

**Barriers encountered by young people from Black and  
Minority Ethnic communities accessing psychological  
services: Clinical psychologists' perspectives**

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## **ABSTRACT**

This research explores clinical psychologist's perspectives on barriers to accessing psychological services for young people from Black, Minority and Ethnic (BME) communities. This study follows an analysis of the current and historical contexts of clinical psychology and its relationship with 'race' thinking. Particular attention is paid to the theory and practice of clinical psychology and its application across different ethnic contexts, as well as the legislative backdrop as it relates to children and young people. These aspects are considered to be implicated in disparities in access to psychology services for BME young people and families.

Eight clinical psychologists were interviewed, and the resulting transcripts analysed using thematic analysis from a critical realist epistemology. Three main themes were identified. Theme One concerns the profession's predominant Whiteness and how this interacts with the task of improving access for BME young people and families. Theme Two considers the individual and systemic enablers and disablers to greater equality and how these are navigated by participants. Theme Three considers clinical psychologist's perspectives on ethnic inequities in respect to how systems of language and service structure might create and ameliorate barriers to access.

Implications for clinical psychology practice and further research are considered. The findings indicate more should be done on individual and structural levels to facilitate clinical psychologists improving access for BME young people and families.

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Saya,

For helping me to see and loving me when I don't.



## **1. CHAPTER ONE – INTRODUCTION**

### **1.1. Part One – Literature Strategy and Language Usage**

#### **1.1.1. Literature search**

An electronic literature search was conducted through EBSCOHost (using the selected databases of 'PsychInfo', 'Academic Search Complete', 'CINAHL Plus with Full Text') alongside searches using Science Direct and Scopus. A number of search terms were used around the topic of my research, inclusive of synonyms and related terms, as well as searches using subject terms. I approached this on a number of axes related to my research topic, including terms related to ethnicity (e.g. race, culture, black and minority ethnic), psychology (e.g. therapy), access (e.g. health care access, mental health services) and location (e.g. United Kingdom, Britain, England). Searches were run using a combination of these terms as well as together so that the relevant literature could be surveyed.

In addition, I have included relevant books and unpublished theses relating to the topic area in appreciation of the many great minds who have contributed to the issues related to this project. Due to overall scarcity of relevant literature, particularly in regard to the contexts of the UK and children and young people, I have drawn on some of the literature from other countries (namely the United States of America) and the adult population.

#### **1.1.2. Terminologies**

In the following thesis, I will frequently draw on the ideas of social constructionism (Burr, 2003) as I cover the heavily contested and debated language and knowledges contained within. Social constructionism's primary position is that of contingency; that our conceptualisations of reality are inextricably linked to the language, history and contexts in which they have

come to be. In this vein, I will use this section to consider some of the terms used so readily in our everyday lives and within the field of academia.

### **1.1.3. 'Race', ethnicity and culture**

The constructs of race, ethnicity and culture are frequently used interchangeably within the literature (Daryanani, Hindley, Evans, Fahy, & Turk, 2001). Dwivedi (2000) provides a simple definition for each of these terms: race as an individual's biological inheritance, ethnicity as how individuals think about their biological inheritance, and culture as the social space where race and ethnicity are constructed through conversation. However, these definitions are insufficient and do not capture the multi-faceted and contentious nature of each of these terms.

### **1.1.4. 'Race'**

'Race' is said to be a permanent fixture of someone's biological inheritance or genetic ancestry (Fernando, 1991) and is seen in the above definition by Dwivedi (2000). However, this claim of a biological basis has been critiqued as pseudo-scientific, as these have previously, and currently, been selected by social and historical processes (Fernando, 2010). Race is considered to have more to do with processes of power than biological differences (Rathwell & Philips, 1986).

Omi and Winant (2015) argue that 'race' is socially constructed in that it differs according to time and place, and that it is ocular in that 'bodies are visually read, understood and narrated' (Omi & Winant, 2015, p.13). They go on to define 'race' socially:

*'A concept that signifies and symbolizes social conflict and interests by referring to different types of human bodies'*  
(Omi & Winant, 2015, p.110)

This definition recognises the importance of bodies in the history of the construct of 'race' and highlights lived experiences of that focus predominantly on appearance (Eddo-Lodge, 2017). The historical context of 'race', emerging first in the sixteenth century (Banton, 1987), is intimately tied up with colonisation and race-slavery.

#### **1.1.5. Ethnicity**

Dwivedi (2000) captures the personal and self-defined nature of ethnicity in highlighting a person's *thoughts* about their biological inheritance. Putting aside the issues related to 'race' and the biological element of this definition, we see the importance of a person's choice and how it can, therefore, be changeable in line with how that person defines themselves in that place and time (Fernando, 1991; Jenkins, 1986).

Hodes, Creamer and Wooley (1998) highlight how definitions of ethnicity are influenced by economic and political factors and are used within existing power relations. This is perhaps observed within research where ethnicity is not decided by the individual themselves but by the researcher (thereby not meeting the definition of being self-defined) and complicating the findings (Daryanani et al., 2001).

The misuse of this term within research can occur for a variety of reasons, such as the result of power relations, the overlap with the construct of 'race' and misunderstandings by the researcher and participant, and issues with categorising a person's complex identity. In relation to the latter point, Hodes and colleagues (1998) noted how mixed ethnic unions prove difficult to categorically record within the traditional format of a single ethnicity, and choices will often privilege a particular ethnic heritage over others. These 'mixed' ethnicities are seen as having little value in research due to the potential for an enormous range of categories (Agyemang, Bhopal, & Bruijnzeels, 2005).

However, even established ethnic categories carry questionable utility. For example, it can be seen that broad categories such as 'South Asian' can mask significant distinctions between unique socio-economic, cultural and historical conditions that are better recognised in the smaller groupings of Indian, Pakistani and Bangladeshi (Modood, Berthoud, & Lakey, 2000). Unfortunately, even within these more defined categories, the heterogeneity within ethnic groups is huge, as is the similarity between ethnic groups (Bose & Jennings, 2005).

#### **1.1.6. Culture**

Perhaps unsurprisingly, the definition of 'culture' has changed across time and place, influenced and transformed into the abstract and vague definition it now holds (Fernando, 2010). This is partly due to recent academic developments in how the categorising of people (as in race and ethnicity) have become suspicious, built upon the writings of Foucault (1980, 1982) and Said (1978), who identified the intimate link between knowledge and power. This postmodern view complicates all and any definitions of culture, however, it is helpful to consider two particular definitions of culture that are pertinent to the study at hand. These definitions refer to two levels: that of individuals, and that of institutions.

##### **1.1.6.1. *Individual culture***

'Culture', when applied to an individual, refers to 'shared patterns of belief, feeling and adaptation which people carry in their minds' (Leighton & Hughes, 1961, p. 447). It therefore applies to both the internal cognitions and external behaviours of an individual. This can be expanded further when we consider the shared culture of collected individuals, such as the social groups of family, village, communities, nations, and so on (Fernando, 2010). Considering these further cultures, it can be seen that more than one culture can exist within a single society as in the United Kingdom (often referred to as 'multicultural' Britain; Sunak & Rajeswaran, 2014). It is also the case that

one individual can be said to be part of many cultures (for example in mixed ethnic backgrounds).

#### **1.1.6.2. *Institutional culture***

Another use of the term ‘culture’ refers to the ecology within which an individual operates, such as at the level of an organisation or institution. As opposed to the individual cultures discussed above, it refers to the ‘ethos or the intangible underlying determinants of people’s behaviour in a particular context’ (Fernando, 2010, p.9). Reference to ‘ethos’ and its ‘intangible’ nature is to say it is not easily observable in the thoughts or actions of just one individual, rather it is the result of a group of people working together in unison. This group adheres to a common way of doing things – an ethos, tradition or system – which constitutes an institutional culture.

Notably, the training of the profession of clinical psychology is based upon the ethos of relevant regulatory and governing bodies, such as the British Psychological Society (BPS) and Health and Care Professionals Council (HCPC). Whilst training is delivered by separate Universities and teaching staff, each emphasising a different kind of training, there remains an adherence to particular ways of doing things across all training sites. Clinical psychology can therefore be said to have its own ethos, tradition or systematic way of doing things and, therefore, an ‘institutional culture’. I discuss the development of this in more detail in Section 1.2.1.3.

#### **1.1.7. Black and Minority Ethnic**

Black and Minority Ethnic (BME), as the name implies, is a way of grouping individuals on the basis of ethnicity. The term is effectively used within the culture of the UK to describe all those ethnic minority groups not contained within the White British ethnic category. It therefore encompasses many ‘non-White’ ethnic identities and are usually non-European in origin (Agyemang et al., 2005). Other terms, such as Black, Asian and Minority

Ethnic (BAME) are also frequently used in the literature and is often used interchangeably with BME.

These broad categories have been criticised due to its part in the process of 'othering' those from different ethnic backgrounds (Canales, 2000). Critics draw attention to how the inverse grouping 'White Majority Ethnic' is not in use and, therefore, how the term BME renders 'Whiteness' as invisible and the default, a norm by which 'others' are judged (Wood & Patel, 2017). The term implies that ethnicity is only located in 'other' BME individuals, disowning the ownership of racial, ethnic and cultural identities in White individuals (Patel et al., 2000).

When we probe the construct of BME, we see that it carries the same issues as any single ethnic category, yet risks multiplying these issues by treating disparate ethnic backgrounds in a single homogenous grouping (Fernando, 2010). Despite these conceptual issues, it remains the accepted term within the research literature and governmental policy (Winker, 2004). I have chosen to use this terminology critically throughout the text of this study, acknowledging some of these complexities and allowing me to position this research within the wider literature. I take some inspiration from the multiple meanings and uses the term can have, and the possibility that it also represents the collective and common experiences of individuals who are subject to racialised discrimination (Griffiths, 2018).

#### **1.1.8. Intersectionality**

Intersectionality arose from feminist studies and aimed to address the diversity in female experiences beyond the dimension of gender, towards consideration of the complex way multiple identities and disadvantages interact (Collins, 1998). It seeks to avoid the sometimes simplistic, additive way of conceptualising multiple identities to seeing the diverse and multiple intersecting components of experience in terms of power relations and inequalities (Crenshaw, 1991; Tang & Pilgrim, 2017).

There is a risk when writing about issues of race, ethnicity and culture to reduce explanations to structural or institutional factors alone and ignore the many other disadvantages both from environment (for example finances, employment, education, housing, etc.) and identity (for example age, gender, sexuality, religion, etc.), that may be foregrounded in a particular context (Bhui, Nazroo, Francis, Halvorsrud, & Rhodes, 2018). These multiple characteristics all intersect with issues of ethnicity, leading to different and varied power relationships, and I ask that the reader keeps in mind these multiple influences.

#### **1.1.9. Mental health diagnosis**

Psychiatric diagnoses and their use throughout this thesis and resultant transcripts are best understood in the historical contexts in which they emerged (discussed in Section 1.1.). They are viewed as highly contested constructs whose relationship to systems of racial oppression are well understood and act to reproduce racism(s) (see Section 1.3.). The use of diagnostic labelling and epidemiological data in this text should be viewed with this critical awareness.

## **1.2. Part Two – Historical Contexts of Racism and Clinical Psychology**

### **1.2.1. Racism(s)**

Historically, racism has developed from race slavery and colonisation by European powers (Akala, 2018; Eddo-Lodge, 2017). This system of exploitation required justification, and so developed ways of identifying and reifying differences between European populations and the populations of countries exploited for labour and resources (Kapuściński, 2008; Searle, 1992).

This process led to the construction of 'non-European', 'non-White' individuals as 'Other' through the concept of 'race' (Fernando, 2017). This 'race thinking' (Barzun, 1937) saw these individuals as inferior, uncivilised and in need of colonisation. The construction of the Other was inextricably linked with power and knowledge, produced and supported by European philosophers and academic fields such as Orientalism (Said, 1978). This process is not limited to the ideological realm, however, and produces structural inequalities in a dialectical relationship (Cabinet Office, 2017; Omi & Winant, 2015).

Goldberg (1993) does not consider racism to be a single static thing, saying 'there may be different racisms in the same place at different times' (Goldberg, 1993, p. 91). Racism takes a particular shape in particular time periods and contexts, and it is difficult to abstract it out or limit it to a single manifestation (Hall, 1996). The various shapes of racisms are covered in more detail elsewhere (see Rattansi, 2007), however, for the purposes of this study I use the definition of the 'systematic application of prejudice across personal and institutional contexts' (Patel et al., 2000, p.31).



### **1.2.1.1.      *Personal and institutional racism***

In similarity with Section 1.1.6. on culture, racism can be helpfully understood at the levels of the individual and the institution. Essed (1990) spoke to a personal experience of racism in the everyday sense, occurring between people as they interact. Personal racism is not necessarily the overt application of prejudice and may be unwittingly expressed through ways of behaving and interacting. It may take on more subtle forms, captured in the concept of everyday 'microaggressions' (Eddo-Lodge, 2017).

These personal, individual acts of racism may become embedded within the structure of society and comprise an institutional culture, where racism moves towards the 'total white community [acting] against the black community' (Carmichael & Hamilton, 1967, p.4). The incorporation of racism into social and professional structures is known as 'institutional racism' and became popularised in the United Kingdom following the Macpherson Report, an inquiry into police handling of the racist murder of Stephen Lawrence (Home Department, 1999). It was defined in this report as:

*The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping that disadvantages minority ethnic people. (Home Department, 1999, p.28).*

This definition was criticised for pursuing a particular purpose, as it is careful to emphasise the 'unwitting' and 'thoughtlessness' of these acts for the political expediency of affecting the most change in the police system at that time. However, the restrictive nature of this definition has been criticised for its potential to absolve individuals of responsibility for personal behaviour, instead the accountability of an individual is cast off as 'institutional' (Fernando, 2017).

