may be less visible, as healthcare staff may see systemic challenges as those which affect them as a wider staff group, and may not associate their experiences to racial issues. Though it is understood that there is not one definitive argument.

With this in mind, FMH professionals may experience less psychological stress from direct individual discrimination (e.g. verbal racism), that is clearly the result of another individuals' prejudicial views. Compared to discrimination that is implicit and embedded in systems, structures and processes. With systemic racialisation, the reason for unequal treatment is usually covert and seemingly without cause (e.g. having reports and decisions be questioned, but not being certain whether racial discrimination is the reason). It is evident that the experiences of everyday racialisation and discrimination negatively impacts racialised minority professionals' wellbeing. Although, it could be argued that for racialised minority FMH

professionals who are 'the only one' in a majority white team (see subordinate theme 'being 'the only one'' in section 4.2.2), they may have more experiences of everyday discrimination. Thus experience more negative effects on their emotional and psychological functioning.

Another participant referred to experiencing reduced compassion as a consequence of the harmful effects of racial discrimination, and the complexities of working in a FMH setting. Figley (1982) coined the term 'compassion fatigue', which can be used to describe how staff members may have a reduction in their capacity to experience a motivation to support others. While compassion is needed in all types of care jobs, it is possible that this is highly necessary in FMH settings. Compassion is a principal component of caring for clients who struggle with mental ill health (Crawford, Brown & Kvangarsnes & Gilbert, 2014). Care in FMH environments often exposes professionals to difficult expressions of suffering (Hammarström, Devik, Hellzén & Häggström, 2020), where they are challenged with being compassionate in difficult situations.

When working in forensic settings, staff are exposed to the trauma that clients have experienced, and this can present with a range of challenges. Regardless of their role or profession, FMH professionals are required to develop positive relationships with clients, whilst managing risk-related behaviour and custodial requirements (Lucre & Taylor, 2020). For racialised minority professionals, the ability to

remain compassionate may have been more difficult given their experiences of racialisation and discrimination. Being able to empathise and be considerate was likely difficult, but this seemed to protect them from being further exposed to emotional and psychological harm. While this serves a function, it potentially has implications on their ability to serve and work clinically with clients within the FMH environment.

To manage with the psychological impact and effects of racialisation and discrimination, racialised minority participants in FMH settings developed coping mechanisms which included; avoidance, maintaining boundaries, resilience and detachment from work related experiences (see section 4.3.1). In both the systematic review and the qualitative study, one of the main strategies participants used was connecting with their colleagues from similar ethnic backgrounds. Seeking support seemed to act as a 'buffer' against the negative experiences they encountered. It may have also been a way to find safety with those who face similar issues (Shah, Wood, Nolte & Goodbody, 2012). Being understood by others enabled participants to feel safe enough to raise race related matters in a non-judgemental space, which could have increased how they display their cultural identity. In the systematic review, seeking support was described as a 'survival strategy' to manage loneliness and isolation when experiencing discrimination. Healthcare professionals spoke of the importance of finding external support as they were unable to rely on their healthcare organisations to support them (see section 2.5.2).

Given the evidence that racialisation and discrimination against racialised minority participants in FMH settings can result in negative psychological outcomes, it is important to consider how this impacts their ability to serve in their respective roles. Participants shared that their relationships with clients were impacted due to a lack of trust towards them. Particularly clients who displayed discriminatory behaviour. Literature on the population of FMH services suggests that they are more likely to have experienced higher levels of trauma, abuse (Garieballa et al., 2010) and display insecure attachment patterns, impacting relationships with others (Olglivie, Newman, Todd & Peck, 2014). Developing trusting relationships with professionals can be difficult for clients in FMH services, as abandoning or avoidance reactions can be re-enacted in their relationships with staff members (Ruszczynski, 2010).

Racialised minority FMH professionals described how their interactions with white majority clients can be met with a barrier to connect, particularly if they have used racially abusive language or discriminatory behaviour towards them. This led participants to avoid having casual conversations with clients, be less inclined to work with them therapeutically, or hold firmer boundaries with them. While each of these methods served to protect racialised minority participants against further racial injury and potential racialised trauma, it is possible that this has a cumulative effect on clients, as it could reinforce maladaptive schemas about relationships. Though in the same vein, these methods may reduce the likelihood of

racialised minority staff members reacting unfavourably or unprofessionally towards FMH clients.

Some participants noted the role played by culture to be a facilitative factor, enhancing their work with racialised minority FMH clients. It is possible that given participants own experiences of individual discrimination and racially systemic processes, they were more aware of how this can manifest and impact psychological wellbeing and mental health. In FMH settings, racialised minority professionals appeared to develop closer relationships with racialised minority clients, through using shared cultural identity. Several participants spoke about how their culture had the potential to impact the clinical process positively. Participants used more culturally sensitive interventions and language, and adapted service provision based on the clients' cultural needs. This likely created better experiences for racialised minority FMH clients, potentially reducing negative racial dynamics and fostering positive therapeutic relationships.

Likewise in the systematic review, healthcare professionals shared that their cultural identity facilitated trust amongst racialised minority clients and enabled them to represent those who are marginalised. However, despite racialised minority professionals using their cultural identity to work with clients, it is possible that this leaves them to carry the weight of racial trauma within FMH environments. Therefore, while this positively affects their ability to serve, racialised

minority professionals still experience the impact of being racialised in FMH settings.

6.2 Recommendations for future research

This research welcomed difficult and thought-provoking narratives highlighting the lived experiences of racialised minority professionals working in FMH settings. Although, additional research is needed to add to the wider body of research in this area. Further research would increase the knowledge base for racialised minority staff members experiences in FMH settings, contributing to how FMH services understand and support staff. Through understanding racialised minority staff members experiences and using this knowledge to influence workplace culture and clinical practice, it may improve staff wellbeing, work performance, cultural competence and clinical outcomes.

It would be useful to replicate this research with racialised minority staff in more FMH settings to enhance the validity of the findings, whilst considering whether the themes revealed in this research are common experiences for this population. Replicating this research is likely to unearth wider understanding beyond this thesis. In addition, exploring areas of intersectionality and social differences from a multi-layered approach, such as gender, class or religion, could produce varied racialised experiences and encounters. For example, a study could explore the experiences of racialised minority male and

female FMH staff separately, or racialised minority staff from specific religious groups. This would provide an insight into how gender or religion exists in relation to its intersection with culture or 'race', in the FMH environment. Also, considering that some FMH services are gender specific, and vary in their degree of security level or specialism (e.g. medium secure male hospitals, community forensic learning disability services), there may be different insights and reflections to be found. Exploring intersectionality as part of this research area, may add to themes in the current thesis such as 'standing out as different', or create new findings that relate to the concept of navigating multiple identities.

In thinking further about intersectionality, the findings of the current research do not specify how participants experiences converge or diverge with individuals from other marginalised groups. For example, those whose personal and social identity is visible, potentially affording them different levels of power and privilege (e.g. sexuality or gender) in society. As, there are no current published studies exploring the experiences of other marginalised groups in FMH settings, this could be an area of potential exploration. Research may reveal similar findings to those participants in the current research, where some felt they had to compartmentalise their cultural and professional identities, and others used their culture to connect with others.

There may also be benefit in studying the experiences of FMH staff in dominant positions e.g. white majority groups. This perspective might shed light on their experiences of working in an environment where the client group is culturally diverse, but the workforce lacks ethnic diversity. It could provide researchers with an opportunity to understand key issues within FMH settings from a racialisation and CRT perspective. By speaking to those who are less likely to be recipients of racialisation and prejudicial treatment. The research could consider whether dominant groups think about issues of difference. As themes such as 'being the only one' and 'carrying the burden' in the current research, provided significant perspectives about the individual level experiences of processing and managing cultural identity, within the FMH environment.

6.3 Research implications

This research offers empirically grounded insights and narratives into how racialised minority professionals conceptualise their individual and systemic level experiences of working in FMH settings. It considers the interplay between cultural identity, racialisation and discrimination, and the psychological impact of this in relation to themselves and their professional roles. In taking the overall findings further, it is important to consider the implications from this research.

The research findings from both the systematic review and qualitative research are valuable, as they highlight the importance of self-

awareness and self-reflexivity. Key insights emerged from this research that demonstrate how racialised minority professionals experience working in FMH settings and are highly aware of themselves and others in relation to the wider system. From this self-aware position, the findings may be useful for new racialised minority staff in FMH settings, to reflect about matters associated to difference. It may encourage more experienced racialised minority staff members or supervisors to be responsive to the cultural needs of their colleagues, and confront challenges or difficult feelings from a cultural competency perspective. This support could then be internalised by the racialised minority staff and be used clinically when working with clients that present with various types of difference. As such, the findings are not only relevant for the staff member, but it may also translate to racialised minority staff becoming attuned to their client's needs and the impact of the wider system.

The racialised discourses that are expressed in participants accounts, also speak to the nature of the system in which FMH services exist in. While the focus of this research was staff experiences, the findings of the study could also impact clinical processes and methods, given that some of the factors are associated to racialised inequality in FMH services more generally. For example, FMH services would benefit by exploring the racialised barriers in assessment, treatment pathways and interventions. This may include integrating discussions about discrimination and racism in the assessment process, and the design

of client interventions. It could also involve using culturally informed engagement styles that consider stigma in minority communities.

As such, the thesis indicates that services can change their approach to become more relevant to the identity of racialised minority clients and professionals. Though in the first instance, FMH services could begin by acknowledging the presence of systemic racism and become more proactive in developing a culture which does not consciously or subconsciously reinforce negative racialised difference.

6.4 Policy and organisational implications

The thesis demonstrates that systemic change must include tackling discrimination, racialisation, and their consequences. As denial is an obstacle to addressing inequalities that result from systemic racism. As a starting point, FMH settings should work towards a standard practice for educating staff about racialisation in FMH settings, from both a client and staff perspective. Many organisations include diversity training and share information on cultural competency. However, this information tends to be brief, and often delivered online in the form of mandatory training across many healthcare services. Training programmes tend to focus on unconscious bias or individual responses to discrimination, which while necessary, can relieve the individual from reflecting on their own position within the system. Therefore, it would be important for training to provide content about the historical and current context of forensic settings, from a race and ethnicity perspective. This would highlight how racialisation is being

perpetuated at all levels in practice. This would be best conveyed with education around racism, discrimination, bias and racialisation. Furthermore, this content should also be embedded in curriculum development for new staff to begin tacking and addressing systemic racialisation.