#### **1.2.1.2.        *Scientific racism***

During the eighteenth century 'Enlightenment' and the development of 'European values', Eze (1997) points to the race thinking in the key thinkers of Hume, Kant and Hegel and their articulation of European racial superiority. Outram (2005) describes the characteristics of this period as reliance on 'reasoning' to come to a 'truth' that is supposed to be free from bias. However, during this period the developing 'European values' of liberty, democracy and equality existed alongside race-slavery and colonisation. In reality, these values were limited to a small minority of people culturally and geographically (Fernando, 2017).

Kuhn (1962) described the emergence of the scientific paradigm that came from the ideas of the 'Enlightenment', a claim that knowledge is rooted in the beliefs of positivism, causality, objectivism and rationality. This impartial backdrop allowed racist knowledges to develop in the name of 'science', using the pseudo-science to classify and delineate differences between established 'races' and claim they form distinct species (Fryer, 1984) or using skull classification to claim lower intelligence in those that are not White (Jordan, 1968).

#### **1.2.1.3.        *Racism and clinical psychology***

In considering the racism of clinical psychology, Fernando (2017) invites us to consider the evidence that clinical psychology resisted dominant racisms during its own history. Tracing the origins of clinical psychology, Fernando shows how clinical psychology developed alongside timelines of race slavery and colonialism and the complicity of clinical psychology engaging in the prevailing constructions of 'race' throughout this history (Fernando, 2017). A way of contributing to these constructions was through the production of 'scientific knowledge' and 'truth'.

As the scientific paradigm led to new discoveries and successes in the natural sciences, so too developed its standing in society and the power it

held in the production of knowledge. Clinical psychology, developing within this context, drew on the same epistemology in the hope to create its own objective 'truths'. Today, clinical psychologists market themselves as 'scientist practitioners' (Belar & Perry, 1992) who apply 'formulation' (Johnstone & Dallos, 2014) to clients' mental health problems.

However, the assumption of knowledge in clinical psychology as universal and culture-free has been disproven across its history. Francis Galton (1822-1911), in developing methods of assessing intelligence, argued that 'race' differentiates intelligence and determined White men as the most intelligent (Richards, 2012). He later used this as evidence for 'eugenics' and the promotion of explicit racism masked as objective empiricism, backed up with convincing statistics.

Fernando (2017) details in length the legacy of racism within clinical psychology and the multiple ways in which the profession has supported racism in its history. Kalathil and Faulkner (2015) cite a contemporary example of racism in the BPS published document Understanding Psychosis and Schizophrenia (BPS, 2014), which they criticise on its basis of White knowledges and the exclusion of BME professionals and service users during its creation (Kalathil & Faulkner, 2015).

### **1.2.2. Clinical psychology workforce demographics**

Clinical psychology has long been recognised as unrepresentative of the general population (Davenhill, Hunt, Pillary, Harris, & Klein, 1989), leading to the latest response from the BPS in the form of an inclusivity strategy (BPS, 2015). Successful applicants into clinical psychology training programmes are more likely to be White (86%), female (84%) and non-religious (71%; Clearing House, 2016). However, these statistics are often compared with census data identifying 86% of the general population as White British (ONS, 2011), and so used to demonstrate that clinical psychology is representative of national demographics and does not exclude BME communities.

However, these claims ignore vast differences in applicants with regards to age characteristics. The Clearing House (2016) shows that 95% of successful applicants were between 20-34 years old, and if we look at the expected proportion of ethnic minorities in this age bracket we begin to see stark differences emerge, as 50% of the BME population are below the age of 30 (Sunak & Rajeswaran, 2014). In sum, greater disparities exist when looking more carefully at clinical psychology representation according to age, which are obscured by ageless national statistics.

Further research shows how BME applicants to clinical psychology are less likely to be successful at multiple stages in the pathway to qualification, getting progressively fewer from undergraduate applications all the way up to employment as a clinical psychologist (Smith, 2017). The BPS's inclusivity strategy (BPS, 2015), aimed to improve the profile of clinical psychology demographics through diversity initiatives, such as outreach programmes and raising awareness in BME communities (Turpin & Coleman, 2010). Turpin and Coleman (2010) acknowledge how little this picture has changed in the decades since these initiatives began.

The inclusivity strategy and wider discourse around 'diversity', have been criticised for highlighting certain solutions and understandings, such as cultural competency (see Section 1.2.4.) and effectively replacing the more challenging aspects of anti-racist practices (Patel, 2010). The debate around inclusivity then becomes about 'reaching out' and 'raising awareness' of BME communities, which remove the responsibility of clinical psychology to change its structural and institutional make-up. The use of inclusivity and a diverse workforce is used to counter charges of discrimination, whilst leaving its assumptions intact, and gives a message that it is the responsibility of BME communities to resolve these disparities (Wood & Patel, 2017).

### **1.2.3. Veils of Whiteness**

'Whiteness' is a term used to describe the consequences of being racialised as White and is useful when considering the implications of the

predominantly White profession of clinical psychology. It can be difficult to define this term owing to it describing an 'absence', that is, 'an absence of the consequences of racism' (Eddo-Lodge, 2017, p.72). Whiteness can be thought of as a set of normative cultural practices recognised most clearly to those it excludes, whereas for those within the category it is typically unexamined and invisible (Frankenberg, 1993).

The term refers to invisible privileges and power afforded to those racialised as White, reproduced through ideological and cultural practices and reinforcing structural, racial and intersectional hierarchies (Clark & Garner, 2009). It acts as a veil, obscuring its wearer to the realities of being racialised as the Other. Keval (2015) notes how Whiteness acts to disappear issues of race, as is seen in the production of psychological knowledge (Kalathil & Faulkner, 2015). There have been several recent publications drawing attention to the operation of Whiteness within the profession of clinical psychology and calling on the profession to change (Patel & Keval, 2018; Wood & Patel, 2017).

#### **1.2.4. Cultural competency**

Cultural competency has long been hailed as a remedy to the aforementioned issues of ethnic representation and Whiteness in the profession. A model espoused by Campinha-Bacote (1991, 2009), operationalises cultural competence as the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters (Campinha-Bacote, 1991). However, some views of cultural competency have been criticised for implying a finality to understanding issues of culture, and that these can be simply learnt and actioned, rather than consistently grappled with (Dogra, Vostanis, & Frake, 2007). This critique can be perhaps seen in the proliferation of 'toolkits' aimed at achieving competence in the field of mental health (Collins 2007; Husain, 2007; Wood, Landry & Bloomfield, 2006).

A singular and essentialising view of culture is therefore problematic when conceiving of cultural competence, and alternative models have been developed that aim to better consider the dynamic and changing nature of culture (Cowan, 2009). Tervalon and Murray-García (1998) adopt a 'cultural humility' that commits the practitioner to lifelong self-evaluation and self-critique, acknowledging some of the inherent power imbalances that occur when majority cultures interact with minority cultures.

Kirmayer (2012) suggests a move away from decontextualising and ahistorical conceptualisations of culture, however, recognises some of the value in programmes of cultural competence as disrupting the 'one size fits all' view of evidence-based mental health care delivery (see also Whitley, 2007). This view promotes better representation and cultural diversity within the profession, coupled with analysis of the structural sources of inequality, as providing the best way to understand and redress the inequities and injustices that are ignored, or even aggravated, by culturally-blind health care (Fraser & Honneth, 2003).

Clinical psychology has developed a number of training initiatives to promote working with issues of race, ethnicity and culture (e.g. Patel et al., 2000), however, Turpin and Coleman (2010) note how despite these efforts and the many available knowledges to clinical psychologists, trainees still rely on trainers for cultural knowledge. Turpin and Coleman (2010) wonder if this difficulty in trainees feeling competent is down to broader issues, such as a lack of culturally competent trainers and supervisors in the profession and well as a 'defensiveness' around issues of culture.

### **1.2.5. Policy**

#### **1.2.5.1. *International legal policy***

The Universal Declaration of Human Rights (UDHR; UN General Assembly, 1948) was created as an international agreement and set of standards for all member states. Articles 1 and 2 detail the obligation of dignity and equality of

all human beings, without distinction of race, colour, national origin, or other status. Article 25 of the UDHR relates to the right to health and wellbeing and an adequate standard of living.

The International Covenant on Economic, Social and Cultural Rights (ICESC; UN General Assembly, 1966) recognises the right for the highest attainable physical and mental health, and the responsibility of the state to progressively achieve these goals through the maximum available resources. It covers the addressing of determinants to ill health, the right to equal opportunity of access to healthcare, and the right to freedom from non-consensual medical treatment. A rights-based approach to health requires policy to prioritise the needs of those furthest behind to achieve greater equity in health. It also features the meaningful participation of stakeholders in all stages of assessment, analysis, planning, implementation and evaluation. It goes beyond a model of consultation or supplemental addition to the meaningful inclusion of marginalised groups.

Article 2 of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD; UN General Assembly, 1969) obligates the state to pursue policy to eliminate racial discrimination in all its forms. Like all declarations and treaties, the ICERD is seen as indivisible, inter-dependent and inter-related to the UDHR and ICESC and cannot be used in isolation.

The European Convention of Human Rights (1950) and the Human Rights Act (1998) develop these rights at the regional and national level, respectively. Public authorities, such as the NHS and its employees (including clinical psychologists), are seen as 'duty bearers' and responsible for upholding the rights of service users ('rights bearers').

#### **1.2.5.2.      *National legal policy***

The Race Relations (Amendment) Act (1976, 2000) was influential during the development of much of the governmental and institutional policy discussed later in Section 1.2.5.3. The Race Relations Act widened the

definition of 'public authority' to include private institutions and lists their statutory duty to actively promote race equality. Public authorities must adhere to a selection of specific duties and in following these can be said to comply with the general duties of the elimination of unlawful racial discrimination, promotion of equality of opportunity and the promotion of good race relations between people of different racial groups.

The Equality Act (2010) later brought together many different legal policies, including the Race Relations (Amendment) Act (2000), into a single policy. It places an Equality Duty on the public sector and the due regard to consider all individuals in their day-to-day practice, in shaping local policy and the delivery of services. All organisations must have a Race Equality Scheme dedicated to addressing cultural diversity and ethnic equality within services, including service planning, delivery and training (Healthcare Commission, 2009).

#### **1.2.5.3. Governmental and institutional policy**

Inside Outside (NIMHE, 2003) was commissioned following the significant policy and service development initiative of the Mental Health National Service Framework (DoH, 1999). At the time of publication, it was felt that not enough was being done to address the needs of BME communities and that current initiatives tended to marginalise or ignore these issues and approach them in a fragmented and limited way. Inside Outside was the first national report to consider service delivery in NHS settings. The authors noted:

*'For decades the disparity and inequalities between black and minority ethnic groups and majority white population in the rates of mental ill health, service experience and service outcome have been the focus of concern, debate and much research. However, there is little evidence that such concerns have led to significant progress... If anything, the problems experienced by minority ethnic groups within our mental health services may be getting worse' (NIMHE, 2003, p.5).*



The document sets out the focus of change on the structures of organisation (inside) and the empowerment of BME communities (outside). Despite the clear goals of the document, the implementation plan was devised separately, which has been seen by some as act of institutional racism owing to the author having little previous interest in the area (Fernando, 2017). This implementation plan, Delivering Race Equality (DRE; DoH, 2003), was developed in an environment where BME communities were not consulted, nor professionals who had worked in the area of identifying the change that was needed (Fernando, 2017). Whilst it used a similar language to the Inside Outside report, its implications were different, and rather than the emphasis on changing statutory services, it instead invested in the collection of further information. The recommendation of ‘community development’ (NIMHE, 2003, p.33) was changed to ‘community engagement’ (DoH, 2003, p.36).

DRE was updated two years later (DoH, 2005) following some of the findings of the David Bennet Inquiry (Sallah, Sashidharan, Stone, Struthers, & Blofeld, 2003), which implicated institutional racism in the death of David Bennet by physical restraint in a mental health hospital. The later revision of DRE largely rejected this inquiry’s recommendations, with the lead author disengaging from the project; this mismanagement being suggestive of institutional racism itself (Fernando, 2009). DRE made a number of promises to be achieved by 2010, such as reduced rates of admission to inpatient units, compulsory detention, seclusion, deaths, as well as many others; however, in its five-year review noted the many areas of improvement that remain (DoH, 2010), with the project criticised for lack of any substantial systemic response (Fitzpatrick, Kumar, Nkansa-Dwamena, & Thorne, 2014).

A number of previous and subsequent initiatives have taken place within the NHS aimed at improving access and outcomes for BME communities (see Palmer, 2018, for a comprehensive overview). Most recently, a House of Lords (2017) debate drew further attention to disparities within the NHS and wider society, with particular attention around the underrepresentation of BME communities within primary care. The debate noted how there

remained “no real specific, targeted and strong national framework for improving mental health care for Black and Ethnic Minority communities since 2010”.

#### **1.2.5.4.      *Policy relating to BME young people***

The policy backdrop in relation to young people is complicated, in part due to the applicability of many of the aforementioned policy which are intended to be implemented regardless of age (DoH, 2011). Furthermore, policy following the Equality Act (2010) requires an impact assessment in relation to protected characteristics. The result of these ageless and impact assessed documents is that recommendations and actions may not specify or account for BME young people in particular, and run the risk of making these important differences less visible.

Major mental health publications, such as Delivering Race Equality (DoH, 2003) and Inside Outside (NIMHE, 2003), have been criticised for their lack of focus on BME young people and families (Malek, 2011). Later publications, such as ‘No Health without Mental Health’ (DoH, 2011) went on to make a staggering amount of omissions in relation to issues affecting BME young people and families, despite having undergone an impact assessment and the intention to produce an ageless mental health strategy. Malek (2011) criticises this strategy’s inadequate research on rates of prevalence, the exclusion of race-specific risk factors in mental health, the over-representation in other mental health services, and the omission of children and young people within sections on race.