With the rich data collected in this thesis, the findings point to the importance of having reflective spaces for racialised minority professionals who currently work in FMH settings. There was a sense that participants did not have safe spaces to openly discuss and reflect on the challenges they experience in the workplace, without feeling their accounts would be dismissed and minimised, or noticing that they were the only individual to raise such matters. This was also true for healthcare professionals in the systematic review. FMH settings could provide spaces for racialised minority professionals to raise issues of race and culture routinely, which may alleviate the burden they encounter of having to address these topics. Such spaces could be implemented within the workday, in the format of individual and peer supervision, or more informal discussion groups, where time can be allocated to matters associated with their culture and ethnicity. Such spaces should be actively encouraged by senior management, and it it would be preferable to have a designated individual who is responsible for ensuring that this is implemented at all levels of FMH organisations.

As another form of support, racialised minority staff in their supervisory relationships could be offered with a space to discuss cultural matters in a way that is meaningful, considering personal and professional spheres, and its impact on different areas of their professional lives. From a CRT perspective, while this provision may not eliminate the everyday negative race-related experiences, it allows racialised minority staff to disclose their concerns around these issues, where their racialised experiences can be understood and validated. It also supports them to process these encounters which could provide a buffer against their impact. Moreover, it may encourage majority groups to reflect more on how they can support their racialised minority colleagues, to integrate their cultural and professional identities, to positively impact their relationships, development and clinical work within the FMH environment. This could also be effective in supporting future work with culturally diverse clients and staff members from a wider system perspective.

In considering policy implications, it is important to note that for FMH settings to become more supportive, inclusive, and less racially discriminative, behaviour change must be the focus, with equity and wellbeing at the centre of the day to day running of organisations.

6.5 Strengths and limitations

A void in the literature has been filled as this research has provided an insight into the experiences of racialised minority individuals working in FMH services. To gain a variety of perspectives, a strength

of the primary research was the variety of job roles included. Most research that focused on the experiences of racialised minority individuals within healthcare environments, centred around nursing staff perspectives. Therefore, including participants with a variety of job roles helped broaden the type of experiences captured, and the similarities and differences between participants accounts. However, it is noted that no FMH nurses were included in the qualitative research, as most of the participants who took part in the study were working in psychological roles. It is possible that FMH nurses would have had a different perspective to other FMH professionals, due to the expectation that they are to provide nursing care whilst working with high risk and mentally unwell clients. They also tend to have frequent or prolonged face to face clinical work with clients. Moreover, given the experiences of healthcare nurses explored in the systematic review, it would have been interesting to explore whether similar experiences were found for FMH nurses.

Another strength of the current research is that racialised minority professionals were recruited from a range of FMH settings for example, male community team, male low secure learning disability unit and a young offenders prison. This reflects the range of FMH services currently in operation and minimises the findings from becoming service specific. The exclusion of racialised minority professionals with less than two years' experience was a methodological strength, as it ensured that participants had attained enough knowledge and understanding of FMH environments prior to

taking part in the research. Therefore, they were able to consider and reflect on the various questions asked as part of the interview with this knowledge. The research remained close to participants accounts of their lived experiences which aligned with the CRT perspective. This suggests that individuals who have been subjected to racism have experiential knowledge to articulate the difficulties they have encountered. However, in reflecting on the inclusion criteria, it is acknowledged that the study focused on a somewhat narrow participant inclusion criteria, with participants needing to have worked in the profession for a minimum of two years. This could have excluded racialised minority professionals who have worked in FMH settings for less than two years, and have encountered significant experiences of racialisation and discrimination during their employment.

The use of social media recruitment must also be considered in relation to its strengths and limitations for the current research study. Using social media as a recruitment strategy was both effective and efficient, as it enabled the study to be shared on various social media platforms to increase its reach. This was ideal in this context, as it enabled the researcher to reach a broader population than what may typically be accessible. It also helped target individuals based on personal information that was linked closely to the inclusion criteria, allowing the researcher to infer their eligibility. Moreover, potential participants were able to maintain physical separation, and a level of

anonymity, which was ideal considering the sensitivity of the research area.

However, while social media recruitment requires less time and effort, it can lead to bias. Recruiting through social media can result in a less demographically diverse sample. While it can capture geographic diversity, it also leans more towards those who connect with or share similar views to each other. This self-selection bias is in part due to the study being advertised on the researcher's personal social media pages, as the research advertisement was likely only viewed by those who had a connection or interest in the research study. As such, the pool of potential participants may have had similar views to the researcher and each other. Although the recruitment strategy matched the sampling needs, it is important to consider how this could bias findings and inform generalisability. In future, it would have been helpful to explore how the target population use different social media platforms, to modify recruitment approaches. This could include targeting certain geographical locations to widen the recruitment of racialised minority individuals, and using other methods of distributing recruitment materials that do not include the researcher's personal social media pages.

In considering further limitations of the current research, only racialised minority staff members who were currently working in FMH settings were included in the study. While this was not part of the inclusion criteria, the experiences of racialised minority staff who had

left FMH services were not captured. This may be an area for future research, as those racialised minority staff who had left the FMH field may provide a different perspective due to no longer being in the setting. Research specifically on racialised minority staff who have left FMH settings may shed more light on the difficulties they experienced within the setting, if the reasons for leaving were related to racialisation, unfair treatment or types of discrimination.

Another limitation of the primary research is that all participants worked in 'inner city' areas. While this helps provide insight into their experiences, it is possible that racialised minority FMH staff working in rural areas, may experience increased exposure to inequitable social conditions that maintain racial disparities. This may impact their experiences within FMH settings. Therefore, future research could explore the intersectionality between geographical areas and the experiences of racialised minority staff in FMH settings.

Finally in considering the methodology, the interview schedule and questions were prepared to explore the research area in depth. Although on reflection, the interview questions could have been aligned more to the IPA framework and principles. Given that the focus of IPA is for participants to share their perspective on a particular phenomenon, the participant should somewhat establish some of the parameters of interview, whilst being guided by the researcher with specific topics, themes, open ended questions and prompts to extend the discussion.

In the current interview schedule, there were some questions that were direct, for example, "*what is important to you in ensuring you maintain elements of your culture?*". This question assumes that all participants deem their cultural identity to be important in the FMH environment. It would have been preferrable to use a broader question with prompts such as *"how would you describe how you navigate your cultural identity within the FMH environment" (prompt: can you provide any examples?).* In this way, the general area to investigate is clear, without leading the participant to elicit a specific answer, although the prompts encourage them to provide more clarification and interpretation.

Using more open-ended questions with prompts would have allowed participants to describe their experience rather than the researcher assuming aspects of their experience. Additionally, it is understood that while IPA discourages leading questions, the researcher has their own biases which can guide the research and data collection process. This could also include the type of questions selected for interview. To increase the rigour of the interview schedule and overall data collection, the researcher could have reviewed the interview schedule with another individual to see how they interpreted the questions. At this stage, changes could have been made to ensure it was more grounded in IPA principles.

6.6 Contribution to Knowledge

The findings have added to the knowledge base as the experiences of racialised minority staff have not been researched in FMH settings before. There have also been no new studies in this area of study since the completion of this thesis. With the emphasis on CRT, the thesis adds to research which shows how racism in its diverse forms, is a part of the way society functions, and more specifically FMH settings. Previous research has not explored this area of study through the lens of CRT, literature on racialisation and concept of cultural identity. All of which were integral to how participants made sense of their experiences. Using these concepts helped highlight the salience of cultural identity for racialised minorities, as it was experienced as complex and contextual in nature. These findings were novel and critical to understanding the complexity of cultural identity, and how intersectional identities are constantly negotiated, whilst acknowledging a shared experience of oppression and racialisation.

This research helps to conceptualise and make sense of why racialised minority individuals may struggle to negotiate multiple identities, which could inform their clinical work and how they serve within this setting. As such, these findings are original and contribute to the literature by providing insights that can inform policies and practices within FMH settings.

6.7 Conclusions

Most existing research has been interested in the experiences of ethnic minority staff members working in healthcare settings (see chapter 2). Little to no emphasis has been placed on racialised minority professionals working within FMH services, where the focus is on those with *visible* ethnic differences, due to the colour of their skin. These are the gaps this study aimed to fill with a focus on cultural identity, and to what extent racialisation and discrimination featured in racialised minority professionals' experiences of working in FMH settings.

Using a qualitative IPA methodology, the research explored the experiences of racialised minority professionals working in FMH settings, as they encounter and live through their experiences. While the accounts of the participants in this research may not be representative of all racialised minority staff members, they highlight rich and important issues that are reflective of this population's experiences. These qualitative findings provide important implications for future research and clinical practice as discussed previously.

Throughout the research, there was a sense of the deep level, complex and emotional processing that participants engaged in, to explore their experiences of racialisation, difference and cultural identity. This was whilst working with complex clients with varying

degrees of mental ill health and risk related behaviours. Future research should continue to explore the experiences of racialised minority professionals working in FMH services, at different stages of their careers and in different roles.

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Appendices

Appendix A: Search syntax

Databases Searched

- MEDLINE via OVID SP
- EMBASE via OVID SP
- PsycInfo via OVID SP
- CINAHL
- Scopus
- ProQuest Databases: ProQuest Dissertations & Theses A&I, Social Science Premium Collection (1914-current)
- OpenGrey.eu

A. MEDLINE via OVID SP 1946 to 17 August 2020

1. exp Ethnic Groups/ OR BAME.mp. OR exp Minority Groups/ OR"black asian minority ethnic*".mp. OR ((ethnic* or racial* or group* or black*) adj2 minority).mp. OR (ethnic* adj2 (communit* or black or brown or carribean or african or asian or indian or hispanic or latino or chinese)).mp. OR (BME or "non white" or "people of colour").mp.
2. exp Health Personnel/ OR ((healthcare or health) adj2 (worker* or professional* or practitioner*)).mp. OR (nurs* or medic* or paramedic* or clinician* or doctor* or physician* or "hospital staff*").mp.
3. exp Employment/ OR (employ* or job or jobs or work*).mp.
4. exp bias/ OR exp social discrimination/ OR (experience* or culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept*).mp.
5. not patient*.mp.
6. exp Racism/ OR ((employ* or job or job* or career* or work*) adj3 (experience* or culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept* or racism)).mp. OR exp Cultural diversity/ OR exp workplace/
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6

B. EMBASE via OVID SP 1974 to 2020 Week 33

1. exp Ethnic Group/ OR BAME.mp. OR exp Minority Group/ OR "black asian minority ethnic*".mp. OR ((ethnic* or racial* or group* or black*) adj2 minority).mp. or exp "ethnic or racial aspects"/ OR (ethnic* adj2 (communit* or

black or brown or carribean or african or asian or indian or hispanic or latino or chinese)).mp. OR (BME or "non white" or "people of colour").mp.