An important historical policy document was the National Service Framework (DoH, 2004) – a 10-year project for children, young people and maternity services. Standard nine relates to mental health provision and lays out the principle that access to CAMHS should be equal regardless of characteristics such as race, ethnicity and culture. This was further supported by the Equality Act (2010) that advanced equality for all protected characteristics. However, young people are in a peculiar situation where they are able to

claim discrimination by services because of their race, but as they are under the age of 18, they cannot claim age discrimination by services despite it being a protected characteristic (Neckles, 2013).

Two of the most recent and relevant policies in relation to access to services for CYP are the Future in Mind (DoH, 2015) and Five Year Forward View for Mental Health (FYFV; Mental Health Taskforce, 2016). Future in Mind was written by the Children and Young People's Taskforce, set up in 2014 to improve access and services in mental health. The document makes a number of proposals across five key themes, with one of these being on issues of access. However, despite the acknowledgement that inequalities of access exist, the document does not go on to analyse or make recommendations that relate to issues of access for BME communities. Notably, the document at no point uses the words 'race', 'ethnicity' or 'BME' at all; the closest it gets is an allusion when mentioning that 'some' young people 'involved in gangs' are 'unwilling to attend' mental health services (DoH, 2015, p.44.).

The Five Year Forward View for Mental Health lays out an 'ageless' strategy aimed at improving provision up to 2020/21. It acknowledges that there has been 'no improvement' relating to inequalities of access following the end of the DRE programme in 2010 (Mental Health Taskforce, 2016, p.13). However, the focus is instead on providing seven-day mental healthcare, integration between physical and mental health funding and settings, and better prevention and early intervention. It makes key promises regarding the strengthening of the workforce and the expectation that service users and staff not face discrimination based on their ethnicity.

No NHS specific recommendations follow from this, however, a governmental recommendation is made that the DoH appoint a new 'equalities champion' (Mental Health Taskforce, 2016, p.77) and pilot a Patient and Carers Race Equality Standard to match the comparable Workforce Race Equality Standard (NHS Equality and Diversity Council, 2016) for staff. FYFV also recommends better national metrics to support

improvements in children and young people's mental health, accepting the dire need for more research specific to this context (Lavis, 2014; Malek, 2011).

The lack of effective policy that relates to BME children and young people has serious consequences beyond the national level. These policy blind spots are later compounded and replicated at the local level, for example, they influence priorities given to local needs assessments and joint health and wellbeing strategies (Oliva & Lavis, 2013). These local processes inform arrangements for local commissioning, and without up-to-date assessments they risk being simply made on historical provision and not current need. The result is that ethnic inequalities remain stagnant or widen ever further in a policy backdrop which neglects the needs of BME young people.

#### **1.2.6. A 'wicked problem'**

The last 50 years has seen many policies and initiatives developed to promote greater equality in the UK. Great strides have been made from the more overt and explicit discrimination that was bound up in law and left unpunished for centuries. However, we also see how policy has also not achieved much of the changes it had set out to do, and in our most recent governmental debates and research (House of Lords, 2017; Race Disparity Audit, 2017) we see that our current context remains woefully inadequate in terms of acting against forms of racial and ethnic discrimination (Palmer, 2018). There is also evidence that things may be getting worse, with the rise of racism and White supremacy in an era of Trump and Brexit (Bhui, 2016; Fernando, 2017).

We can think of the dispiriting results in terms of racism being a 'wicked problem' (Rittel & Webber, 1973). Rittel and Webber coined this term to describe the difficulty policy has in addressing what are, by their very nature, indefinable and multivariate issues, with any goals or desired outcomes being heavily disputed and indescribable. They go on to argue that the paradigm of science and engineering that underlies 'evidence-based policy'

(Shaxson, 2005) cannot be applied to problems of open societal systems. An issue like 'inequality' is not definable or separable, and so cannot be solved 'at best they are re-solved – over and over again' (Rittel & Webber, 1973, p.160). This can help us understand why after these many policy interventions and initiatives, race and ethnic inequalities remain to be re-solved.

### **1.3. Part Three – Clinical Implications for BME Young People**

#### **1.3.1. BME young people in the United Kingdom**

The percentage of individuals identifying as White has declined over the past two decades, alongside a proportionate increase in those identifying within the BME category (Jivraj, 2012). When considering age characteristics of the population, it is estimated that 20 per cent of BME young people are under the age of 20 compared to eight per cent of White young people (Sunak & Rajeswaran, 2014). In 2016, the median age was predicted to be between 11 and 13 for BME individuals when compared to 40 for White individuals (Sunak & Rajeswaran, 2014).

Services and institutions will increasingly need to serve young people from BME communities in response to these demographic changes. Furthermore, young people are subject to unique circumstances when compared to adults, and there remains a need to explore how ethnicity impacts outcomes for young people in the UK (Lavis, 2014) that can account for the many differences in experiences and contexts (Gonzalez, Alegria, & Prihoda, 2005; Montazer & Wheaton, 2011), as well as a service structure that is delineated between adults and young people.

#### **1.3.2. BME young people and mental health**

The 'prevalence' of mental health problems and diagnoses in BME communities have been the subject of epidemiological study. These studies include research from many countries, where living conditions may differ widely, and where the composition of BME communities may be very different from the UK. This current section examines studies looking at the rate of mental health problems according to ethnic identity, and does not address the provision or use of mental health services, an issue discussed later in Section 1.3.6.

Before highlighting the findings of epidemiological research, it is important to recognise the aims of epidemiology as to 'prevent, control or manage the problems under study' (Bhopal, 2002, p.xxii). An epidemiological approach aims to look at whether children and adolescents have different rates of mental health problems and, if this is found, why this is. Through a process of accounting for known variables, this research enquiry aims to suggest that differences in mental health problems can be said to be due to a person's ethnic identity. This endeavour has been criticised for a number of reasons (e.g. Bhopal, 1997; Chaturvedi, 2001), namely as pursuing a kind of scientific racism (see Section 1.2.1.2.). However, it might also be viewed as beneficial in suggesting how to best provide services that address these differences, providing further understanding of the aetiology of mental health problems, and better enabling future approaches that resolve these inequities (Senior & Bhopal, 1994).

There are other pitfalls with this kind of research relating to the complexities of categorising ethnicity (see Section 1.1.5.), issues of generalisability across specific communities and across time, the applicability of conceptualisations of mental health problems across culture (see Section 1.3.4), amongst many others (for an overview, see Ramchandani, 2004). The text below should, therefore, be interpreted with caution and these issues held in mind.

The majority of epidemiological research has been on adult populations, however, the available research suggests there are observable differences in mental health problems in young people across ethnic groupings (Singh, Greenwood, White, & Churchill, 2007). These differences appear to vary according to age, with epidemiological studies of Asian and White British children under the school age showing no difference in behavioural and emotional difficulties (Newth & Corbett, 1993). A study of primary school age children showing a lower presence of psychological difficulties for Gujarati children when compared to White British children (Hackett, Hackett, & Taylor, 1991). For older children, studies have shown Punjabi Moslem children to have higher rates of adjustment disorder and lower rate of conduct disorder (Roberts & Cawthorpe, 1995). A greater likelihood of

receiving a diagnosis of psychotic disorders and autism in Afro-Caribbean children has also been recorded (Goodman & Richards, 1995).

One of the most important and recent investigations into the prevalence of mental health problems in young people (aged 5-16) was commissioned by the Office for National Statistics (ONS) and surveyed the population of Great Britain (Meltzer, Gatward, Goodman, & Ford, 2000). Meltzer and colleagues (2000) observed a prevalence rate of 10 per cent in White children for common mental health disorders as defined by the International Classification of Diseases, tenth edition (ICD-10; WHO, 1992). The prevalence rates were higher for Black children at 12 per cent, lower for Pakistani or Bangladeshi children at eight per cent, and lowest for Indian children at four per cent.

Following this, Goodman, Patel and Leon (2008) conducted the first systematic review in the United Kingdom looking at differences in mental health presentations across ethnic groupings. Amongst their findings, they observed higher scores on questionnaires for eating disorders in South Asian females and a higher risk of self-harm when compared to the 'general' population, as well as increased rates of psychosis in Black Caribbean children, a finding similarly observed in the adult population (Arai & Harding, 2004). Despite these findings of greater representation in some areas, Goodman and colleagues (2008) concluded that, in general, there was an underrepresentation of BME young people with mental health problems and suggested one reason may be due to overall better mental health in the BME population.

Conducting research in this area, as has been discussed previously, is difficult and fraught with limitations. The aforementioned studies represent the most significant attempts at conducting this research in the context of the United Kingdom. Many of the questions epidemiological might help elucidate are still left unanswered due to the large variance in findings, with this paucity in the literature perhaps being the most striking finding of all (Ramchandani, 2004).



### **1.3.3. Mental ‘illness’**

When considering the prevalence of mental health problems across ethnic groupings, it is important to return to what it is mental health diagnoses are said to represent. As discussed in Section 1.2., the relationship between the ‘psy’ professions (Rose, 1990) and mental health diagnosis is the result of social and historical contingencies. This can be seen most clearly when we consider the proliferation of psychiatric diagnoses from the first publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I; APA, 1952) to the most recent and expanded fifth edition (DSM-V; APA, 2013), which serves as a blueprint for global conceptualisation of mental ‘illness’ (e.g. ICD-10; WHO, 1992). ,

Despite the ubiquity of mental health diagnoses, their reliability and validity has been the subject of considerable debate (Johnstone, 2000). Boyle (2007) argues that psychiatric diagnoses represent the attempt of the psychiatric and psychological professions to attain status by borrowing from metaphors of disease and pathology in the field of physical health. In contrast, mental health diagnoses have been found to have far less reliability, validity or prognostic value in comparison to physical health diagnoses (Bentall, 2010; Johnstone, 2000).

Conceptualisation of mental ‘illness’ and their associated diagnostic criteria, despite appearing in a form and language which evokes objectivity and scientific ‘truth’, are instead lay constructs (Banton, 2016); socially constructed and context dependent, carrying with them a collection of assumptions and norms that require interrogation. There is a risk, when analysing the previous epidemiological research, to consider the correlation between ethnicity and mental illness as due to a characteristic inherent within either category. These are essentialist understandings of ethnicity and mental illness, and risk reifying these constructs as explanatory and causal (Bhui, Nazroo, Francis, Halvorsrud, Rhodes, et al., 2018).

### **1.3.4. Eurocentricity and misapplication**

The backdrop in which the knowledgebase of mental illness arose from is inevitably impacted by the context and demographics of clinical psychology in the UK (see Section 1.2.2.). This context leads to clinical psychology exhibiting a bias towards Eurocentric and ethnocentric ideals that are inevitably represented and wrapped up in its theory (Coleman, Brown, Acton, Harris, & Saltmore, 1998; Halsey & Patel, 2003; Lokare, 1992; Meldrum, 1998; Nadirshaw, 1992; Williams, Turpin, & Hardy, 2006). The term of Eurocentrism refers to the global dominance of predominantly Western theory, which might be more specifically termed as Anglo- and andro-centric owing to the greater historical operation of English and patriarchal power in current research. However, I use the term Eurocentric due to its wider use in the literature.

Evidence for the problematic nature of applying Eurocentric conceptualisations of mental health can be seen in the aforementioned epidemiological research on other nationalities and cultures, which typically result in highly elevated rates of mental health problems (Kurtz & Street, 2006). For example, the Child Behaviour Checklist (Achenbach & Edelbrock, 1983) is widely used in prevalence research on children and was one of the questionnaires used in Meltzer and colleagues' (2000) study in the UK. However, the validation and standardisation of this questionnaire was undertaken on 'general' populations from North America and Europe, so that when this questionnaire was administered to a Puerto Rican population, the prevalence rate of mental health problems was found to be 49.5 per cent (Bird et al., 1988).

Whilst Puerto Rico might be thought to be within the norms used to validate the Child Behaviour Checklist, owing to its North American geography, being part of the United States of America, and including population where the majority identify as 'White, alone' (Allen, 2017), there exists a more complex relationship between racial and ethnic identification that emerges out of histories of Spanish colonial power structures and extant cultural differences

to the 'general' North American population residing on the mainland (Allen, 2017). Bird and colleagues (1998) attempted to address some of these differences by taking into account the level of impairment of the mental health problems; reducing the prevalence rate to 18 per cent. Even this was thought to be far too high, demonstrating how the application of Eurocentric conceptualisations of mental health problems can be fraught even within the very country where the norms were developed.

Littlewood (1990) notes how applying these Eurocentric conceptualisations of mental health often ignores the alternative expressions of mood embedded in language and culture, such as the use of metaphor. Kleinman (1977) refers to the 'category fallacy' of using these lay constructs, and the risk of erroneous diagnosis when applying our conceptions of mental illness on multi-ethnic populations. Kleinman went on to encourage research with different ethnic groupings that starts with their own conceptions of mental health and how this is articulated or expressed, rather than the application of our own cultural values inextricably woven into the very meanings of mental health and illness.

### **1.3.5. The structure of services for young people**

It is necessary to distinguish what mental health service provision looks like in child and family contexts. Access to services for children and young people differs in some meaningful ways to adult services. Typically, CYP will present to their health visitor or GP, depending on their age. More frequently, help is sought through the young person's network, such as their parent, carer or teacher, who express their concern for the child's wellbeing (Appleton & Hammond-Rowley, 2000; Garralda, 2004).