2. exp Health care personnel/ OR ((healthcare or health) adj2 (worker* or professional* or practitioner*)).mp. or exp health practitioner/ OR (nurs* or medic* or paramedic* or clinician* or doctor* or physician* or "hospital staff*").mp. or exp hospital personnel/
3. exp Employment/ OR (employ* or job or jobs or work*).mp. or exp work/
4. bias.mp. OR exp social discrimination/ OR (experience* or culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept*).mp.
5. not patient*.mp.
6. racism.mp. or exp racism/ OR ((employ* or job or job* or career* or work*) adj3 (experience* or culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept* or racism)).mp. or job experience/ or experience/ or work experience/
7. exp Cultural diversity/ OR exp workplace/
8. 1 AND 2 AND 3 AND 4 AND 5 AND 6 AND 7

C. PsycINFO via OVID SP 1806 to August Week 2 2020

1. ethnic group.mp. or exp "Racial and Ethnic Groups"/ OR BAME.mp. OR minority group.mp. or exp Minority Groups/ OR ((ethnic* or racial* or group* or black*) adj2 minority).mp. OR (ethnic* adj2 (communit* or black or brown or carribean or african or asian or indian or hispanic or latino or chinese)).mp. OR (BME or "non white" or "people of colour").mp.
2. ab:health personnel.mp. or exp Health Personnel/ or medical personnel/ OR ((healthcare or health) adj2 (worker* or professional* or practitioner*)).mp. OR (nurs* or medic* or paramedic* or clinician* or doctor* or physician* or "hospital staff*").mp.
3. employment.mp. or exp Employment Status/ OR (employ* or job or jobs or work*).mp. or exp Health Care Services/ or healthcare setting.mp.
4. bias.mp. OR social discrimination.mp. or exp Social Discrimination/ OR (ab:experience* or culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept*).mp. or exp "experiences (events)"/ or exp Phenomenology/ or exp Qualitative Methods/ or exp Qualitative Measures/
5. not patient*.mp.
6. exp Racism/ OR ((employ* or job or job* or career* or work*) adj3 (experience* or culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept* or racism)).tw.
7. exp diversity in the workplace/ or exp cross cultural differences/ OR workplace.mp.

8. 1 AND 2 AND 3 AND 4 AND 5 AND 6 AND 7 (not school*.tw. not child.mp.)

D. CINAHL

1. (MM "Ethnic Groups+") OR (MM "Minority Groups") OR BAME OR ethnic minority group* OR minority ethnic group* OR black Asian and minority ethnic* OR black minority ethnic* OR BME OR racial* group* OR people of color OR ethnic* communit* OR racial* communit* OR ethnic* OR racial* OR black OR non-white OR caribbean* OR african* OR asian* OR hispanic* OR indian OR latino* OR Chinese
2. MM "Health Personnel+" OR (MM "Nursing Staff, Hospital") OR (MH "Personnel, Health Facility+") OR healthcare professionals OR healthcare staff OR (healthcare OR health) N2 (worker* OR professional* OR practitioner*) OR nurs* or medic* or paramedic* or clinician* or doctor* or physician* or "hospital staff*"
3. MM "Employment+" OR job* or employ* or work* or health care setting*
4. (MM "Life Experiences+") OR (MM "Job Experience") OR lived experience* OR encounter* OR perspective* OR life change event* OR (MH "Discrimination") OR (MH "Cultural Bias") OR culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept*
5. employ* or job or job* or career* or work* N3 experience* or culture* or bias* or encounter* or perspect* or discriminat* or outlook* or percept* or racism
6. "workplace" OR (MM "Work Environment+")
7. qualitativ* OR "semi structured interview*" OR interview*
8. nurs* or medic* or paramedic* or clinician* or doctor* or physician* or "hospital staff*")
9. 1 AND 2 AND 3 AND 4 AND 5 AND 6 AND 7 AND 8 NOT patient* NOT child*

E. Scopus

("Ethnic Group*"* OR *"Ethnic Minorit*"* OR *"Minorit* Ethnic"* OR *"Racial Minorit*"* OR *"Minorit* Group*"* OR *"Multi-ethnic* group*"* OR *"Ethnic Communit*"* OR *"Black Minority Ethnic*"* OR *"Black and minority ethnic"* OR *"Black Asian minority ethnic"* OR *black* OR *brown* OR *caribbean* OR *african* OR *asian* OR *indian* OR *hispanic* OR *latino* OR *chinese* OR *bame* OR *bme* OR *"Non-white communit*"* OR *"Non-white"* OR *"People of Colo?r"* OR *"People of Colo?r"* OR *"Racial group*") AND (Experience* OR "life experience*"* OR *encounter** OR *perspect** OR *outlook* OR *percept** OR *"work*

experience"* OR *employ** *"experience"* OR *"job experience"*) AND
(*bias* OR *"social discrimination"* OR *"racism"*) AND
(*employment* OR *employ** OR *job* OR *jobs* OR *workplace) AND*
(qualitative OR *interview* OR *"semi structured interview") AND (*AUTHKEY (*"Health Personnel"* OR *"healthcare worker"* OR *"health worker"* OR *"healthcare professional"* OR *"health professional"* OR *"healthcare practitioner"* OR *"health practitioner"* OR *nurs** OR *medic** OR *paramedic** OR *clinician** OR *doctor** OR *physician**))

F. ProQuest Databases

ab("Ethnic* Group*" OR "ethnic minorities" OR "ethnic minority" OR "Minorit* Ethnic" OR "racial minorities" OR "racial minority" OR "Minorit* Group*" OR "Multi-ethnic* group*" OR "ethnic communities" OR "ethnic community" OR "Black Minority Ethnic*" OR "Black and minority ethnic" OR "Black Asian minority ethnic" OR Black OR Brown OR Caribbean OR African OR Asian OR Indian OR Hispanic OR Latino OR Chinese OR BAME OR BME OR "Non-white communit*" OR "Non-white" OR "People of Colo?r" OR "People of Colo?r" OR "racial group" OR "racial groups") AND (Experience* OR "life experience" OR "life experiences" OR encounter* OR perspect* OR outlook OR percept* OR "work experience" OR "work experienced" OR "work experiences" OR employ* "experience" OR "job experience") AND (Bias OR "social discrimination" OR "racism") AND ab(Employment OR employ* OR job OR jobs OR workplace) AND ab(Qualitative OR interview OR "semi structured interview") AND ab("Health Personnel" OR "healthcare worker" OR "health worker" OR "healthcare professional" OR "health professional" OR "healthcare practitioner" OR "health practitioner" OR nurs* OR medic* OR paramedic* OR clinician* OR doctor* OR physician*)

Databases:

- ProQuest Dissertations & Theses A&I
- Social Science Premium Collection (1914-current)

G. Opengrey.eu

ethnic minorit* OR ethnic group* OR ethnic identit*OR multi-ethnic* OR BME AND life experience* AND Health professional*

Appendix B: Critical Appraisal Skills Programme (CASP) quality assessment form

First author, date, name of study: _____			
CASP Appraisal Checklist			
Questions	**Guidance**	**Outcome**	**Further Comments**
Section A: Are the results valid?			
1. Was there a clear statement of the aims of the research?	• What was the goal of the research? • Why it was thought important? • Its relevance?	Yes/No/ Unclear	
2. Is qualitative methodology appropriate?	• Does the research seek to interpret or illuminate the actions and/or subjective experiences of research participants? • Is qualitative research the right methodology for addressing the research goal?	Yes/No/ Unclear	
3. Was the research design appropriate to address the aims of the research?	• Does the researcher justify the research design? (e.g. have they discussed how they decided which method to use?)	Yes/No/ Unclear	
4. Was the recruitment strategy appropriate to the aims of the research?	• Does the researcher explain how the participants were selected? • Have they explained why the participants selected were the most appropriate to provide access to the type of knowledge they sought by the study? • Are there any discussions around recruitment (e.g. why some people chose not to take part)?	Yes/No/ Unclear	

5. Was the data collected in a way that addressed the research issue?	• Is the setting for the data collection was justified? • Is it clear how data were collected (e.g. focus group, semi-structured interview etc…)? • Has the researcher has justified the methods chosen? • Has the researcher made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)? • Were methods modified during the study? If so, has the researcher explained how and why? • Is the form of data clear (e.g. tape recordings, video material, notes etc..)? • Has the researcher discussed saturation of the data?	Yes/No/ Unclear	
6. Has the relationship between researcher and participants been adequately considered?	• Has the researcher critically examined their own role, potential bias and influence during: a) Formulation of the research questions? b) Data collection, including sample recruitment and choice of location? • How has the researcher responded to events during the study? • Have they considered the implications of any changes in the research design?	Yes/No/ Unclear	
Section B: What are the results?			
7. Have ethical issues been taken into	• Are their sufficient details of how the research was explained to	Yes/No/ Unclear	

consideration ?	participants for the reader to assess whether ethical standards were maintained? • Has the researcher discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)? • Has ethical approval has been sought from ethics committee?		
8. Was the data analysis sufficiently rigorous?	• Is there an in-depth description of the analysis process? • If thematic analysis used, is it clear on how the categories/themes were derived from the data? • Has the researcher explained how the data presented were selected from the original sample to demonstrate the analysis process? • Is sufficient data presented to support the findings? • To what extent contradictory data are taken into account? • Does the researcher critically examine their own role, potential bias and influence during analysis and selection of data for presentation?	Yes/No/ Unclear	
9. Is there a clear statement of findings?	• Are the findings explicit? • Is there adequate discussion of the evidence both for and against the researcher's arguments? • Has the researcher discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)? • Are the findings discussed in relation to the original research question?	Yes/No/ Unclear	
Section C: Will the results help locally?			
10. How valuable is the research?	• Does the researcher discuss the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature	Yes/No/ Unclear	

	if they identify new areas where research is necessary)? • Have the researchers discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used?		
Conclusions/Comments			

Appendix C: Reasons for exclusion at quality assessment stage table

Study No.	Ethical Considerations	Relationship between researcher and participant	Design and Data analysis
Study 11	Sufficient details were not provided relating to how the research was explained to participants to assess whether ethical standards were maintained. Furthermore, there was no information relating to informed consent or ethical approval.	Researcher bias was a limitation as the researcher was an internationally educated nurse who had worked in hospitals for many years before transitioning to academia. Therefore, personal biases and preconceptions were likely challenging to bracket, though the researcher did not express how they examined their role.	There was no information on whether an interview method was used and how interviews were conducted.
Study 12	Limited information about ethical considerations or approval. There was no information relating to how they managed experiences for the participants.	Limited information on whether the relationship between researcher and participants was adequately considered and how the researcher responded to events during the study.	Limited information on the semi-structured interviews and whether a guide was used. There was no information on the setting of the interviews or focus groups. Additionally, data saturation was not discussed.
Study 13	Limited information about ethical considerations or approval. There was no information relating to how they managed experiences for the participants.	Limited information on whether the relationship between researcher and participants was adequately considered, including the role of potential bias and influence in the development of questions or data collection.	There is not an in-depth description of the analysis process. Nor does it state which method was used. The researcher does not discuss credibility, triangulation, or validation.

Appendix D: Data extraction tool

1. Bibliographic information	
	Tick
Article title:	
Extracted by:	
Checked by:	
Type of publication, date and page numbers (if journal article also give title of the journal):	
Country of setting:	
2. Researcher details	
Authors and affiliations (list as presented on paper):	
Ethnicity of researchers who collected the qualitative data (if stated):	
Academic discipline of authors:	
3. Aims and methods	
Study description:	
Study aims:	
Ethnicity of participants:	
Setting choice/occupation/job role(s):	
Phenomena of interest:	
Research questions – Stated explicitly or implicitly within the general text? In what section(s) of the paper are questions mentioned?	
Theoretical and epistemological perspective underpinning the qualitative research (if not explicitly stated the researcher will offer an interpretation):	

Qualitative methods used:	
Data analysis technique and procedure:	
a) Sample	
Sample:	
Sample size:	
Sample characteristics:	
Sample selection process:	
Sample inclusion criteria:	
Sample exclusion criteria:	
4. Findings	
a) Themes	
Which key themes are stated to have emerged from the qualitative research?	
What are the key concepts from the qualitative research?	
Are there any relevant quotes?	
Were there any other emergent themes or gaps/omissions not covered?	

General conclusions:	
b) Area and context	
Are there any wider media, cultural, political or contextual factors that might be influencing their experiences?	
5. Quality	
a) Reflexivity	
Any evidence of researcher reflexivity?	
b) Ethics	
Evidence of attention to ethical issues	
c) General	
Are the findings adequately supported by the data presented?	
Any other quality issues not covered above?	

Appendix E: Table of identified themes from evidence synthesis

Theme (n)	Number of studies (n) which identified the theme	Study numbers	Number of studies (n) for which the theme was not highly significant, or the theme was not mentioned
1. Unequal opportunities and being disregarded	7	1,2,3,5,7,8,10	3
2. Manifestations of discrimination from patients and families	6	2,3,4,6,7,9	4
3. Manifestations of discrimination from colleagues	9	1,2,3,4,5,6,7,8,10	1
4. Being prejudged and stereotyped	8	1,2,3,4,5,7,9,10	2
5. Responding to discrimination from avoidance to confrontation	4	2,7,8,9	6
6. Going above and beyond	7	2,4,5,6,7,8,10	3
7. Healthcare institutions silent about discrimination	6	2,4,5,6,7,9	4
8. Un-comfortability and reluctance to address race-related concerns	3	2,3,4	7
9. The emotional and psychological responses to race-related experiences	6	1,2,3,4,8,10	4
10. Seeking support	5	2,4,5,7,8	5
11. Benefits of being an ethnic minority professional in healthcare	7	2,3,4,5,7,8,9	3

Appendix F: Interview schedule

Interview Schedule

Exploring racialised minority staff experiences of working in forensic mental health settings: A qualitative approach

Before Interview Script

- Thank you for agreeing to take part in this project.
- If you haven't already you may want to display a do not disturb sign on the door to ensure the interview is free from interruptions or distractions.
- Just to tell you a little bit about the project, there isn't much known about the experiences of racialised minority staff in Forensic Mental Health settings and we recognise and research mentions to difficulties staff in forensic settings experience with the split between being a carer and a custodian which differentiates forensic mental health staff from other disciplines. We know that forensic mental health settings have an overrepresentation of racialised minority clients. But what we don't know is how racialised minority staff describe their own experiences of working in forensic health settings. So, this study aims to explore the experiences of racialised minority staff in FMH settings. Some of the questions in this interview may be require some thought and for some may be difficult to respond but try your best and if you are unable to answer any questions that is not a problem.
- All information relating to the research and personal data will be stored confidentially and to ensure your privacy you will be assigned a pseudonym which is a fake name so that none of the data will have your real name associated with it. Also, any identifying information in the audio file will be beeped out and specific names, places or other identifiable information will not be included in the transcript or write up of this research.
- Today's interview will be recorded for the purpose of the research, are you happy for this to be recorded?
- You do have the write to withdraw from the interview or entire study at any time and if you would like a break or for the interview to be stopped please do inform me.
- Do you have any questions?
- *Ensure participant has read and signed two copies of the consent form*

Interview

- Begin audio recording device
- Option to pause recording at the participants request or if the interview is interrupted at any point.

Questions and discussion points to consider:

Note: This is a comprehensive list of questions. Therefore, all questions may not be asked due to time constraints. However, some questions can be used as prompts to encourage the participant to provide more information.

Job/Role/Employment/Setting:

- Before we start could you let me know your age?
- How would you describe your ethnicity or cultural background?
- Where do you currently work?
- What is your role?
- Have you worked in any other FMH settings in the past?
- How long have you been working within forensic mental health?
- What attracted you to working within this field, with this population group?

Race/Ethnicity and Identity experiences within the FMH setting:

- How would you describe your experiences of being from a racialised minority background whilst working within a Forensic Mental Health Setting? (*Prompt: With clients, colleagues, supervisor or professional development*).
- How important is your ethnicity, culture or identity in considering your sense of who you are? Is being [insert ethnicity] important towards your sense of who you are? *(Prompt: Why? Why not?)*
- Does the importance of your ethnicity or identity vary in different contexts? (*Prompt: Which contexts?)*
- Has your perception of your ethnicity or identity changed while working in the Forensic Mental Health setting? (*Prompt: How has it changed? Why do you think it has changed?)*
- How much do you think your identity and ethnicity plays a part in how your colleagues in FMH settings view you?
- Considering your ethnicity and identity, how do you feel you 'fit in' with the environment (FMH setting) and with your colleagues? *(Prompt: What do you do with the part of you that does not 'fit in'?)*
- Do you feel you are able to freely express your unique ethnicity and identity within the FMH setting? (*Prompt: If yes, how does this look for you? If not, why not?)*

Discrimination/Racism/Racialisation:

- Have you experienced racism or discrimination at all during your life? (*Prompt: If yes, can you describe this experience?) (Prompt: Has this caused you to have an increased awareness of racism or race-based discrimination?)*
- Have you experienced any discrimination, harassment or racism within the Forensic Mental Health setting (*Prompt: If yes, can you describe this experience?*
- Have you experienced any microaggressions whilst working within the Forensic Mental Health setting? (*Prompt: If yes, can you describe this experience?)*
- How do you manage the challenges of discrimination or institutional racism within the FMH settings?
- Do you feel your experiences within the Forensic Mental Health environment has impacted your ability to serve or provide care whilst in the workplace, either positively or negatively?

- Have these experiences of discrimination/racism effected your relationships with clients and also staff?
- How has it affected you personally?

Cultural Identity Model:

- Do you feel you need to gain the acceptance and approval of others within the FMH setting? *(Prompt: If so, why?)*
- Do you feel a sense of belonging to your cultural group within the FMH setting? (*Prompt: what does this look like for you?)*
- What is important to you in ensuring you maintain elements of your culture? (*Prompt: How do you maintain this within the FMH setting?*)

Forensic Mental Health Setting:

- Do you enjoy working within the Forensic Mental Health environment?
- How would you describe working in the Forensic Mental Health sector?
- What are the positive and negative aspects of working within Forensic Mental Health settings?
- Do you find the Forensic Mental Health environment as supportive, diverse, inclusive and open minded? Or unsupportive, critical and judgemental? *(Prompt: Towards staff and towards clients)*
- How have you found access to training opportunities, professional development and management opportunities?
- How do you feel about how ethnically diverse forensic mental health settings are? (*Prompt: in both clients, colleagues*)

Concluding Questions:

- Are there any strengths or positives that come with being a racialised minority staff member in a Forensic Mental Health setting?
- Aside from the challenges you have spoken about are there any challenges, limitations or dilemmas that come with being a racialised minority staff member in a Forensic Mental Health setting?
- What is necessary for your career satisfaction within Forensic Mental Health settings?

After Interview

- Stop the recording device
- Check participant is not distressed or upset, if the participant is upset, offer space to discuss this and provide sources of support (this will also be gauged during the interview).
- Provide the participant with their signed copy of the consent form and debrief sheet
- Answer any final questions
- Thank the participant for their involvement in the study

Appendix G: Reflective journal

Terminology for the research project:

Whilst I was reading, some key areas became apparent to me. One of these thoughts was around the terminology I will use to describe the population of concern in this research. Many other research papers refer to those from ethnic minority groups as 'BME' (Black Minority Ethnic) or 'BAME' (Black and Minority Ethnic). This is not my personal choice of terminology, as I feel terms such as POC (People of Colour), BME and BAME are problematic, as they do not explicitly define who or what an 'ethnic minority' is. The aforementioned terms could misrepresent or underrepresent people, as it groups individuals together who have historically experienced a range of different prejudices, with no differentiation between different ethnic groups. For example, the experience of a Pakistani male is likely to be significantly different to a Chinese female. Additionally, reducing the unique experiences of different people under a 'one size fits all' category, constrains different cultural identities and fails to encompass how individuals might like to be defined. However, while those are my personal thoughts, the term BAME is commonly understood in society and in research, to report information or describe phenomena related to ethnic minority groups. Therefore, this has prompted me to think about the terminology I decide to use in my research. I believe definitions of racial backgrounds are not necessarily easy to define, and whilst participants should not feel compelled to subscribe to other people's definitions, for the purpose of research, there does need to be some form of definition or criteria for those who will participate in the study. With this in mind, I have decided use the term 'racialised minority'. This makes it explicit that the research is solely focused on this who are from non-white backgrounds, but it also does not state one specific ethnic group e.g., 'black'. While this term is still quite broad, it I believe it distinguishes this particular group, as it focuses solely on those with skin of other colours (e.g., black, brown etc…). While this derives from the concept of race, it is used as an indicator of ethnicity and highlights the specific nuances and differences between white majority groups and those who are from racialised minority groups.