Child and adolescent mental health services (CAMHS) are usually structured according to the framework Together We Stand (HAS, 1995). The framework describes service delivery according to 4 'Tiers' which span many agencies and sectors and have clear referral pathways. Broadly speaking, Tier 1 services are delivered by professionals that often do not have specialist

mental health training and are usually delivered in primary care settings. As we go up the Tiers, interventions become more targeted and address more severe mental health presentations, from uni-disciplinary early intervention initiatives at Tier 2, to specialist multi-disciplinary approaches at Tiers 3 and 4. Clinical psychologists play a key role in the delivery of services for Tiers 2, 3 and 4 (Rowland & Beinart, 2009).

Recent strategy has suggested these tiers be removed (DoH, 2015), with some Trusts changing the structure of CAMHS to a 'tierless' provision (Waltham Forest CCG, 2017). This is in response to an acknowledgement of some of the problems of access in a system of Tiers, with referrals between services requiring discharge and additional re-referral between Tiers, leading to an inevitable delay. Future in Mind (DoH, 2015) also promotes a 'single point of access', where multi-agency staff act as a single contact point for referrers and are responsible for risk assessing and deciding who can best meet the child or young person's needs, thereby reducing the delay caused by inappropriate referrals.

It is important to note that children and young people can access mental health support outside of a mental health setting like CAMHS, and may receive support by clinical psychologists in settings such as schools, social care (Golding, 2009) and physical health settings (Spinks, 2009), amongst others. As these services sit outside of CAMHS, they are not subject to the same kinds of unifying policy and strategic frameworks that CAMHS are, and so it is impractical to speak comprehensively about the various pathways to access across all these services. However, what can be said is that clinical psychologists often take an active role in the process of assessment and formulation of young people referred to services, whether as part of a CAMHS 'single point of access' to general mental health provision or, most commonly, as the gatekeepers to psychological intervention delivered by clinical psychologists.

### **1.3.6. Inequity in pathways to services**

Having discussed the problematic nature of constructs of ‘mental illness’ and ‘ethnicity’, I now look towards the effects of this complex backdrop on service provision. Ethnic inequalities in accessing services have long been recognised as additional discriminatory process within adult mental health (Griffiths, 2018; Keating, Roberston, McColloch, & Francis, 2002). Pathways to services for children and young people is a comparatively under-researched area, however, the adult literature contains robust and consistent evidence of the inequity BME individuals experience in the NHS system.

#### **1.3.6.1.        *The case for unmet need***

An essentialist reading of the aforementioned epidemiological research may lead to conclusions that ‘Asian’ individuals exhibit psychological ‘robustness’ and, therefore, do not require psychological services (Beliappa, 1991; MacCarthy & Craissati, 1989; Nadirshaw, 1994; Webb-Johnson & Nadirshaw, 1993), or that cultural factors are seen as dysfunction and linked to mental illness (Nadirshaw, 1992; Smaje, 1995). These conclusions do not reflect on the inherent Eurocentricity of psychological knowledge (see Section 1.2.) and frequently reference BME individuals lacking the ‘psychological mindedness’ to engage in psychology, or that they have not successfully integrated enough into Western culture to benefit (Fatimilehin, 1989; Kareem & Littlewood, 2000; Littlewood, 1992; Slater, 1994).

Those racialised within the category of BME are subject to multiple dimensions of structural and institutional disadvantage (Cabinet Office, 2017). Interpersonally, BME individuals regularly experience acts of interpersonal racism from White Majority Ethnic groups, which is known to have a harmful effect on mental health (Kwate & Goodman, 2014; Williams & Williams-Morris, 2000). Children of Black and Mixed heritage are in family structures that increase the likelihood of mental health problems (Green, Meltzer, Ford, & Goodman, 2005; Holms & Kiernan, 2010; Maynard & Harding, 2010). Education attainment in Black children was lower than other

ethnic groups (DoE, 2013). BME young people are more likely to live in poor housing (Phillips, 2008) and poverty (Equality and Human Rights Commission, 2010). These inequalities all contribute to a greater probability of having a mental health problem, and the more risk factors experienced the greater this probability will be (Sabates & Taylor, 2013).

Furthermore, ethnicity is one of many identities and gradients of disadvantage which intersect differently (See Section 1.1.8.), with these various combinations leading to further unequal outcomes and different power relationships (Bhui, Nazroo, Francis, Halvorsrud, & Rhodes, 2018). For example, BME young people who identify as lesbian, gay or bisexual have higher rates of self-harm and suicide (Guasp & Taylor, 2012). Half of BME individuals with a disability live in household poverty, experience social isolation, stigma and discrimination (Trotter, 2012). As boys, Black Caribbean and Mixed White and Black Caribbean are one and a half times more likely to be identified as having behavioural or emotional difficulties and excluded from school (Men's Health Forum, 2006).

The greater burden of disadvantage and, therefore, greater likelihood of mental health problems, raises the question of why epidemiological research and services do not bear this out. There is evidence that services are 'underserving' BME individuals, perhaps seen in the results of a service-led initiative aimed at increasing service use amongst South Asian adults, leading to an eventual 'overrepresentation' within the service (Hackett & Patel, 2004). Similar under-representation has been found for Asian (Stern, Cottrell, & Holmes, 1990) and Bangladeshi (Messent & Murrell, 2003) young people. Research suggests that services which were seen as having a good reputation, reasonable waiting lists and ease of access are more acceptable to BME communities and have greater representation compared to the local community (Pacitti, Hughes, Statter, Alvarado-Rivero, & Chaddha, 2011). These results are suggestive of the significant role of services in equitable access, and that service representation of BME young people is best seen as an unmet need (Malek, 2011).

### **1.3.7. Pathways to care**

#### **1.3.7.1. *Pathways for BME adults***

One explanation for differences in service representation for BME communities are the disparities in pathways to care. Ethnic inequalities in how services are accessed have long been recognised as a discriminatory process within adult mental health, with the literature containing robust and consistent evidence of the inequity of BME individuals experience in the NHS system (Griffiths, 2018; Keating et al., 2002).

For example, research on the adult population has long established a disproportionate number of BME individuals detained under the Mental Health Act and the Criminal Justice System (Mann et al., 2014; Morgan et al., 2005). A systematic review and meta-analysis related to differences in pathways to care for those with a diagnosis of psychosis (Halvorsrud, Nazroo, Otis, Brown Hajdukova, & Bhui, 2018), highlighting decades of research that recognised a higher likelihood of compulsory treatment, involvement in the criminal justice system, police contact and hospital admissions (see also Anderson, Flora, Archie, Morgan, & McKenzie, 2014; Anderson, Fuhrer, & Malla, 2010; Bhui et al., 2003; Singh et al., 2007).

#### **1.3.7.2. *Pathways for BME young people***

Kramer, Evans and Garralda (2000) found that BME young people were more likely to be referred by primary care health services and self-refer than White counterparts, and less likely to be referred by secondary services. Fewer BME young people were referred for developmental problems, however, following assessment more were diagnosed with a developmental disorder. Goodman and Richards (1995) found a trend for African Caribbean young people receiving a diagnosis of conduct disorder. Messent and Murrell (2003) looked at pathways to a CAMHS and found African and Caribbean young people were more likely to be referred with urgent problems, and Asian and Bangladeshi young people were more likely to wait longer for a

first appointment compared to the White population. It appears that for BME young people, their experiences of mental healthcare are similar to the well documented inequalities in the adult population.

Malek and Joughin (2004) reflect on the picture of services for young people as compared to adults, concluding that there is an underrepresentation of BME young people in services that is best understood as an unmet need, and that this in turn contributes to BME adults being overrepresented in urgent care pathways such as inpatient settings. Services that are inaccessible to BME young people begin a journey of injustice where services increasingly opt for more coercive and controlling methods of mental health treatment, alongside BME individuals being less likely to seek help earlier on – a ‘circle of fear’ (Keating et al., 2002).

### **1.3.8. What are the barriers for BME young people?**

What contributes to these differences in pathways to care? Research exploring inequitable access to services can be loosely placed into two categories: patient-related and service-related explanations.

#### **1.3.8.1. *Patient-related explanations***

Patient-related explanations have a tendency to locate the barriers within BME young people. For example, attributing the lower representation to a lower prevalence of mental health problems (Goodman et al., 2008), a lack of knowledge about mental health problems and how to seek support (Loewenthal, Mohamed, Mukhopadhyay, Ganesh, & Thomas, 2012), suffering in silence (Kovandzic et al., 2011), perceived stigma and gossiping within communities (Knifton, 2014), religious affiliation (Guerin, Guerin, Diiriye, & Yates, 2004), migration (Montazer & Wheaton, 2011), language (Loewenthal et al., 2012), and the socio-economic costs of treatment (Lamb, Bower, Rogers, Dowrick, & Gask, 2011). Consistently, those racialised as BME are considered ‘hard to reach’ (Bradby et al., 2007) and campaigns



often centre around being educative and involve giving information to BME communities (Children and Young People's Mental Health Coalition, 2012).

#### **1.3.8.2.        *Service-related explanations***

Service-related explanations refer to the services themselves and are usually drawn from qualitative studies exploring BME individuals' experiences of services. Participants typically cite discrimination from healthcare professionals (Bradby et al., 2007), a lack of effective information and communication (Kovandzic et al., 2011) and inadequate interpretation services (Stein, Christie, Shah, Dabney, & Wolpert, 2003). However, in common with research identifying patient-related issues, there is a continuation of theorising that leaves little interrogation of the 'default', predominantly White-serving mainstream service. These research enquiries, whilst no doubt offering useful contributions to the understanding of barriers to access, may serve to reduce any real scrutiny on the nature of services themselves and instead continue to look for an answer 'out there'.

#### **1.3.9. The role of practitioners**

Halvorsrud and colleagues (2018) identified how GPs were less involved in the care of Black adults when compared to White adults with psychosis, a finding that is recognised in other psychiatric diagnoses (Goldberg & Huxley, 1980; Lloyd & Fuller, 2002). There is tendency to view these discrepancies under terminology that sees the problem as 'institutional' in nature, however, this may obscure the more individual and interpersonal interactions of practitioners when providing access to mental health services.

Daryanani and colleagues (2001) looked at the influence of practitioners on pathways to child mental health services, and found differences in referrals according to ethnic grouping that was dependent on the interaction of different professional identities. They found a greater likelihood of Black young people referred by specialist doctors and education services, Mixed

Race young people by social services, South Asian young people by specialist doctors, and White young people by GPs.

In an adult primary care mental health service that delivered psychological therapies, Brown and colleagues (2014) found a striking effect when looking at the proportional representation of individuals from different ethnic groups who self-referred. Using demographic data from a recent community health study as a benchmark, they found GPs were more likely to refer White male individuals and less likely to refer those identifying as Black African. In stark contrast, an analysis of the service's self-referral pathway revealed no such differences across characteristics of age, gender, benefit status and ethnicity accessing the service.

In questioning the reasons for these disparities, Daryanani and colleagues (2001) consider whether these referral practices were due to differences in mental health 'morbidity' (see Section 1.3.4. for an analysis of this view) which leads to presenting to different referrers, or whether these are due to patient- or service-related factors, such as those explored above. The authors go on to consider whether professional groups have particular biases in relation to their knowledge, definition of problems, experience of CAMHS or whether own ethnic and cultural location impacts on referrals. Whilst current research does not explore the causes for these practitioner-related differences, these findings are suggestive of the pivotal role of practitioners as a 'gateway' – and barrier – to equitable service provision for BME young people.

### **1.3.10. The impact of clinical psychologists**

Talking therapies are typically delivered by clinical psychologists in NHS settings, and BME individuals are less likely to be offered psychological intervention and more likely to have negative experiences of talking therapy (Dwivedi, 2002; Keating et al., 2002; Loewenthal, 2006; Malek & Joughin, 2004; Nadirshaw, 1992). Service users frequently refer to services as inadequate and irrelevant to the particular needs of those from various racial,

ethnic and cultural backgrounds (Agoro, 2014; Griffiths, 2018). BME young people have shared experiences of feeling that psychology services did not have the skills to understand important differences in culture and ethnic background (Street, Stapelkamp, & Taylor, 2005).

Research shows that BME individuals are more likely to drop out of therapy (Arnow et al., 2007; Wierzbicki & Pekarik, 1993), have worse therapeutic outcomes (Cochrane & Sahidharan, 1996) and poorer therapeutic alliance (Walling, Suvak, Howard, Taft, & Murphy, 2012) than the White population. Evidence from a dedicated clinical psychology service for the African and Caribbean population saw referrals to clinical psychology increase from 6% to 16% of the total referrals after a project to change the delivery of psychology to better consider aspects of cultural identity and experiences of racism (Street et al., 2005).

My literature review did not highlight any quantitative research that might illuminate the specific impact of clinical psychologists providing differential access to BME individuals accessing psychological, as has been shown in other professional groups (e.g. Brown et al., 2014; Daryanani et al., 2001). However, the structure of mental health services is such that some form of assessment by a professional occurs before being accepted for treatment (Sass, Moffat, Bhui, & McKenzie, 2009), either as part of a 'single point of access' (see Section 1.3.7.2.) or within the service before receiving a psychological intervention. Clinical psychologists are an important part of the assessment process at these stages, hence represent a gateway to accessing services in much the same way as other professional groups.

Fernando (2017) asks the difficult question of whether any specific anti-racist practices have been put in place by a profession. Indeed, the evidence that clinical psychologists are complicit in acts of institutional racism is vast (Fernando, 2017; McInnis, 2002), with important accounts from within the profession revealing institutional and personal acts of racism by fellow students, staff and practising clinical psychologists (Adetimole, Afuape, & Vara, 2005; Memon et al., 2016a; Paulraj, 2016; Shah, Wood, Nolte, &

Goodbody, 2012). There is a case, therefore, that the profession operates in a discriminatory way across both individual and institutional levels and, as yet, no specific anti-racist practices exist within the profession to counteract what is endemic to the context of the United Kingdom.