(Taken from reflective journal: January 2021)

Thoughts after first interview:

I have just completed my first interview and I am reflecting on my role as a researcher in this project. Whilst completing this interview, the participant shared some shocking experiences in relation to discrimination and overt racism. I found it difficult to not interject, impose my views or engage in a discussion during the interview process. Naturally, I identified with many of the experiences disclosed by the participant, as I am a black Caribbean woman who has worked in Forensic Mental Health settings myself. I found myself inwardly agreeing with a lot of the participants experiences, and they strongly resonated with me. As such, I almost wanted to validate her experiences, whilst sharing some of my own. However, I tried to remain mindful that I was in a researcher role, and I was aware that my own views and opinions may distort the research process and the results of the study. I also did not want to prime the participant to respond in a certain way or collude with them. Therefore, I listened without interjecting or agreeing and this became a little easier as the interview progressed. The first participant was warm and open to talking about her experiences. This made the interview a lot easier and it flowed quite naturally. Although, I also noticed that she was very passionate about the subject matter and provided a lot of examples and information. While the information was rich, it was hard to keep the interview to time. This is something I will need to be mindful of in future interviews.

(Taken from reflective journal: January 2021)

Appendix H: Research poster



Appendix I: Participant Information Sheet

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
School of Medicine
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Jubilee
Campus
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Nottingham
NG8 1BB

Dr Shihning Chou
Registered Practitioner Psychologist (Forensic)
Associate Professor of Forensic Psychology
Director of Doctorate in Forensic Psychology
Email: Shihning.chou@nottingham.ac.uk

Amber-Reneé Gayle
Forensic Psychologist in Training
DForenPsy Forensic Psychology Top-up Student
Email: Amber-renee.gayle@nottingham.ac.uk

Study Title: Exploring racialised minority staff experiences of working in forensic mental health settings: A qualitative approach.

PARTICIPANT INFORMATION SHEET

Research Ethics Reference:
Version 2.0 Date: 10/12/2020

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read through the information sheet and if you have any questions, the researcher is happy to answer any questions you have.

What is the purpose of the research?

Little is known about the experiences of racialised minority staff within Forensic Mental Health settings. Staff in forensic settings face the obligation of being a carer and a custodian, differentiating forensic mental health staff from staff in other disciplines and work environments. Literature has highlighted the overrepresentation of racialised minority clients in forensic mental health settings where more individuals from racialised minority backgrounds are detained and secluded more often than those from none racialised minority backgrounds.

Given this, there is a question as to how racialised minority staff describe their experiences working in forensic mental health settings. The current study aims to explore and capture the experiences of racialised minority staff in forensic mental health settings through use of interviews to provide an opportunity for their voices to be heard and for others to

understand how best to support and take into consideration their experiences and the impact on forensic mental health settings.

Why have I been invited to take part?

You have been invited to take part in this research because you showed your interest in the study and:

1. Are from the United Kingdom
2. Identify as a Black and Minority Ethnic group
3. Have worked in or currently work in a forensic mental health setting
4. Have had a minimum of 2 years' experience in a forensic mental health setting
5. Work in either a private or NHS trust setting
6. Are over the age of 21
7. Speak English fluently
8. Are able to give informed consent

Participants will be selected on a first come first served basis.

Do I have to take part?
No. It is up to you to decide if you want to take part in this research. We will describe the study and go through this information sheet with you to answer any questions you may have. If you agree to participate, we will ask you to sign a consent form and will give you a copy to keep. However, you will still be free to withdraw from the study at any time, without giving a reason and without any negative consequences, by advising the researchers of this decision. This will not affect your legal rights.

1. What will happen to me if I take part?

If you agree to take part in the study, a researcher will contact you to go over the information sheet, explain the procedures, and go through a pre-screening with you to check if it is safe for you to participate.

If you agree to take part in the study, you and the researcher will arrange a date and time to take part in the interview. Thirty minutes before the interview is due to take place, the researcher will send an email to you with a one-time use link and password, which once selected, will prompt you to enter the password to gain access to the video interview. This will help ensure the interview is secure and to ensure there are no uninvited guests joining the interview. Once you have entered the video interview, you will be introduced and given a brief outline of the study. The researcher will discuss confidentiality, risk and your right to withdraw, whilst ensuring you have read the information sheet. The researcher will explain that you can ask for clarification at any point and ask for a break

where necessary. We will give you an opportunity to ask any questions. If you are still happy to take part, then you will be asked to read and sign a consent form to ensure you are happy with involvement in the interview regarding your experiences as a racialised minority staff member in forensic mental health settings. At this point, once you are happy with the information provided and your participation in the study. The interview will last between 45 minutes to 1 hour. Due to the interviews taking place in an online format, you are able to participate in an environment you are comfortable with, providing it is a quiet location where people cannot overhear the interview taking place and encounters can be avoided. You will only be required to attend one interview session.

Interviews will be recorded by a digital audio recording device to allow the researcher to fully engage in the interview process. Following the interview, the researcher will transcribe the data and personal references will be removed and all identifiable data will be anonymised. You are welcome to say as much or as little as you feel comfortable with and can request to stop the recording or the interview at any point.

2. *Are there any risks in taking part?*

There are no risk issues anticipated for taking part in the study. However should you feel distressed either as a direct result of reading this information sheet, from taking part in this project, or at some point in the future, the following resources may be of assistance: The Samaritans (www.samaritans.org tel: 116123) or East Midlands Centre for BME Health *(*http://arc-em.nihr.ac.uk/about/centre-bme-health).

3. *Are there any benefits in taking part?*

There will be no direct benefit to you from taking part in this research. However, participants may find taking part in the interview process interesting and may enjoy the opportunity to engage in a reflective discussion regarding their experiences.

4. *Will my time/travel costs be reimbursed?*

Participants will not receive an inconvenience allowance to participate in the study. Time costs will not be reimbursed as a result of participation.

5. *What happens to the data provided?*

The research data and personal data will be stored confidentially. To help ensure your privacy, you will be assigned a pseudonym, a pseudonym is a fictious name and will be used instead of your name. We will save all data relating to the research using the pseudonym name given to you, so that none of the data will have your real name or other individual identifiers associated with them. Your name and any information about you will not be disclosed outside the study. In considering the audio files, to ensure confidentiality, any identifiable information will be ‘beeped out’ on the audio files. The researcher will change the specific names of

people, places and other identifiable information in the transcript and will consider whether the specific quotations and examples participants present could lead to them being identified. In the event that information in the transcripts are identifiable, the data will be modified slightly to maintain confidentiality. For example, details of specific examples of discrimination shared by racialised minority staff will not be reported in its entirety to prevent participants from being recognised by their peers or employer and to protect the participant without compromising their identity.

The researcher will have access to the research data and data collected will be stored securely where only the researcher conducting the project will have access to this data. Personal details gathered in order to arrange interviews will be kept confidential and separate to your interview responses, only the researcher will have access to this information this and this information will be destroyed after you have taken part in the study. Audio recordings will be kept in a locked cabinet and stored in a secure electronic location. The transcript of your interview will be made anonymous using pseudonyms and removing all identifying information. Identifiable information will be 'beeped out' on the audio files and will not be transcribed to maintain the anonymity of participants involved. Electronic files will be stored in the University's server. Access will be restricted by user identifiers and passwords (encrypted using a one-way encryption method). Electronic data will be backed up every 24 hours to both local and remote media in encrypted format.

After the project is submitted, scanned electronic copies of research documents will be kept securely for 7 years. At the end of this period they will be deleted.

We would like your permission to use fully anonymised direct quotes in the thesis write-up and potential research publications.

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

Even after you have signed the consent form, you are free to withdraw from the study at any time up to two weeks after the interview, without giving any reason and without your legal rights being affected. In order to withdraw from the study please contact the researcher via the email address provided, informing them that you wish to withdraw from the study. You may wish to provide a reason for leaving the study, though you are not required to provide a reason. If there are any concerns or questions after withdrawing please contact the researcher directly. Ending your participation in the study means; any personal data collected from you in the study until the point at which you withdraw will be destroyed immediately, and you will no longer be contacted about this research study.

If you wish to withdraw after two weeks since the interview took place, please follow the above instructions, contacting the researcher via email. The analysis may have begun, so it may not be possible to remove your data from the study. We will no longer collect any information about you or from you, but we will keep the anonymous research data that has already been collected and stored as we are not allowed to tamper with study records. This information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally identifiable information possible.

7. Who will know that I am taking part in this research?

Data will be used for research purposes only and in accordance with the General Data Protection Regulations. Audio digital recordings and electronic data will be anonymised with a pseudonym as detailed above. All such data are kept on password-protected databases sitting on a restricted access computer system and any paper information (such as your consent form and contact details) would be stored safely in lockable cabinets in a swipe-card secured building and would only be accessed by the research team.
Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

Anything you say during an interview will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the appropriate persons. This may involve implementing the University of Nottingham, Safeguarding policy.

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

The research will be written up as a thesis. On successful submission of the thesis, it will be deposited both in print and online in the University

archives, to facilitate its use in future research. The research may be published on student thesis online publication and may be deposited both in print and online in the University archives.

There is a possibility the research may be published either in poster or journal publications. If the thesis is published, participants will not be identified in any publications, pseudonyms will be used.

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee.

9. Who is organising and funding the research?

Dr Shihning Chou is organising the research at the University of Nottingham. Research is being funded by the researcher and the University of Nottingham

10. What if there is a problem?

If you have a concern about any aspect of this project, please speak to the researcher, Amber-Reneé Gayle or the Principal Investigator, Shihning Chou (shihning.chou@nottingham.ac.uk), who will do their best to answer your query. The researcher should acknowledge your concern and give you an indication of how he/she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk.

11. Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Amber-Reneé Gayle
Doctorate in Forensic Psychology
School of Medicine
University of Nottingham
B Floor, Yang Fujia Building
Wollaton Road
Nottingham
NG8 1BB
Email: amber-renee.gayle@nottingham.ac.uk

Appendix J: Informed consent form

Participants Consent Form
Final version 1.0: 23.05.2020

Title of Study: Exploring racialised minority staff experiences of working in forensic mental health settings: A qualitative approach.

REC ref: (10-0420)

Name of Researchers: Amber-Reneé Gayle, Forensic Psychologist in Training and Co-Investigator, Shihning Chou, Lead investigator and Academic Supervisor.