Clinical psychologists, acting as assessors to psychological services, risk acting in ways that pose a barrier to BME young people accessing services. The role of clinical psychologists at the important juncture of assessments is under-researched and under-explored in the literature and little is known about the factors influencing the interaction between clinical psychologist and BME young person. An understanding of this gateway is necessary for greater equity in service provision.

#### **1.3.11. Summary and rationale**

The literature discussed thus far demonstrates the complexity of what 'equity' looks like in the context of mental health service for BME young people. However, there is significant evidence that the representation of BME young people is inequitable and that a multivariate series of barriers exist that act to sustain inequitable access to mental health services and psychology (Sass et al., 2009). The underrepresentation of BME young people in mental health services can be seen as an unmet need (Malek & Joughin, 2004).

In developing this rationale, it is worth again highlighting the unequal and unfair outcomes for those racialised within the category of 'BME' that exist in the UK, with these disparities observable beyond the sphere of mental health and across society as a whole (Cabinet Office, 2017). The institution of clinical psychology, like all other institutions, has been developed within the historical context of race slavery and colonisation and has been complicit in the development of knowledges and actions that position BME individuals as inferior to the White majority (Fernando, 2017; Patel & Keval, 2018). Clinical psychology can be, therefore, considered to be institutionally racist, a view supported within the profession (McInnis, 2002).

The profession is overwhelmingly White, middle class and female (BPS, 2015; Williams, Turpin, & Hardy, 2006), and it is suggested that without explicit action to counteract institutional racism in clinical psychology, it is likely that it will continue to perpetuate it (Fernando, 2017). The onus is then placed on clinical psychology to have explicit anti-racist practices, rather than rely on the omission of overtly racist practices. Whilst important action has been taken by clinical psychologists (e.g. Constantine & Sue, 2006; Fleming & Daiches, 2005; Howitt & Owusu-Bempah, 1994; McInnis, 2017; Patel et al., 2000; Wood & Patel, 2017), this has not been actioned by clinical psychology's wider governing institutions such as the British Psychological Society (BPS) and Health and Care Professions Council (HCPC), beyond its criticised diversity agenda (BPS, 2015; Patel, 2010; Wood & Patel, 2017). There remains a great need for clinical psychology to de-colonise its knowledge base and take greater action against institutional and personal acts of racism (Memon et al., 2016a; Patel & Keval, 2018; Paulraj, 2016).

Research on the role of practitioners on access to mental health services highlights an important juncture where referrals are selected and accepted differentially according to ethnicity (Brown et al., 2014; Daryanani et al., 2001). Clinical psychologists regularly provide assessment of BME young people to determine acceptability to services, and risk acting as a 'barrier' to access, as indicated in research with other professional groups. Clinical psychologists' views on barriers to access for BME young people is unknown and is the focus on this research project.

### **1.3.12. Research questions**

Accordingly, the research questions are:

- What do clinical psychologists say about difficulties in accessing psychology services for BME young people?
- What do clinical psychologists say about applying psychological theory in the work with BME young people?

- What do clinical psychologists say about ensuring equitable access to psychology services for BME young people?
- What wider discourses and contextual factors influence clinical psychologists' accounts?

## **2. CHAPTER TWO – METHODOLOGY**

### **2.1. Ontological and Epistemological Considerations**

In this section, I expand on the ontological and epistemological assumptions that underpin this piece of research. Ontology relates to the researcher's belief in what is constitutive of reality, and epistemology with a researcher's belief about knowledge creation, acquisition and communication (Bryman, 2012). A critical realist (Maxwell, 2012; Pilgrim, 2015) approach has been adopted to meet the overarching aims and conditions of this research.

This approach allows me to commit to the ontological position of realism (Price & Martin, 2018), acknowledging the reality of material difference in the environments, opportunities and resources available to BME communities when compared to WME communities, as shown in the disparities across a variety of metrics revealed in a recent national audit (Cabinet Office, 2017). The existence of this reality operates outside of my own or others' perceptions or constructions upon these circumstances, and so it is necessary to take these aspects for granted and 'true' for the purposes of this research. Regardless of the contestable nature of race and ethnicity (see Section 1.1.), these groupings are frequently applied at individual and societal levels both voluntarily and involuntarily, impacting upon the reality of BME communities. A critical realist position also allows for political and moral positions to be taken regarding this reality and normative assertions and actions suggested (Price & Martin, 2018), which might be minimised by more relativistic social constructionist approaches (Harper, 2011).

The 'critical' portion of this position states that these realities are made sense of through language and discursive constructs (Georgaca & Avdi, 2011) and so are socially constructed (Burr, 2003). It offers a way of understanding the socially constructed nature of reified concepts, such as psychiatric diagnoses, race, ethnicity, etc., that impact our research enquiries and claims to knowledge.

This position allows the research to navigate the complexity of the topic, taking for granted a reality of the material environments that BME communities occupy whilst also accounting for the socially constructed nature of these conditions. These conditions are seen to be mediated through discursive constructs such as ethnicity and social policy, and so shape life in the United Kingdom. This criticality allows me to include ideas of power in their myriad forms; their operation in overt and explicit ways, as well as the covert and implicit ways that can prove more difficult to quantify (Lukes, 2005), such as is seen in the operation of structural and institutional power within clinical psychology (Fernando, 2017; Smith, 2017).

A critical realist approach holds that it is possible to collect data that can elucidate the processes and mechanisms that contribute to the disparities in access to mental health services for BME communities, and that these can be seen as concrete and commented on, with implications for change (Price & Martin, 2018). It lends itself to qualitative methodologies where transcripts might be analysed hermeneutically beyond a surface reading of the text (Braun & Clarke, 2006), discussed further in Section 2.6.

## **2.2. Methodological Considerations**

### **2.2.1. Qualitative approach**

A qualitative methodology was chosen to best address the need to explore the accounts of clinical psychologists, as responsibility-bearers, on potential barriers to access. A qualitative approach can move beyond the current establishment, of practitioner-led inequity through quantitative measures, and towards the 'illumination and understanding of complex psychosocial issues' (Marshall, 1996, p.522). Whilst recognising these inequities are not easily definable, separable or solvable at any single point in the pathway (Rittel & Webber, 1973), this approach will allow for a deeper understanding of the role of psychologists and an insight into their accounts of these inequities, as



well as potential mechanisms and processes that may serve to explain these discrepancies.

### **2.2.2. Reflexivity**

Another tenet of critical realism is its commitment to reflexivity (Price & Lee, 2018), which can be understood as the researcher's interrogation of their own influences on knowledge production and claims (Willig, 2013). During this research, I have engaged in reflexivity during the multiple stages of my research through regular journaling and discussions with my supervisor. One theme of which I have expanded on in my discussion chapter. Here, it is pertinent to situate myself within this particular piece of research.

I am, of foremost importance to this research, ethnically White. This ethnic identity confers possibilities and limitations on this endeavour. Of limit, is my necessarily incomplete view on issues of race and racism. I have lived a life where my own ethnic identity has been backgrounded and rendered invisible (Eddo-Lodge, 2017), and much of my knowledge around these issues has been gleaned from a slow and ongoing realisation of the privileges conferred to me over my lifetime. This I owe entirely to those who have patiently given their time to educate me on my unseeing and unknowing, be it in my personal and professional relationships or through academia.

Despite growing some of the way, I acknowledge I have much further to go. I will have made many errors and missteps in the process of this doctoral thesis owing to my current conceptualisation of these issues from a White perspective. I hope to one day be able to look back on this piece of research and better identify and resolve these from a place of further growth.

However, I also acknowledge that there are opportunities afforded to me because of my Whiteness and that this research has been enabled by my ethnicity as well as limited by it. Being White may have allowed me access to a certain demographic of participants and helped shape these conversations in a particular way. My Whiteness will undoubtedly impact upon my analysis

and what captures my interest and imagination. These differences may be useful in some ways, and not useful in others.

Finally, it is my belief that those sharing my White identity have a responsibility to confront these issues and contribute to achieving greater levels of ethnic equality. This involves engaging in issues of race, despite not being subject to the same processes of racialisation and systems of historical and social oppression. This belief – in turning towards these issues, and not away – is a key motivation for this thesis.

## **2.3. Method**

### **2.3.1. Recruitment**

My recruitment entailed approaching qualified clinical psychologists who are currently involved in the assessment of young people for psychological input (therefore acting as ‘gatekeepers’ to services). Given the plethora of approaches to psychological assessment, as well as the multiple services in which they work, I recruited from a wide variety of services for children and young people to allow for breadth and richness in the data (Bryman, 2012).

My recruitment information encouraged participation of clinical psychologists from more typical child and adolescent mental health services (CAMHS) as well as other settings, such as physical health, forensic, and charity/third-sector services. I did not attempt to actively recruit from a variety of different demographic characteristics and expected these to be approximately representative of clinical psychologists. I attempted to recruit between eight and 12 participants in line with recommendations for qualitative research using thematic analysis (Guest, Bunce, & Johnson, 2006).

Initially, recruitment was pursued through my own and my supervisor’s established relationships with clinical psychologists working with children and young people. These contacts were encouraged to share the information sheet (Appendix A) with colleagues in their respective service. I also

recruited a portion of participants through social media using an invitation image detailing my study (Appendix B) and link to my information sheet. Finally, the Clinical Director at the University of East London disseminated the invitation image and information sheet to clinical psychologists in the London area. Participants were given the opportunity to contact me and ask questions before we organised an interview.

### **2.3.2. Participants**

Eight participants met the requirements and participated in interviews, six identifying as female and two as male. There was a reasonable spread of services in the recruitment pool, with clinical psychologists working full- and part-time across services supporting young people in the areas of social care, trauma, physical health, neurodevelopment, learning disabilities, CAMHS, forensic, and schools-based projects. Table 1 lists some demographic information, though I have at times used a limited description of their identity (for example, 'White Other' rather than 'White Italian') so as to preserve anonymity. This was particularly necessary with those from an underrepresented ethnicity in clinical psychology, and I agreed with participants the use of a more general ethnic grouping for the purposes of this write up.

There are of course problems with this approach; whilst I think demographic information helps to contextualise the contribution of each participant, and can prove useful for understanding the position in which participants speak from, the categories presented here are sometimes not their expressed ethnic identity, which entails some discomfort in opting for a broader category due primarily to the lack of diversity within clinical psychology.

Table 1:

<b>Pseudonym</b>	<b>Gender</b>	<b>Ethnicity</b>
Kim	Female	South East Asian
David	Male	Mixed
Emily	Female	White Other
Rosie	Female	White Other
John	Male	White British
Holly	Female	White British
Amy	Female	White Other
Steph	Female	White British

### **2.3.3. Data collection**

Following from my critical realist position, the process of data collection can be seen as the fulfilment of the interviewer's intentions, influenced by the development of their epistemology, rationale, research questions and method that provide a structure to the interview (Mason, 2003). Whilst there is no 'corrective' for these impositions, I am also interested in providing a space for the perspective of clinical psychologists and so have chosen to use semi-structured interviews to provide an opportunity for the varied and multiple constructions with which clinical psychologists engage when approaching the topic. I hoped these accounts would be neither unduly constrained by the closed-ended and specific nature of a structured interviews, nor so open-ended so as to not relate to my intentions for the research (Bryman, 2012).

### **2.3.4. Interviews**

#### **2.3.4.1. Interview schedule**

The development of my interview schedule involved questions that best attended to the level of the individual clinical psychologist, as well as the wider field of clinical psychology and broader context. Through conversations

with my supervisor, I included questions around the personal identities and context of the clinical psychologist, questions on their views related to access for BME communities, and a space for discussions on the wider issues of the profession and other contexts (Appendix C). I also benefitted from carrying out a pilot study with a counselling psychologist in an NHS CAMHS setting, who provided invaluable feedback on the structure, flow and content of the interview schedule.

#### **2.3.4.2.      *Interview procedure***

Interviews were conducted at a time and place suitable to participants and were either face-to-face, on the telephone or via online video conferencing. Interviews were done in a setting of their choice that ensured their privacy, such as their home or a room procured at or near their work premises. Participants were given the opportunity to review the information sheet (Appendix A) before and during the beginning of the interview, either as a paper or digital copy, and were asked whether they had any additional questions. They were then asked to sign either a paper or digital consent form (Appendix D). Interviews varied in length from 57 to 79 minutes in total.

#### **2.4.      *Transcription***

Interviews were audio recorded using a digital voice recorder, before being transferred to an encrypted and password-protected personal computer. Transcription was done on verbal material and noteworthy non-verbal material (such as extended pauses or laughter). I chose not to include any speech acts that represent 'filler' or common vocalisations of hesitancy, such as 'um' and 'uh', so that the transcripts could be as readable and close to the speaker's message whilst still containing as much verbatim and necessary information (Braun & Clarke, 2006). Identifying information, such as names or unique places of work or geography, has been anonymised using pseudonyms and general or comparable locations as an alternative. Some identifying information, such as gender and ethnicity were transcribed with the consent of participants, with the exception of two participants from an

uncommon ethnic background who agreed to more general ethnic categories to preserve their anonymity.

Punctuation was added to the transcript with a mind to improving readability with consideration on how best to represent the intended meaning of participants (Parker, 2005). The process of transcription is seen as an interpretative act (Lapadat & Lindsay, 1999), and whilst the intended meaning of the participant cannot be 'known', it is the beginning stages of my own meaning-making and forms a key part of the later analysis (Section 2.6.).

## **2.5. Ethical Issues**

The development of my ethics application was done in line with the BPS Code of Ethics and Conduct (BPS, 2018) and granted approval by the UEL School of Psychology Ethics Committee prior to the research commencing (Appendix E).

Informed consent was supported through the information given during the recruitment and interview stages using information and consent sheets (Appendix A and D, respectively). During the interview, participants were provided with the opportunity to ask any further questions and reminded of their right to withdraw up to three weeks after the interview and given a debrief sheet with this information (Appendix F).