Name of Participant:

	Please initial box
1. I confirm that I have read and understand the information sheet for the above study which is attached and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without any negative consequences on my course of study.	☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.	☐
4. I understand that the interview will be audio recorded on Microsoft Teams and that anonymous direct quotes from the interview may be used in the study reports.	☐
5. I understand that information about me recorded during the study will be made anonymous before it is stored. It will be uploaded into a secure database on a computer kept in a secure place. Data will be kept for 7 years after the study has ended and then destroyed.	☐
6. I understand that what I say during the interview will be kept confidential unless I reveal something of concern that may put myself or someone else at any risk. It will then be necessary to report this to the appropriate persons.	☐
7. I understand that the information discussed in the interview may be sensitive and is confidential. I agree to respect other participant's privacy and will not disclose what others have said in the interview.	☐
8. I agree to take part in the above study.	☐

Name of Participant: _____

Signature: _____ Date: _____

Name of Person taking consent (researcher): _____

Signature: _____ Date: _____

Appendix K: Ethical approval letter

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
Research Ethics Committee
Faculty Hub
Room E41, E Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH
Email: FMHS-ResearchEthics@nottingham.ac.uk

29 September 2020

Ms Amber-Reneé Gayle
DForenPsy Forensic Psychology Top-Up Student
c/o Dr Shihning Chou
Associate Professor of Forensic Psychology
Division of Psychiatry and Applied Psychology
Centre for Forensic and Family Psychology
B Floor, Yang Fujia Building
University of Nottingham Jubilee Campus
Wollaton Road, Nottingham
NG8 1BB

Dear Ms Gayle

Ethics Reference No: 10-0420 **– please always quote**	
Study Title: Exploring black and ethnic minority staff experiences of working in forensic mental health settings: a qualitative approach.	
Chief Investigator/Supervisor: Dr Shihning Chou, Registered Practitioner Psychologist (Forensic), Director of Doctorate in Forensic Psychology, Psychiatry and Applied Psychology, School of Medicine.	
Lead Investigators/student: Amber-Reneé Gayle, Forensic Psychologist in Training, Psychiatry and Applied Psychology, School of Medicine.	
Proposed Start Date: 01.10.2019	**Proposed End Date:** 31.07.2022

Thank you for submitting the above revised application which was considered by a sub-committee meeting on 26 August 2020 and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 23.05.2020

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp Lamiggini

Dr Bethan E Phillips, Associate Professor
Clinical, Metabolic & Molecular Physiology, Medical Sciences & Graduate Entry Medicine
Acting Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix L: Example of transcribed interview

Interviewer
So how would you describe your ethnicity or cultural background?

Participant
I'm British, South Asian,

Interviewer
And where do you currently work so in terms of settings, medium, high, low community,

Participant
Medium mens forensic

Interviewer
So you're a senior forensic psychologist, have you had any experience being a HCA or any other role within the forensic mental setting?

Participant
Yeah, so I started off as a health care assistant, working on the wards. And then I spent some time as a community support worker. And then assistant psychologist, trainee psychologist and then qualified.

Interviewer
Were the assistant, trainee, and HCA all medium male secure?

Participant
So the HCA work was low and medium secure. Men then one or two, or very rarely some women. So this, and then the community forensic support worker was obviously community, but that was male and female. Assistant psychologist was mainly low, Men's forensic service. And being qualified is in a medium secure service. Trainee was a bit of both, trainee was low secure and medium secure. I've been in forensic services since 2010. I was on placement when I was in my masters in a male medium secure unit as an MSc student.

Interviewer
So how would you describe your experiences of being from a racialised minority background specifically, whilst working in forensic mental health settings?

Participant
I think it really has differed depending on the role I've been working in. And the roles I've been in. So for example, I've done more of the HCA work and support work. A lot of my colleagues are similar to me in terms of being BME. So I think that's very different to when you become qualified or enter the kind of psychology world where your colleagues are very different in terms of their ethnicity. A lot of times you work with white middle class women. So I think that kind of, in a way, shapes the way

you might interact with your colleagues, I think. On reflection, because I think right now, the department and our colleagues have really reflected on being BME in the psychology environment, and kind of how that has an impact on the way we work or just interact with our colleagues. I think, for me and some of my colleagues, we notice that our interactions or the way we speak or the way we kind of conduct ourselves is slightly different, or we feel sometimes we might feel we need to change the way we kind of conduct ourselves. Possibly because we might feel a bit more judged by our non BME. colleagues. And I feel like in my experience and in some of my colleagues' experiences, it sometimes might feel that you are under maybe scrutiny sometimes, or maybe some of your decisions might be questioned a bit more compared to if the same kind of decision was made by a different psychologists from a different ethnicity. I feel like sometimes you might need to kind of, you might feel like you might be having to prove your point a bit more or work a bit harder. But that's what I found, maybe initially, when I first started in psychology, but now I just kind of try and be myself. In the back of your mind you do question do certain people treat you differently because of your ethnic background? And do you get scrutinised a bit more? Or do people are saying questions a bit more? Or is there unconscious bias going on, as well? So that's in terms of the colleagues, in terms of your interactions with the service users, I think being from a BME background can sometimes help build up some of the relationships and build up the therapeutic rapport with service users who are from racialised minority backgrounds. I'm not sure exactly why that is, it might, there might be lots of different reasons for that. But I feel possibly sometimes the service users may feel that I may be able to understand them a bit better, if they think that I'm from a similar background. But I'm not too sure why that that could be.

Interviewer
So how important would you say your ethnicity, culture or identity is in considering the sense of who you are?

Participant
I think I'm quite proud to kind of have my cultural background, my ethnicity. So I think that's a real big part of who I am. And I think it's really important to me, and I feel like in my work, I acknowledge where I'm from. And I acknowledge that some of my cultural background, I will be influenced by my cultural background. But I'm just mindful that I need to ensure that I'm aware of it, and where I need to be careful if I'm overstepping the mark for example. But generally, though, I feel like my cultural identity is important.

Interviewer
So would you say that the importance of your cultural identity varies in different contexts?

Participant
I feel like if I'm kind of having a session with a patient, and they're from a non-white background. So from a BME background, I feel like I can be

myself a bit more in terms of my identity. So the way maybe I talk and my interactions whereas if I'm in a different setting. For example, such as a senior meeting, or a meeting where predominantly the ethnicity is white, then I feel like I do end up having to kind of, I do find that I would have to talk differently. Well, I feel like the need to talk differently. So definitely, I feel that I would need to do that. And I'm more mindful of doing that now. And I try not to do I try not to do that. But I think it's just kind of entrenched in you. I think when you start the journey of psychology its kind of drilled in you that you kind of need to conform to a certain standard or what people perceive is the standard. Of a certain way of talking or a certain way of interacting. So I feel like I'm more aware of it now and I try not to do that. But yeah, I think definitely it does have an impact.

Interviewer
Do you think that was the case when you were a HCA or any other support worker role?

Participant
No, I don't think it is, because when I was in the healthcare assistant roles or in a different role, I think, again, the majority of my colleagues who were nurses or were predominantly nurses when I was a HCA, are from BME backgrounds. And maybe that's a reflection of being in London where there's lots of diversity. But no, definitely, I think it's quite specific to the psychology department or the psychology world.

Interviewer
So do you think that all your perception of your cultural identity changed while working in the forensic mental health environment? So this might be split between being a HCA and being a psychologist?

Participant
I think it has. Because when I started the role, I feel like I wasn't...I thought when I started in, forensic services as a healthcare assistant, or a support worker, you might tell people where you're from, and kind of have a little chat about that. But then beyond that, you don't really, I didn't feel like that needed to be brought up, or that the focus needed to be on my identity, my cultural identity. But, when I moved into psychology, I feel like the spotlight then becomes on you, and then you kind of have to think about your cultural identity to be a bit more. And when there's certain situations that happen at work, you do tend to question yourself and think...question whether the way certain people may respond to you in terms of your colleagues, is that because of your cultural identity? So then you kind of think about your cultural identity bit more. And I feel once I've done that, it makes me feel I need to kind of ensure that my cultural identity is then kind of removed or changed or I feel like I need to adapt it. And I think again, the biggest difference lies with your colleagues, because I think when you're working in a multi-cultural city like London, people who are from my ethnic background, or other BME backgrounds, are represented quite well, or even overly represented in the forensic population. And in terms of the nursing staff, it's very represented, or

some people might say over-represented in terms of BME staff. It's when you move into psychology where your colleagues are very much different in terms of their ethnic background and that's where I feel things then switch.

Interviewer
Do you think your cultural identity plays a part in how your colleagues view you?

Participant
I think it does. Because in my experience, I feel like and from what I've heard from other colleagues is, I feel like some colleagues or not everybody, but I feel like sometimes you might feel like you're being judged in a way, or needing to prove yourself a bit more because you're from a certain background. It's like, if I was white, for example, I don't think somebody may question some of the decisions or kind of the key points that I do make. Which is fine for people to ask questions, I have no issues with kind of people asking questions in that sense. But it is quite interesting that it came from a different person, a white person, then it will be very, it will be viewed very differently. So I feel like you do feel a bit more judged, under the spotlight a bit more. Also, I do feel that the respect isn't there as much sometimes. So I can give you an example? So this happened not so long ago, I was sharing an office, so I'm a senior psychologist and I was sharing an office with two assistants. So the two assistants are white British. And we had a new member of staff who was a clinical psychologist who had only recently started. So she introduced herself and she was in the office for like two days. So being mindful that I've been in the office for about seven years. So on her third day of being in the office, or being with us in the office, she literally changed the furniture and the office around without talking to anybody at all in the office. So she was actually quite rude. She actually moved the desk, she said that she was cleaning, but she actually moved the fridge, the desk and everything around in the room. And I thought I was actually quite rude because she didn't talk to me about it, and she didn't talk to anybody in office about it. And I thought, in some ways, she kind of said that somebody had given her the okay to do it. But that's not that person's office, so I just thought quite rude. And it made me think that if I was a senior psychologist, but was white, would that have gone on? Like, would that person have felt okay to just move things around in a shared office. And I spoke to my colleagues about it and I think everybody was like, really shocked by it, having just been in the office two days, pushing around not talking to anyone. I just put another two other senior colleagues in my place and to me, I didn't think they would have ever moved anything around in office. So I just basically said to this person that that was really disrespectful. So that's just one example of kind of where you feel like maybe the respect isn't there. And also, just in terms of that example as well, the, the person's line manager who had given her the okay to kind of move the stuff in the office. Again, it might be some bias going on as well there. Because, again, if I was somebody else from a white background, I don't think that person would ever have

given the okay for that to happen. So again, it's like, well, is it because I'm from an ethnic background, regardless of my seniority, but even if I was a band seven newly qualified, it shouldn't really matter. Somebody giving it the okay, who's not even in the office and has no kind of business and kind of given authorization, would that person have done that? If I was a white British psychologist, for example? And I don't think that's the case, I don't think they would have.

Interviewer
So considering your ethnic background, do you feel like you fit in with the environment as in the forensic setting?

Participant
I would say I felt more comfortable being a HCA in terms of the environment and fitting in, I felt more comfortable in that setting. And again, it's because I felt like you don't really get judged on your ethnicity as much. That could be for various reasons, but I feel like as a HCA or support worker in a forensic mental health environment, I do feel a lot more comfortable. So in terms of all the psychology side of things, I think I'm probably in the minority in psychology, in terms of being male and from a BME background. I think there's only one other person who's qualified, who's mixed race. And in terms of ethnic minority background, I think in the whole department, there's only about four people from ethnic minority backgrounds. So in terms of fitting in, again, I feel like sometimes I might need to change my behaviour or the way I talk in order to fit in, in a way that, I think in my head that people would kind of respond better to me in. I'm mindful of that and I need to kind of be aware of when that happens, and not to do that.