Confidentiality was discussed with each participant, and some of the limits inherent to this piece of qualitative research and the particular interests of the study, such as the inclusion of some demographic information (for example, ethnicity). After the interview, participants were asked about whether there were parts of their interview they would be concerned about in relation to their anonymity. In the case of three participants, we agreed a way to preserve their anonymity more carefully in regard to where a specific service or aspect of their identity was such that they might be identified.

To further ensure anonymity, each participant was assigned a number and a pseudonym during the research process and any agreed anonymity strategies were written directly into the transcription. Any further identifiable information from consent forms or email correspondence was kept separately and securely away from the research data. Audio recordings were kept securely throughout the research process and are due to be deleted after the research is completed. In line with the information sheet, anonymised transcripts will be kept for two years for future publication. Only the principal investigator has access to the original audio, and research supervisors and the examiners access to the anonymised transcripts.

I recognised that there was a possibility that the planned interview questions may cause some distress to participants due to the nature of talking about issues of inequality that may relate to their own experiences of marginalisation. This was managed through forewarning of the nature of the interview and consistent 'check-ins', throughout the interview, to ascertain their level of discomfort. It is worth noting that, due to clinical psychologists' training and practice, they likely have experience discussing these issues.

The potential for issues relating to the safeguarding of children and young people, or practices that contravene professional codes of ethics, spoken about during the interview was planned for. The limits of confidentiality were discussed and that, in the case of disclosure of information that relates to the harm to the participant or others, appropriate safeguarding procedures were to be followed, and my supervisor and the ethics panel consulted, so that the response was effective.

## **2.6. Data Analysis**

### **2.6.1. Thematic analysis**

Thematic analysis is regarded for its flexible approach and is described as applicable from a range of theoretical and epistemological positions (Braun & Clarke, 2006). Whilst being said to be 'essentially independent of theory and

epistemology' (Braun & Clarke, 2006, p.78), this is not to say that it is untouched by it. Willig (2013) identifies how themes identified through thematic analysis relate more to the researcher's decision as to what the themes represent, with respect to their epistemological position and research questions. I have, therefore, chosen to employ thematic analysis in line with my critical realist stance.

Willig (2013) goes on to refer to how a thematic analysis can go beyond a more constrained and singular analysis of the text towards a rich, detailed and complex account of the data. A thematic analysis is at a minimum descriptive but can also involve a hermeneutic layer with interpretations identifying any meaningful processes and mechanisms that are deemed to relate to the research questions (Boyatzis, 1998; Braun & Clarke, 2006). These aspects of thematic analysis resonate with my critical realist epistemology, and my hope to consider clinical psychologists' meaning-making of their experience, as well as how their context inevitably impacts upon the process of meaning-making (Nightingale & Cromby, 2002).

Braun and Clarke (2006) detail the choices, polarities and dilemmas in thematic analysis and provide guidance on differing approaches. I have chosen to guide my analysis in a more deductive, 'top down' way that is influenced by my theoretical interest, as opposed to an inductive process. Here, there is less of a focus on rich descriptions of the whole dataset, and instead a detailed analysis of the data in relation to my research questions. Through the process of interpretation, I will develop 'latent themes' (Braun and Clarke, 2006, p. 84) that go beyond the explicit meaning and theorise their broader meanings and implications.

It is in the analytical space afforded by a critical realist, 'deductive' and 'latent' thematic analysis that I introduce an additional influence of Michel Foucault's works (Foucault, 1977, 1980, 1982, 1984a, 1984b). In Section 1.2., I made the case that clinical psychologists are engaged in production of knowledge and are afforded power at an individual and institutional level, demonstrated in clinical psychology's capacity and complicity in the



construction and material realities of BME communities. Foucault (1980) theorised the significance of this link between knowledge production and power, and their relationship to reproducing and legitimating existing social conditions. Key to this view is the role of 'discourse' (Parker, 1999) and the discursive resources available to a culture, and the implications for those within it. I aim to use some of Foucault's ideas as a way of adding further interpretative depth to my thematic analysis where appropriate and possible.

#### **2.6.1.1.        *Considering Foucauldian discourse analysis***

When deciding how best to analyse my data, I considered whether a Foucauldian discourse analysis (FDA; Willig, 2003) would be appropriate given my concern with professional knowledge and institutional power, however, I take the view that such an analysis would complicate the 'realism' in my epistemology that sees issues of racism as unequivocal, and the greater relativism of such an approach may, as Paulraj (2016) put it, undermine the historic, social and material realities that I see to be incontestable.

There are moral positions here too, and I fear FDA with its concern for a higher level of abstraction risks obscuring individual social actors that are implicated in current practices. Arribas-Ayllon and Walkerdine (2008) acknowledge the potential for FDA to give thin descriptions at the level of the individual owing to its method. However, in this piece of research, it is the clinical psychologist and their everyday practices that I am most concerned with and wish to keep attention to an individual level of social action as well as this contextual and historical backdrop.

There are further methodological reasons for not choosing FDA. Namely, this analysis typically requires a wide 'corpus of statements' (Arribas-Ayllon & Walkerdine, 2008, p.100) in which to conduct a satisfactory analysis. Due to my recruitment strategy and participants (see Section 2.3), I felt that I could not claim to have a suitable range of statements that would allow for FDA. Instead, it is more likely my participants represented a subsection of clinical

psychologists that were willing to engage in a piece of research such as this. I discuss these limitations later in Section 4.2.1.

Further, FDA requires an analysis that focuses on the temporal variability of its subject (Arribas-Ayllon & Walkerdine, 2008). Whilst my introduction attempts to provide a brief historical account of the issues as they relate to this research, it is not a Foucauldian analysis, and the interview and subsequent transcripts do not attempt to explicate the genealogical background on the issues to which participant's talk to. I think there is a great value in such an analysis, but it is beyond the feasibility of this piece of research. I pick this up in relation to opportunities for further research in Section 4.5.4.

### **2.6.2. Process of thematic analysis**

In conducting a thematic analysis of the data, the six steps outlined by Braun and Clarke (2006, p. 86-93) were followed in turn. They are detailed below:

#### **2.6.2.1. *Familiarisation with the data***

This step involved an immersion in the data, beginning during my initial listening, followed by the transcription and repeated readings of the interviews. This is an active process of searching for meaning and patterns in the data and involved making notations and initial ideas for coding.

#### **2.6.2.2. *Generating initial codes***

Systematically working through the data, I applied initial coding that identified features that appeared interesting in relation to my theoretical interest, coding this segment of raw data and organising it in relation to other codes (Tuckett, 2005). I worked through all the data equally and applied coding to as many potential patterns and themes as possible. Segments that were coded were inclusive of the wider text, to include as much context as is useful (Bryman, 2012).

#### **2.6.2.3.      *Searching for themes***

The codes were organised into potential themes, starting at the levels of individual transcripts and the entire dataset. This process began the movement from codes to broader themes, aided by ‘thematic maps’ (Braun & Clarke, 2006, p.90) and resulted in candidate themes and sub-themes, alongside their respective text extracts.

#### **2.6.2.4.      *Reviewing themes***

This step involved refining candidate themes through a process of assessment, using criteria such as repetition, distinctiveness, lack of data, etc., that resulted in themes being split, merged or discarded. A final thematic map was developed and reviewed alongside the original transcripts to ensure representation to the data.

#### **2.6.2.5.      *Defining and naming themes***

The developing themes were then further ‘defined and refined’ (Braun & Clarke, 2006, p.92) in relation to each theme’s essence. Each theme was considered by itself and in relation to other themes, and then the theme was assigned a name that speaks to a wider narrative about the data.

#### **2.6.2.6.      *Producing the report***

Throughout the analysis and write-up, attention was paid to the quality of the analysis so that the merit and validity can be conveyed to the reader. The evidence for this is presented in the results section where I summarise my findings.

### **2.7.      *Evaluation***

Further to following these six steps, it is necessary to evaluate the goodness of the analysis through criteria aimed at judging its quality. I have chosen to

employ the criteria of credibility, rigour and contribution as proposed by Spencer and Ritchie (2011) and I detail this as part of my discussion (see Section 4.4).

### **3. CHAPTER THREE – ANALYSIS**

#### **3.1. Presentation and Discussion of Themes**

I present here the themes following the data analysis of the transcripts from the eight participants. After developing initial codes, I grouped these into three main themes and corresponding sub-themes. The main themes are described as:

1. 'Consequences of Whiteness', which concerns participants' and the profession's predominant Whiteness and how this interacts with the task of improving access for BME young people and families.
2. 'Realities of practising equality', which considers the enablers and disablers to greater equality and how these are navigated by participants.
3. 'Pathways to services', considers clinical psychologists' perspectives on ethnic inequities in respect to how systems of language and service structure might create and ameliorate barriers to access.

Table 2 details these main themes alongside their respective sub-themes:

Table 2:

Main Themes	Sub-themes
Consequences of Whiteness	White blindness and unknowing
	‘It’s about avoiding the uncomfortableness’ – White fragility when confronting issues of race
	White-centricity and empowerment
	‘Okay, today let’s think about racism’ – scheduling and one-off initiatives
Realities of practising equality	‘I’m very passionate about it’ – the responsibility and reliance on the individual clinical psychologist
	Under pressure – ‘we don’t have time’
	Choosing an approach – navigating the evidence base
Pathways to services	The implications of language
	Service and diagnostic distortion

### 3.2. Consequences of Whiteness

This theme represents participant’s frequent references – explicit and implicit – to the construct of Whiteness and its broad impact on participants’ awareness, comfort, perspective-taking and action in regard to achieving equity of access for BME young people and families.

#### 3.2.1. White blindness and unknowing

Many participants referred to issues relating to Whiteness (Clark & Garner, 2009) and its interaction with their own and others’ knowledges, the assessment process, and their relationship to the profession of clinical

psychology. Participants often remarked on the overwhelmingly White make-up of the profession:

*... it's only now that I'm thinking about it ... the majority of people who work in this hospital, like the proportion of White British staff in this [service] is mad, absolutely bonkers ... like we've written this assessment framework from our perspective as White British atheist and where someone else from a different position might write it differently. (Rosie)*

*... I've never had to think about my ethnicity, it's not something I ever have to question, I ever have to think about, I don't have to worry about it. I can walk into pretty much any space anywhere and never have to think about that stuff, and therefore I don't talk about it because it's not an issue to me and that's what happens when you get a group of White people together. (Holly)*

In Holly's talk we can see how Whiteness can be characterised by an absence of experiences that elicit thought or worry relating to her White identity, with Rosie seemingly only becoming aware of the (in)visibility of White practitioners within her professional context during the interview. Holly and Rosie also raise some of the implications for this on how it impacts our methods of assessment as written by predominantly White practitioners, and what frameworks produce valid forms of knowledge for the psychologist (Foucault, 1980).

Rosie goes on to reflect on having not provided psychological support for BME communities despite working in areas with ethnic diversity, again appearing to become aware through our dialogue that she served a mostly White British population:

*... so I worked in [geographical area] for training and that is famously very, very diverse, and that included CAMHS actually, but actually all of my solid cases were all White British. That's really interesting.*

Some participants spoke to an awareness of their White identity and effort to raise consciousness in relation to their underlying beliefs, assumptions and service provision:

*I'm very aware that I'm a White female. I always try and be aware of that and think of that, in the work that I'm doing ... I would say that the culture of most NHS services, definitely most, a lot of clinical psychologists, is that we're living within our own assumptions and the structures of the models that we've created and believe in, and so I don't think often that we've stepped outside enough to think maybe this isn't meaningful or appropriate for some of the community that we're working with. (Emily)*

Whilst Emily talks about an awareness of her White identity, what is left implicit are the references to an NHS service culture and clinical psychology that is unaware of its Whiteness. This manifests in models and assumptions that are rendered all but invisible and Emily encourages (White) psychologists to step outside of this and think, to look at these structures and models that we have produced critically. This alludes to a 'blindness' and 'not knowing' common in WME psychologists, one that disconnects the White person from experiences of those racialised as BME.

Holly and Kim both speak to the consequences of White blindness on BME psychologists:

*... I think it continually falls upon people who themselves are marginalised in the profession of clinical psychology to actually make the moves and do the moves, because the people that aren't from those communities don't get it. (Holly)*

*I don't know if this is because I'm from an ethnic minority myself, I am more attuned to seeing these things and thinking about it a bit more. And I say that because when I'm in team meetings or I'm thinking about things, not to big myself up or anything like that, just, I'm usually the*



*one that raises 'actually, what are we doing to increase the access?'.  
(Kim)*

White blindness places the sightedness, knowledge and labour within those clinical psychologists racialised as BME to think about issues of access and affect change. Kim goes on to exemplify her own efforts to raise awareness of BME experiences but talks to a fear of what happens when she is not in these spaces and whether White blindness precludes any discussion without her:

*... I raise things in meetings that are heard, and things have been changed as a result of that, but I wonder sometimes if I wasn't there saying that, would these things be picked up? Would changes be made?.*

In Holly's account, she goes on to consider how necessary research and knowledge production on the topic of access for BME communities is in the current context, implicating the role of this piece of doctoral research in this:

*... some okay good intentioned, White psychologist gets it in their head that I'm going to research this a bit more, and then other psychologists say 'you need more data on this' ... I don't mean this disrespectfully, this research has to be done, but actually does it have to be done? Do we know this stuff, you know what I mean? ... It's not for me to talk about it, it's for me to go and listen and to hear it, because someone could tell me what the barriers are exactly.*

Holly highlights the proclivity for WME psychologists to produce ever greater amounts of research and data, whilst disqualifying knowledges from BME communities where the barriers could be relayed 'exactly'. Holly raises the question of whether research from the 'good intentioned, White psychologist' can ever get at the precise mechanisms for this inequity, instead suggesting that this approach serves to self-perpetuate as more and more data is demanded by the White psychologist. This may be seen as a testimonial

injustice (Fricker, 2007), where the knowledge of BME communities remain unexplored due to these relations of power.