Interviewer
So do you feel that you're able to freely express your ethnicity, your identity within the forensic mental health setting?

Participant
I feel like where I work could because it's such a diverse area, I feel it can be very easy to kind of express your cultural background and identity. But again, in terms of the psychology environment, it sometimes feels like there aren't many opportunities to kind of express your cultural background or identity as much. I think with Black Lives Matter has definitely helped in raising people's awareness of cultural identity, which has been really helpful. And I know in my department, we're looking a bit more how we can kind of change things to improve things for colleagues and our service users from BME backgrounds. But I think this is a constant battle to kind of raise the issues. And it's often people from BMA backgrounds who have to raise these issues or bring these issues and awareness up. But it would sometimes be nice for it to come from elsewhere. But yeah, I can I think that it's very, it's very difficult. No, there's not a lot of opportunities to be able to kind of express your cultural identity.

Interviewer
So we're going to be talking a bit about discrimination, racism, race racialisation. So just a general topic to get started with, have you experienced racism or discrimination at all? And if so, could you describe that experience, if you're comfortable with that?

Participant
In terms of non work environment, I can't think of anything specific. But I think, actually, I can think of some specific things. But maybe just because it happens so often that you just kind of, you don't really pick up on it, or you just learn to kind of see that as the norm. But I feel like, Did you want some examples?

Interviewer
If you could provide one or two that'd be really helpful.

Participant
Okay, I think just one example is when I was on holiday, this happens quite often. But being at the airport, I was the only Asian person within the kind of terminal waiting area. And out of everybody there, the police were looking at me and asked to see my I.D and asked me questions. And were literally, what's the word...interrogated me, for whatever reason, just because they said that I had looked at them. So I feel like that was that was quite interesting because I was the only person that they spoke to and the only person there from a BME background. Again, at the airports, I get a more thorough search. Also, when I go into the shops, sometimes in different areas of London, you might get people looking at you as if you're you shouldn't be in the shop, for example, or you might not have enough money to be in the shop to look at stuff. Maybe people just making the assumption that you're this doesn't happen as much, but sometimes people will assume, in the work environment for example, people might assume that I'm not a psychologist, and I'm a HCA or a nurse and that happens quite often. Sometimes they might think I'm a psychiatrist as well, but maybe that's because of the environment. But typically people might think that you're lower down in the in the banding system. And again, maybe there's a lot of unconscious bias going on. But I'm fortunate enough that I've kind of been successful in all my interviews in terms of psychology and work. But in the past, I do wonder if, based on my ethnicity that you kind of are judged differently.

Interviewer
So do you think those experiences have caused you to have an increased awareness of racism or race based discrimination?

Participant
Yes, I think I'm much more aware of when there's biases or unconscious biases. I don't know if unconscious biases are just another way, another word for just describing racism, but it's just more palatable for some people. But either way, it has made me more aware of when things don't

seem quite right. And it could be based on somebody's ethnic background. For example, we have two assistants. One of them is from a BME background, and one of them is white British. And when I was talking to one of them, they mentioned to me that they're doing some research with another psychologist. And these two assistants are both working in the same department, same supervisor and their supervisor chose only one of them to be involved in the research project. When the other one had expressed on a number of occasions being interested in getting involved. And I just thought that was that could have been some bias going on there, in terms of just a selection, maybe make an assumption that the person from the BME background isn't good at research, or isn't as competent as the other person. And I just felt that to be fair, it would have been better to kind of ask everybody in that role. Who would be interested and kind of have a more fairer selection process. And in my experience, I have found that some supervisors are more critical perhaps, or seem to supervise, some BME assistant psychologists a lot closer than they would another white assistant psychologist for example. I have noticed that, so maybe the feedback is a bit more thorough. Because I've had a look at their work and I would say there probably is some bias going on there. I think, again, it goes back to thinking like being BME in psychology are kind of on the spotlight a bit more. So they need to prove themselves a bit more. And again, not every supervisor, but I think a lot of times that does happen. Yeah, more often than not, unfortunately. I know that when I see other people, there was a white, British assistant psychologist, and I supervising their work. And actually, this is another example actually. I gave her some feedback on a report that she'd written and it was thorough feedback, as she was in a new role, she'd been working in service the for a little while. But it was the first time she was working in the men's medium secure role. I gave her lots of feedback, and she kind of questioned it, because I think previously she had been given lots of positive feedback from a white clinical psychologist. But I had given a very detailed feedback, and again, when she questioned it, I just thought to myself, is she questioning it? Okay, fair enough. But I just wondered whether if it was somebody else would she have questioned it as much? If I was from a white background for example. So I gave him the opportunity when I gave the feedback to sit down and go through it. By the time we went through it, her face actually went red, and she actually recognised that all of the feedback I gave her was valid. So from that point on, it was fine. But it just made question and made me think that in the past, had that other supervisor not given her sufficient feedback and was that because of her cultural background? Because the other person that you're supervising who mentioned to me that she always got very critical feedback. So it was very different from the BME staff, assistant psychologist and the white assistant psychologist staff. So that just made me question a little bit about what was going on there again.

Interviewer
Would you say you've experienced any discrimination, harassment or racism in the forensic mental setting personally?

Participant
As a healthcare assistant, or support worker, I have experienced kind of racial abuse. It's very rare, though, so in total with me working in forensic services for 11 years, maybe on two occasions, someone has kind of racially abused me, in terms of the patients. So that's kind of throughout my career. Obviously its not acceptable even it happens once, but I think that's not too bad, two in 10 years. In terms of harassment or anything, I just do feel like some, sometimes you just feel under the spotlight a bit more. Actually, you know, I think that would come under kind of racism or discrimination, because of my ethnic background, people will kind of question things a bit more, or look bit more or not overlook certain things.

Interviewer
So have you experienced any microaggressions whilst working in the forensic mental health setting?

Participant
How would you describe microaggressions?

Interviewer
So things that come across a little bit jokey, or it sounds like it's banter, but it's not. So some people may say, "I went on holiday last week, I'm almost as dark as you" ?

Participant
If I'm honest, I don't think I have as much for me. Or maybe I haven't really noticed it because I'm aware not as aware of when it happens. And I'm sure I'm sure it does happen. But maybe I just overlook it. Because I think when I first started, because I felt different to everybody in the environment. I felt like I needed to let things go. And that is another example, which is interesting, but I'll come back to that. But I just felt that I needed to let things go. So I wouldn't want to cause waves. So it was just like, let me do my job, shut my mouth and get on with what I need to do. It's a tough world in terms of psychology, just got to get on with it. I feel like maybe I just let things go a little bit. A little bit and not aware of it. I'm sure it does happen. But the example I wanted to give you was when I was a an assistant psychologist, I think within my first couple of weeks, I completed a report for somebody, for their ward , but was supervised by somebody else. So when I gave my report to the psychologist, before she even looked at it, she just said to me in the one to one but if she disagreed with the recommendations, what she could do was literally tear up the report and not even look at it and not even use it. I thought that was very aggressive at the time, I just thought you know, it is very unusual for her to even say this. But at the time, I was just like you know what, I should have bought this to supervision because obviously a qualified psychologist had overlooked the report and whether this person agreed or disagreed with it, to even be thinking that it's okay to rip up a report once it's completed by a qualified member of staff supervising it. And I just shut my mouth and didn't mention anything

cause I just thought, you know, I don't want to cause any waves and problems. So I just kind of kept it to myself. But I did think to myself, well, now looking back, I do you think if I was a white assistant psychology, would that person have done the same thing? And I'm not sure, I feel like maybe some people feel like they can get away more to BME staff. I think they think they can get away with a bit more. For whatever reason, maybe it's because some people might think that people from BME backgrounds aren't going to raise it, or are going to challenge it, or are going to complaint about it. But for whatever reason, I feel like people tend to feel like they can get away with a lot more. In terms of treating people from BME backgrounds with less respect.

Interviewer
So how do you manage those challenges, the challenges of racism, microaggressions and discrimination in forensic mental health settings?

Participant
For the most part, in the past, anyway, I think, I kind of learned to just let it go. Use self talk and just kind of end up making excuses for some of the behaviours from other people. "Oh, they didn't really mean that", or "I don't think that's what their intention was" to kind of make up excuses. Kind of, like cognitive distortions really that to make it okay that people have treated you. Well, it's kind of a cognitive distortion, you kind of give people allowances, you kind of make up excuses for them. But I think I've moved on, and maybe in terms of me kind of moving in my seniority as well. I don't allow that to happen anymore. So if I do feel disrespected, I will raise it. And I will say something, I'll bring it to supervision, or I'll just talk to that person directly and say, "I feel disrespected", or "I don't think that was okay". So I think I'm a lot more vocal now and I think one of the reasons is, I've just had enough of kind of letting things go, which in the past I have done, and I just feel like I just can't sit down and allow things to happen. So a lot of times, it might not happen to me as frequently now. But if I notice that my colleagues who maybe don't have a strong voice, as I do now. For example, the assistant psychologists, if I do find something of discrimination, or some sort of bias or disrespect going on, I will raise it and I will make sure that people are aware of it. And I do hope that they feel comfortable in talking to me about new things, so I can raise it for them if they want me to. But if they haven't spoken to me about it, but I've noticed it, I will raise it. So that's how I now manage it, I just bring it to supervision thinking about a way of managing it. Whereas in the past, I'll just let things go and let things slide and make excuses. And I understand that that's actually not helpful with the kind of racism and discrimination that happens in the workplace.

Interviewer
So have your experiences of discrimination, racism, etc, in the forensic mental health environment, has that at all impacted your ability to serve or provide care in your roles?

Participant
I think my experiences of racism or discrimination has made me more aware of when it happens to other people. It makes me more aware of when discrimination occurs in the forensic mental health setting. So if I feel like maybe some decisions are unfair, and potentially it could be based on somebody's race, or cultural background, I will raise it and have a discussion what happened. I feel like in a way that helps me to ensure that there is fairness and people are working ethically. So I feel like sometimes, it's me that has to raise the awareness about some of these cultural backgrounds. So it's like, well, maybe in their cultural background this is quite normal for this person from this cultural background to maybe talk or behave or communicate in this way. A lot of times, I feel like, particularly many service users from a black, African Caribbean background, sometimes their communication style, can be interpreted as very aggressive. So I feel like I need to kind of question when people do use the word 'aggression' to describe some of those behaviours, and I'm kind of a more mindful to think about, what exactly is aggressive about this? And just thinking about is it based on this person's kind of cultural backgrounds, or whatever it is, for example. So I do pick up on things like that and just try and find out exactly what people mean by some of the terms that they use. So I feel like it's maybe improved things a bit more. So because I'm aware, I'm aware of when it happens to me, I'm a bit more mindful and switched on in a way to recognise when it happens to other people. I think during my training as well, we talked a lot about discrimination and ensuring that people are treated fairly. So definitely, I feel like that improves things as well. Can I just go back to the microaggression thing? There have been occasions when I've been in a ward round meeting, for example, and there'll be certain members of staff, sometimes there was a certain member of staff who was half British, and half Malaysian or something. But she was actually white passing so if you looked at her she'll seem like a white British person. Even though she said that she was mixed race. So I think she would joke about a lot or make comments about other people's culture but then felt that it was okay for her to say that because what she would "oh, I'm allowed to say that but because I'm mixed race" But what she would say is actually quite offensive. And I did let it go on the first time. I thought maybe she wasn't aware of it or it was just one off but then after happened on a few more occasions, I kind of brought it up. Cause I think she mentioned like, something to do with like Indian families, and that's what happens in Indian families or something. And she kind of made a joke out of it. And I was like, even though I'm not from India, I just felt that could still be very offensive. So there are occasions where there are little kind of microaggressions or things that come across as a joke, but they're actually very inappropriate.

Interviewer
So have the experiences you've had of discrimination, racism, etc affected your relationships with staff or service users?

Participant
I don't think it generally has affected my relationships with service users. But I think I am more mindful if I am working with a white British individual. In the back of my mind, when I initially meet with them, I'm just, I would be a bit mindful about how they would perceive me as being a non-white British psychologist. And I'll just be a bit mindful of that, I think. But just generally, with service users, I don't think my experiences of racism has a negative impact on my interactions. And in terms of my colleagues, I don't think I don't think it has. I am a bit more mindful perhaps to keep more of a boundary in terms of, more boundaries with my white British colleagues compared to other colleagues that are from BME backgrounds. And when I talk about boundaries, what I mean by that is, obviously everything is completely appropriate, in terms of my interactions, no matter who my colleagues are, but just in terms of kind of making jokes or kind of having banter with somebody, or just being a bit more...I think I can have a bit more of a joke, and I feel more comfortable. But I do feel like, I need to be a bit more mindful about what I do say to non BME colleagues if that makes sense. So I think I'll be a bit more not guarded, but a bit more reserved. And that's based on my kind of experience of prejudice, discrimination or racism in the past.

Interviewer
So coming off the racism discrimination topic, just thinking about cultural identity now. So do you feel you need to gain the acceptance or approval of others within the forensic mental health setting?

Participant
I feel like it's not so much when I was working as the healthcare assistant, or as a support worker, but definitely when I'm an assistant trainee, or qualified member of staff. I feel like, in some ways, for example, the training maybe, actually, no. I genuinely, I feel like in psychology, you do feel like you need to prove yourself. So prove to other people that you are actually competent, when you kind of know you are already, but it just feels like you need to prove it a bit more. Or just let people know, highlight it, but prove yourself a bit more in some ways. And I try not to do that anymore, because I feel that I am competent, and I don't need to prove it to anybody else. But in the back of my mind.

Interviewer
Do you feel a sense of belonging to your cultural group within the forensic mental health setting?

Participant
I feel like I do with service users and colleagues. But to be fair, I think it's just generally from minority groups and not just specific to kind of an Asian or South Asian background. I feel like the belonging with kind of black, African, Caribbean, Asian, South Asian backgrounds as a whole, I think.

Interviewer
What does that sense of belonging look like to you?

Participant
I think it's hard to describe, but I think possibly, it's a mutual understanding. I think, a lot of the time, there's quite a lot of... in terms of BME background, I think a lot of the time, the humours quite similar. Or maybe I just, hopefully, I'll get it a bit better. Or I'm able to kind of receive it as well. I feel like my cultural background in Mauritius is very diverse anyway. So we've got a lot of both predominantly Asian, but we've got a lot of African people kind of in terms of their racial background. It's very diverse. So I think that's possibly a reason why. But generally, what does it look like? I think there's a lot of shared experiences. I think that's really important, the shared experiences of discrimination, prejudice in the environment. Especially in the forensic mental health environment where I think discrimination occurs at every level, every professional kind of discipline, different seniority grades, I think you have a sense of belonging or there's some sort of shared experience. I think that's one of the reasons I think there's quite similar values as well. So I think, again, I think it goes back to do you feel comfortable in kind of having a conversation with somebody, and you're not worried in case somebody will be offended? Or kind of feel like you're breaching a boundary? I feel like I'm less concerned about other people kind of judging my interactions with them.

Interviewer
So what would you say is important to you in ensuring you maintain elements of your culture in the forensic mental health setting?

Participant
I think what, what does help is kind of having conversations with people from similar backgrounds. And just people around you being open to kind of discussing people's cultures, even if they're from a white background, for example. But just generally people being open to talking about cultural identity, discrimination as well. Because I think if we do talk about discrimination, then it's an opportunity for people to kind of hear other people's experiences of discrimination as well. So I think kind of having that on the agenda and kind of people being open to the idea of discussing issues that affect BMEs, for example, is important. I don't know where this will come in, I'll give you an example is, I have a colleague who is from the Caribbean, black Caribbean. And she had sent the department a resource around how we can support our black colleagues with cultural identity. They talked about code switching, she shared that resource to the whole department. And there was a white colleague that sent her an email, in response, only sending the email to her. And basically saying that the email that she received, she felt very uncomfortable and distressed by it, and she asked her not to send her any more emails related to Black Lives Matter. However, this wasn't related to Black Lives Matter, at all anyway. Even if it did, it didn't warrant that response anyway. But it was just around kind of how to support our

black colleagues in terms of supporting them with their cultural identity and kind of minimising their need to or supporting them in terms of kind of code switching or whatever it was in the email. So again, if that person was from a white background who sent the email, would that person have responded in the same way? Because this colleague was a senior psychologist as well. So I very much doubt that that person would have got an email for this white staff member. But it happens so that it just merges into one, so we don't recognise it as much.

Interviewer
So just generally, do you enjoy working in the forensic mental health environment?

Participant
Yes, I do.

Interviewer
How would you describe working in the forensic mental health environment?

Participant
I'd describe the environment similar to a prison setting where there is a lot of security in place. However, in my opinion, the difference between a prison setting and the hospital is that the focus is on treatment and supporting people to manage their mental health difficulties that they might experience. And it's hopefully a more therapeutic environment, with the aim of supporting the service users to recover from mental illness and achieve as much as possible independence and reducing their risk at the same time.

Interviewer
And what would you say the positives and negative aspects are of working in the forensic mental health environment.

Participant
So the positives of a forensic mental health environment, I think you do get a sense of teamwork. In forensic mental health. You kind of have to work together as a team to ensure peoples safety. So I think you can build up relationships quite quickly. So that's a positive. I think in forensic mental health settings as well, you work with colleagues from lots of different disciplines, professional backgrounds, so you're always kind of learning from each other. And you're working as a team to meet a shared goal. And I think you don't get that necessarily and other mental health environments or settings. I think a positive in forensic mental health as well, is there's a lot more funding compared to other non-forensic mental health settings. That's another positive as well with more follow up care. And unfortunately, sometimes people say something serious like an offence needs to happen before somebody is able to get the support for their mental health, the appropriate support. And unfortunately, they may not have received that in the past. And it's only now when they've

offended that they're able to receive this. So I'm not really positive, but in a way, there's a lot more resources, definitely a lot more resources in forensic mental health. Another positive is that there lots of structure. In terms of kind of meeting reviews, the policies are there, hopefully to ensure people are working ethically, professionally. So I feel like there's a lot of structure in place in forensic of mental health settings that's helpful. In terms of things not being so great in front of mental health settings is the risk of abuse and aggression from service users. I think it is not specific to forensic services, but in general, you get discrimination or prejudice from other colleagues. I don't think that's unique to forensic mental health. Other negatives about forensic mental health settings is I'm not sure, it really depends on what, what where you're working, what department you work in. I think, again, sometimes the offending histories and people's personal histories are quite difficult to kind of think about or work with. For example, if service users have offended against children or elderly people that would affect me a great deal. So sometimes you might have to hear unpleasant kind of offence histories and work with people. So your resilience has to be really built in forensic settings. And also, a lot of time, there's a lot of trauma with our service users. So its not pleasant having to read people's histories, it is quite difficult. Another negative about forensic mental services is often more often than not, you see the same service users coming back to hospital. So it feels like in some ways, you're not able to support them as well as you can. And again, it sometimes feels that that you've let them down or you haven't done what you ever you thought you could have done in some way. Because I think often the people that do really well, you don't hear from them. Its only the people that don't do so well that you hear that they are coming back or they've committed another offence, and you see them so I think that’s not so great.

Interviewer
So do you find the forensic mental health environment supportive, diverse, inclusive, or the opposite, unsupportive, critical, judgmental?

Participant
I think generally, I think it is supportive. I think generally, I think a lot of times, especially in the psychology department, perhaps some discrimination isn't so obvious, or there’s a lot of microaggressions. Or there's a lot of unconscious bias going on. But generally through the policies and the way we work, we do try and ensure that there is fairness and we're working ethically and professionally and in a non discriminatory manner.

Interviewer
How have you found access to training opportunities or professional development management opportunities?

Participant
I think, generally that's been positive. But we're actually doing an audit to find out in some ways, whether is there some discrimination going on

between BMEs access to kind of training compared to non BME staff members. So we are looking into that, but I don't personally feel that there has been in terms of that. Actually last year, I applied to a BME leadership programme, and the idea was to support from people from BME backgrounds to prepare them for more senior roles in forensic services. So during that period of time, I was actually successful in my new position as a senior psychologist. So that was helpful, but again, it wasn't other people that push pushed me forward for it or suggested that this could be helpful. It was me seeking my own opportunities for that. But just generally in terms of the working environment, there is an increased push for people supporting people from being BME backgrounds to go into more senior roles. Considering that the evidence shows that when it gets to more senior levels, it's just such a huge gap between, in terms of the diversity its not there really, terms of ethnic backgrounds, or ethnic representation?

Interviewer
What would you say is necessary for your career satisfaction within the forensic mental health setting?

Participant
This might sound cliche, but I think in terms of my work, it will be to be providing evidence based quality care to the service users, and being able to see a positive difference in the people that we work with, regardless of their kind of cultural background. I think that's what I think, and also to have my colleagues and the workforce being kind of...what's the word? Just ensuring that the staff members are equally looked after in this environment?

Interviewer
That's the end of the interview. So I'm just going start recording now.

Appendix M: Emerging codes



Appendix N: Themes mind map