Also implicit in Holly's talk is the positioning of BME communities as holding the solutions to issues of access, with the pursuits of the White psychologist expected to be fruitless. This puts an undue onus on BME communities to provide the answers and transform the profession and its structures for the better, rather than conceiving of research that might enable a greater responsabilising and interrogation of the profession by WME psychologists.

### **3.2.2. 'It's about avoiding the uncomfortableness' – White fragility when confronting issues of race**

Many participants spoke about the discomfort speaking about issues of race and ethnicity in their service contexts. Some participants, talking from positions of being racialised as BME, spoke about their experience of raising these issues alongside their personal relationship to what is being said, describing a fear of disenfranchising the listener or leaving the listener questioning their professionalism:

*... I can also fall into that thing of inhibiting myself for fear of what other people might say ... we inhibit ourselves because we're thinking that, it's basically that we're making it personal, that's really it, in a profession like this you don't want to seem that way, you want to seem very objective and cold and you have a very good boundary and therapeutic stance. (David)*

*... you have to choose the time to talk about it really, as well. I think, and maybe it's a fear, a fear that's not necessarily a reality, but one of my worries is, and maybe that's based on my personal experiences, is that if you talk about difficult things that people may not be ready to hear about that can cause disenfranchisement quite early. (Kim)*

Implicit in these accounts is the cautiousness and care to not disturb the (likely White) listener's comfort, with Kim talking about the great care to consider the readiness of the listener. David talks of a similar modulation in his talk within the 'profession', and how he is fearful of sharing personal aspects of his ethnicity in a predominantly White profession that devalues these characteristics. David goes on to illuminate the interaction of Whiteness in his account, and that this caution is not present when speaking to BME psychologists:

*I mean honestly, I have only spoken about these issues with other psychologists who are also from ethnic minority groups, which is, not many ... it's sometimes a little bit chilly, it's about avoiding the uncomfortableness ... the idea of apologising to White people for offending them for not knowing about these things.*

David here talks to a 'White fragility' (DiAngelo, 2019) and his tendency to avoid the 'uncomfortableness' of raising these issues with his mostly White counterparts. The result is that these conversations around issues of race predominantly happen in the absence of the fragile WME psychologist, further blinding them to the experiences and perspective of psychologists racialised as BME.

Many WME participants confirmed this perspective and spoke to their own discomfort when talking about issues of race either in their therapeutic work or with colleagues, relating it to the inherent Whiteness of the profession:

*... There is something about it being maybe a little bit taboo, a little bit difficult to talk about ... if you look at our psychology team, for example, they are mostly White British female, and then if you look at our nurses they're almost exclusively Black British, and even things like that I think is something that we find difficult to talk about. (Amy)*

Some participants spoke to the consequences of this discomfort and fragility, and how it resulted in a lesser likelihood of WME psychologists speaking out

or taking part in initiatives and service-level changes. They talk to the level of action at an individual level with the BME young person, stopping at addressing structural and service-wide changes:

*When you're talking about inclusion and trying to increase accessibility that is when the room then, when the White people leave the room.*  
(Holly)

*No, again it's, I will probably do it on an individual level in terms of formulating and speaking with the young person, but I haven't really spoken about things like representation in the service as a whole.*  
(Amy)

The talk here of WME psychologists adds another layer of consequence to what has been discussed previously from BME psychologists' perspectives. Here, Holly and Amy talk of the shying away of White psychologists from inclusive practices, particularly those that might address the structural roots of inequity. Placed alongside the previously quoted BME psychologists, we see a system in which the fragile White psychologist not only has reduced opportunities to hear the perspectives of those from different ethnicities to theirs, but also withdraws from settings in which these perspectives are promoted. Fragility thus creates a pattern of interaction that leads to little meaningful action.

### **3.2.3. White-centricity and empowerment**

Some participants talked about BME communities in ways that implied their position of disempowerment, either through lacking the necessary capacity to pursue access to services, or that BME communities lacked the requisite knowledge of mental healthcare:

*... There's more of a chance for it to affect those communities and for them not to feel empowered enough to complain about it ... you feel*

*like they don't necessarily really understand what's going on sometimes. (Steph)*

*... To get a Tier 4 service you have to be a bit pushy, quite often, and it might be things like that you've asked for a second or third opinion of an ASD assessment for example, and I wonder if that's one of the things that is getting in the way of people from ethnic minorities to access those kind of services ... maybe not feeling like they should ask for those things ... maybe being more 'okay, it's like what the doctor said' and not questioning as much. (Amy)*

In Steph and Amy's talk, BME communities are spoken about as passive and accepting to the authority of services, and that because of this reluctance to be 'pushy' and 'complain', they are not afforded access to psychological services. These ideas refer to the concept of 'social capital' (Savage et al., 2015), and introduce the intersection of class and an idea that (predominantly White) 'middle class' communities are more likely to leverage social capital for preferred outcomes in services. In participant's talk is an implicit White, middle-class position spoken from, where a degree of pushiness and complaining is the default.

From this perspective, BME communities are spoken about as if the deficit lies within them, rather than a system that positively responds to the leveraging of social capital. Rosie goes on to speak about an idea that BME communities are more responsive and accepting of medical knowledges and authority:

*... the clients we've seen in clinic here, they've responded to the medical team and I wonder whether that's a sweeping generalisation, and I don't have any research to back this up, but it feels to me sitting with the medical model and that's what they're responding to, and what they want to work with, and we are different to that culture because it is a cultural idea, the medical model versus a social model or psycho-social.*

Whilst cautious of its generalisability, Rosie here talks as if psycho-social understandings, the remit of clinical psychologists, are contrary to what BME communities 'want to work with'. Instead, medical understandings are thought to hold more cultural currency in BME communities, and the implication again is that this difference is a deficit in the BME individual, rather than a failure of clinical psychology to present more resonant cultural ideas.

These narratives amount to a disempowered view of BME young people and families accessing services; that they lack the wherewithal to pursue services for second and third opinions, that they too easily acquiesce to medical teams, and that their beliefs are not compatible with psycho-social ways of thinking. What is less present in their talk is the White, middle-class position that BME young people and families are compared to, and how this is institutionalised.

#### **3.2.4. 'Okay, today let's think about racism' – scheduling and one-off initiatives**

Most participants expressed not knowing about any specific practices or initiatives to improve access to BME young people and families in their professional contexts:

*Initiatives? No. I don't ... there isn't a thought-out initiative. (Kim)*

*... The only thing I've seen that's to do with race at all in this [service] is they mentioned at the induction this morning about staff user groups for disability, LGBT, BME and women. (Rosie)*

The uncertainty about current initiatives extended beyond practices to the (lack of) knowing and thinking about inequalities of access. This was characterised by an absence of recording or monitoring by disaggregation of access rates according to ethnicity:

*... The thinking that we do, we haven't really thought at the level of the pockets of people who are missing out. (Steph)*

*... They might have also done things like the Food of the World or Black History month, but I'm not sure how much time that they've actually had to be able to actually look at data. (Amy)*

In their talk, we see a similar enactment of Whiteness and its blind unknowing, but, more than this, we see the resulting inactivity and that recording and measuring these inequalities do not take place. There is little action towards knowing, and little knowing to spur action. Instead, seen in both Amy and Rosie's talk, we get a sense of how teams and services respond with cursory, superficial acts of consciousness raising, either only at their induction or through the appreciation of world foods and Black history. Whilst these initiatives do go some way into raising issues of race and culture, they appear to have no effect on any ongoing and meaningful awareness beyond these events.

Some participants spoke to the limited nature of such initiatives and conversations about issues of race and culture, often occurring as one-off or scheduled events. Holly contrasts her current experience with a previous service, where she joined BME psychologists in addressing racial inequalities and where issues of access were spoken about more readily and regularly:

*... If we were to have those kinds of conversations [in the current service] it would be a scheduled event, 'okay, today let's think about racism' ... I've come from an organisation where it's the bread and butter of everything, it's all that we talk about, to now being in a place where we all probably have to schedule a chat on that ... as opposed to just being there, fluid, talked about.*

In contrast to this scheduled, one-off approach to addressing ethnic inequalities, Emily spoke about the appreciated aspects of her workplace,

where there is a readiness to consider BME communities and how it is characterised by dynamism and responsiveness:

*... one thing I would say about this service is that it's been very good at adapting, so unlike a service that might have thought about it for a year, and then taken another year to create it and then move forward, it had to be just very responsive ... and I think what they've always been very good at is listening to the community, taking on board what the community feels they're doing wrong, or that isn't helpful, and then trying to change that.*

Talking from the context of a mental health service within the criminal justice system, John describes an overrepresentation of BME young people in services with associated initiatives aimed at reducing this overrepresentation. John talks to the potential inappropriateness of such service-led action in regard to the inter-connectedness of other services, such as CAMHS:

*How do you deal with the disproportionality of BME groups in [the service]? And my argument is actually, if you go outside the [service] to CAMHS, the disproportionality is the wrong way around. So, this group isn't accessing [mainstream] mental health services ... if they are coming in the door and I know they're not going in any other door, this is our opportunity.*

John here talks to a consequence of these service-level initiatives in contexts of overrepresentation that may serve to reduce the accessibility for BME communities overall, as there are not commensurate initiatives to increase access in local CAMHS. Whilst we might praise the continuous nature of initiatives within his forensic context, it may counterintuitively or even intentionally act to widen inequalities of access at a broader level.



### **3.3. Realities of Practising Equality**

This theme represents participants' accounts of the everyday opportunities and challenges of actioning equality agendas, utilising their passion to overcome time-pressured services, and navigating discourses of the 'evidence-base' towards more culturally appropriate practice.

#### **3.3.1. 'I'm very passionate about it' – the responsibility and reliance on the individual clinical psychologist**

Many participants spoke to their individual passion around improving access for BME communities, referring to their personal drive and motivation to develop and introduce initiatives in their respective services:

*... because one of my values and one of the things I, feels really important to me, is that we kind of help anyone who wants psychology access support to access it, whatever background they're from, whatever ethnicity they're from. (Kim)*

*The initiative was the initiative that I started and run ... there's one particular staff member that comes to mind straight away in the CAMHS team, that that's her passion. (Emily)*

These participants demonstrate how important values and passion are to the active participation in such initiatives. Implicit in their talk is an idea that these values and passion are not widely shared or distributed in staff teams, rather, 'one particular staff member' comes to mind rather than the entire team. The extent of passion is captured in their perseverance within some participants' accounts:

*I think it's having, having one person who's really enthusiastic about it, who's pushing forward because it's really hard ... in reality it's very, very difficult to have the time to start new projects. (Amy)*

Amy talks to the need for one person whose personal passion and enthusiasm can overcome the time constraints in services. These initiatives, driven by the passion and perseverance of clinical psychologists are spoken about as if at odds with their service context; requiring them to push through the impoverishment of time. Emily talks to the impact of taking on this responsibility:

*... I don't have the time to move forward on some of these things and no-one's given a full-time just role to do these things ... at times we feel like we have to fight for it and then when you're tired and exhausted and you're doing many other things sometimes you just feel like I can't fight for it anymore.*

Emily's talk hints at a future where this individual-led and passionate taking up of responsibility for change is ultimately unsustainable, and the fight for equal access leaves you 'tired and exhausted'. These activities and professional responsibilities are not routinely encouraged in the current context of mental health services for BME young people and families, and any attempts to address this must be held singularly and with great individual costs.

### **3.3.2. Under pressure – 'we don't have time'**

Many participants spoke to the pressures of the services within which they worked and how this restricted their practice, particularly in relation to the time available to adequately assess young people:

*... my CAMHS placement told me 'no, we don't formulate because we don't have time'. (Rosie)*

*... I'll be honest, that we didn't have the staff or the time to assess 500 kids, so we had to do a really quick screen and then go straight into the, a more of the doing phase, rather than doing that thorough assessment. (Holly)*

Rosie and Holly capture the challenges working as a clinical psychologist in the context of current mental health services for children and adolescents, and the impact of time pressure on their practice. The expectation is for activity in the 'doing phase' of therapy, rather than time spent on assessment and formulation. The result is a service preference for brevity and timesaving in areas deemed not to be productive, resulting in a brief screen as preferable to a thorough assessment.

Emily goes on to talk about these same service-level pressures by drawing attention to the roles of management in developing this culture. Talking about her experience of talking to management about initiatives to improve access, she is met by responses that are limited to the level of talk rather than action. In sharp contrast to the expectations of active and interventive practices of psychology, management are spoken about as if they do little to support actioning changes:

*... it's about actually actioning it as a priority rather than just going 'oh, we really agree with that we'll try and do that'.*

Many participants spoke about the tension between this apparent encouragement from managers and the constraints of time pressure on their work. Participants spoke to a latent message that addressing issues of access went above and beyond managerial expectations. Taking part in initiatives is seen as extra work and seemingly not valued in line with other responsibilities, where other practices are prioritised first:

*... with managers and things, I think initiatives are welcomed, but then because the service is quite stretched there's not, it's something that will be encouraged by words ... it's not that someone's going to come and say 'that idea you had was really good, why don't you take on a few less people this month and you can have that time to do that project', it's more something that you are seen to do, maybe not in your spare time, but in addition to the work you already are doing. (Amy)*

Some participants spoke to a wider context still and raised the level of commissioning and how this goes on to shape the priorities of local management and everyday practice:

*... There is the pressure in terms of money to be released, it's associated with certain requests, like 'you meet this number', 'you have screened this number of young people' ... it's there, it's a pressure, it's very anxiety provoking for the senior management. (Emily)*

Emily here talks to the impact of money and funding on service priorities, and how service priorities are shaped by the requests of commissioners. Some participants spoke to complexity of funding arrangements and their politicised nature:

*... I don't quite understand the buying concept of who pays what ... but at the heart of funding is commissioning, is these decisions about what your area needs ... the political swing as well so in terms of where funding goes. (John)*

John here captures the obscurity of current funding arrangements following greater marketisation of the NHS (King's Fund, 2015). John also talks to the 'political swing' that can impact funding and ergo the service's ability to resource access initiatives.

The political zeitgeist can provide benefits, with some participants speaking of the politicisation of issues of access acting in their favour and giving them the confidence, and permission, to take things forward:

*... When I have raised it [managers] have been responsive, because there's something happening, I think, more politically, about inclusion and discrimination and inequalities in the politics at the moment ... that's given me more confidence to raise it. (Kim)*

### 3.3.3. Choosing an approach – navigating the evidence base

Many participants spoke to their awareness of current dominant knowledges and practices within clinical psychology and their historical development within a Western context. Some participants raised the problematic nature of applying these conceptual and philosophical assumptions during the assessment process with BME young people:

*... the way we conceptualise mental health is a very Western way of thinking about things that can be quite foreign to families and some cultures ... so actually maybe the way we're positioning ourselves and the way we are thinking isn't actually so in tune with some families from different cultural backgrounds. (Kim)*

Kim goes on to talk about the implication for how these Western conceptualisations impact on access to psychology for BME young people and families through a set of moralistic ideas about what is 'right'. These expectations often result in BME parents' care for their children being called into question when entering such services, and being exposed to ideas that are unhelpful to them and result in being less likely to find a service acceptable:

*... to come into a system where they're saying that actually, 'no, you're not probably doing this or that right', 'you know the way you're parenting isn't the way' ... who are we to say that's not the right way to parent coming from Western ideas that might not be helpful to them?*

Some participants elaborated beyond the issues of misapplication of culture-bound knowledges and practices to raise the importance of what is mostly absent and excluded in many of our current conceptualisations and 'evidence-based' practice, such as the experiences of racism for BME young people:

*... I often have conversations with clients about how they feel, how they feel prejudiced, how they feel attacked racially ... I am sure that that we are, we are not considering enough the role of being from an ethnic minority for clients and how much this is a difficulty for them. (David)*

Some participants spoke to the limitations of their own practice and how a particular approach might obscure more social and political understandings from assessment:

*... I was trained quite a lot in CBT approaches that are very, very much about the individual, ... the role of the psychologist is very hard because, my experience is, we are training in a, to see things in isolation really, and not so much considering the wider context and the political. (David)*

Here David raises the tension between his training in CBT and his practice as a socially and politically aware psychologist, and how this approach to assessment creates challenges for understanding racism and the wider context of the BME young person and family. Many participants talked about adhering to, or being limited by, the dominance of ‘evidence-based practice’ in how they work. That is, the idea that best practice be primarily informed by the use of standardised approaches and those that have preferably undergone the scrutiny of randomised control trials (Vita & Barlati, 2019). Some participants spoke about how ‘evidence-based practice’ restricted the psychological approaches available to them:

*... what is expected of me is to use an evidence-based treatment, so if something is behavioural, it's working with parents ... if it's about anger or impulsivity or regulation of emotions, there are very clear psychological theories and techniques to work with this. (David)*

Many participants referred explicitly and implicitly to the ‘evidence base’ in their talk, so that even when they talked about their preferred ways of assessing and formulating BME young people, which they saw as better

addressing equality of access, they felt themselves to be practising outside 'the team's remit' and against the 'evidence base':

*... I feel pressured to perhaps sometimes work within the more therapeutic, not therapeutic, theoretical box ... because that is what the team's remit is, but I think for me and for my background I draw on a much more Narrative approach, Systemic thinking ... more the Community / Liberation Psychology theory of looking much more at the broader systems. (Emily)*

*... I think it's interesting because the Narrative approach ... it wouldn't be considered one of the evidence-based [approaches]. And this is the other barrier I think, what kind of interventions are we offering that feel acceptable to people? I think sometimes we try and fit them into an intervention that might not be acceptable. One of my worries and why I don't introduce it straight away because I think that I'm not an evidence-based practitioner, which is what psychology should be. (Kim)*

These accounts talk to a preference for psychological approaches that are felt to better attend to the wider context and systems around the BME young person, therefore contributing to better recognition and access. However, to use these approaches is to always be in the shadow of the 'evidence base' and it is implied that these preferred approaches are somehow at odds or contrary to what is acceptable to the 'evidence base'. This fits with critiques of 'evidence-based practice' having a tendency towards therapeutic nihilism, and that in the absence of randomised trial evidence there is a great reduction in therapeutic options for the practitioner (Mullen & Streiner, 2004). The approaches Emily refers to, such as Narrative (White & Epston, 1990) and Liberation Psychology (Martín-Baró, 1996), are positioned as outside what is permitted in the evidence base, and so practitioners are cautious when introducing these ideas not to be seen as acting against this 'evidence base' and 'what psychology should be'.

Some participants spoke to their preference for alternative approaches that they viewed as less problematic and non-Western. Holly talks to her use of Solution-Focused Therapy (O'Connell & Palmer, 2005) and Narrative approaches in her work, with these approaches spoken about as somehow free from the assumptions and theory of other, presumably mainstream, 'evidence-based' approaches:

*... that service kind of took a more Solution-Focused, sometimes more Narrative approach to working with families ... so we're not going to bring any assumptions to this or any theory I guess ... we didn't bring Western theory onto services, onto service users.*

The use of alternative approaches appears to be a well-meaning attempt to appreciate and draw on more applicable and acceptable knowledges in pursuit of equality. However, some participants raised how difficult it is to conceive of any knowledges or ways of practising that were not Eurocentric:

*... I probably don't actually know what those philosophies are, but there will be other philosophies out there that aren't Eurocentric, that aren't Western-centric ideas, and that's my ignorance that I don't know what they are but there will be other ways of understanding people out there.*  
(Holly)

### **3.4. Pathways to Services**

#### **3.4.1. The implications of language**

Many participants spoke to issues relating to the different languages of various BME communities, particularly for the parents and families of BME young people, and how these differences act as a barrier to English-speaking mainstream services:

*... the children we're working with, second generation children and families, [who] migrated over, it might be that language is difficult, so it's*



*hard for their families to learn about our service, to ring up and ask about it, to go to their GP and know about it. (Holly)*

Differences in language provision, therefore, impacted on how the knowledge of a service is distributed across the population, with those speaking non-English languages provided with less opportunities to know what is available to them. Language and the use of interpreters was also cited by some participants as a common difficulty during the assessment process:

*... interpreters don't get booked for hospital appointments, families [are] constantly being called on to interpret, including children, are interpreting for their parents and that's not always consistently thought about and I see this as such a big issue ... the affect that has on the family and on an interaction with the therapist. (Rosie)*

Rosie here raises the challenges and inconsistencies of English-speaking psychologists often not booking or having ready access to interpreters, relying instead on family members to interpret on behalf of the service. She talks about this as a 'big issue' and alludes to the impact on what can be said and understood between the therapist and family when relying on interpretation in this way and the associated consequences on access to services.

Some participants spoke of the importance of language in regard to mental health stigma, and how stigmatisation was felt to be particularly pronounced in communities racialised as BME. Kim goes further to highlight the intersection of age, and how young people are made to sensitively navigate these stigmatised identities so as to 'fit in' during this key life stage:

*... in this time of adolescence, they're wanting to fit in and there are issues there, so it's not just about ethnic minorities so much, but I think this helps with the engagement, that it's not as stigmatising. So we don't mention mental health at all in the workshop, we say managing*

*stress, that stress is really normal, we don't mention low mood or anxiety, although a lot of the theory that underpins the workshop is for anxiety and depression, we don't call it that at all.*

Kim introduces the judicious use of language as a way of mediating the stigma attached to mental health difficulties and nomenclature of clinical psychology. Using more everyday descriptors, such as 'stress', Kim suggests this reduces barriers to access for BME communities by offering more palatable language. However, whilst changing language is seen as a way of improving access to services for BME communities, the underlying psychological theory and practice remains unchanged. The language might be presented differently, but the knowledges drawn upon remain the same.

### **3.4.2. Service and diagnostic distortions**

Many participants spoke of the differences in ethnic representation of young people that was modulated by service- and diagnostic-led factors. The impact that the service context had on access for BME young people was frequently commented on, with some participant's noting the differences between their novel service settings when compared to a typical mainstream CAMHS. Kim reflects on a recent audit of access to services in a schools-based psychology service that showed more equal ethnic representation:

*... across the school, and we've done some statistics on this, in terms of auditing our data. The ethnic makeup of the school is more or less represented in the people who attend our workshops.*

Some participants were in contexts where direct comparisons could be made between pathways of care across different services and disciplines. For example, Rosie spoke from a hospital context where she could contrast the racial representation she observed in medical appointments when compared to psychology appointments:

*I'd say there's much more racial diversity in clinics and, actually, thinking about my last placement in paediatrics, that was the case as well. Obviously, in medical conditions like the ones that we're seeing don't discriminate between [races].*

Rosie talks to the differences in ethnic representation between physical and mental health services, raising how 'conditions' in each field of knowledge acts to discriminate based on race, with psychological constructs leading to reduced representation of BME young people in the mental health service.

Some participants expanded on this idea of discriminatory pathways when talking about particular mental health diagnoses acting as a determinant to the ethnicity of those accessing psychology services. David reflects on his experience of working with those labelled as having a 'conduct disorder' and how this diagnosis intersects with ethnicity:

*... those children who are accused of offending, gang affiliation, school exclusion, substance, basically all the things that could lead to forensic later on, abuse towards others, and things like that ... this is absurd, this is not something that I've run the numbers, but I can see that most of my clients tend to be Black and it's something that I find actually quite curious because I'm thinking to what extent are we replicating society, in that more Black people are going to prison, and how much are we replicating that from early on? ... I almost never encounter White families that would come with this diagnostic label, which is conduct disorder and things like that, when actually probably they would have met the criteria. (David)*

David here refers to other sections of society that are well understood to be replicating inequalities and criminalising young Black boys (Centre for Mental Health, 2013). David asks the important question of whether services that provide disproportionate access to this demographic are in turn perpetuating and even beginning the systematic discrimination of Black young people.

David considers a key component of this process as the unequal application of diagnostic labels, here seen as not a matter of criteria, but ethnicity.

The criminalisation of BME young people was again referred to in John's account within his context of forensic services, where he notes how the thresholds of mainstream CAMHS services often preclude those with criminal offences from accessing these services:

*... generic CAMHS services outside of youth offending have thresholds and particular referral requirements that just, there just isn't that set up here ... the whole point of being in [this service is] to capture a group of young people that aren't captured by generic CAMHS.*

John's talk recognises how the (in)accessibility of mainstream CAMHS services for those with criminal offences has led to the creation of a forensic mental health service and pathway. Such pathways have disproportionate representation of BME young people because of wider inequalities that criminalise BME young people, with access to mental health care restricted to these forensic settings and diverted from mainstream CAMHS through the enactment of 'thresholds'.

The challenges of accessing mainstream CAMHS are present in many participants' accounts:

*... you do need to meet the threshold and it's quite difficult to meet the threshold. (Amy)*

*... Getting through the golden gates to Tier 3 CAMHS and past that threshold. (John)*

This is in common with the recent literature on CAMHS, which suggest increasingly higher thresholds required to access services due to historical underfunding in proportion to increasing demand (Young Minds, 2018a). For many young people and families with mental health problems, access to Tier

3 CAMHS can be too difficult and a pathway that, even if accessed, may not result in a service due to these high thresholds.

Emily, in talking about access for BME young people, views these high thresholds and pathways as a barrier and excluding of certain groups, so much so that access is seen as an impossibility:

*... I absolutely think for certain groups of young people we need to take that pathway system out or they'll never access our service, I mean I've worked with young offenders as well and similar things. They will never access our service unless we adapt and change and make a service that feels appropriate for them, and not just accessible, but acceptable.*

## **4. CHAPTER FOUR – DISCUSSION**

This chapter considers how the themes address my research questions, with reference to the existing literature. I go on to critically evaluate the study, attending to the limitations and implications of this piece of research, and ending with my reflections on the research process and suggested areas for further study.

### **4.1. Revisiting the Aims**

The aim of this study was to gain a greater understanding of the talk of clinical psychologists in relation to issues of access for BME young people and families; a rationale that followed from the relative paucity of research exploring these perspectives in the literature within a clinical psychology context. It was hoped that this focus of enquiry might elucidate service- and practitioner-oriented barriers to access, rather than further a tendency to locate barriers within BME communities that may replicate discourses of inferiority (Van Dijk, 1993) and position BME communities as a 'hard to reach' group (Kovandzic et al., 2011).

I have chosen to interweave the findings related to the research question 'what wider discourses and contextual factors influence clinical psychologists' accounts?' alongside the findings for other research questions. This decision was made in line with my epistemological and methodological stance, which sees wider discourses and contextual factors as present in all clinical psychologist's talk. I, therefore, see this particular research question as inseparable from the findings of the other research questions.

#### **4.1.1. What do clinical psychologists say about difficulties in accessing psychology services for BME young people?**

##### **4.1.1.1. *The trouble with diagnosis***

Participants cited many difficulties that both directly and indirectly affect the BME young person's equal access to services. Many examples were raised about the structure of services and how these structures resulted in a reproduction of social inequalities. This was starkest in forensic services and service provision for those with diagnoses of 'conduct disorder', which saw a much greater representation of BME young people than WME young people (Potter, 2014). These accounts relate to one aspect of 'institutional racism' (Fernando, 2017), that is, that services are structured in ways that act to support racial division and reproduce it through the application of racialised labels (Potter, 2014), and the utilisation of 'criminality' as part their de facto inclusion and exclusion criteria, as in forensic and mainstream CAMHS.

The impact of how clinical psychologists contribute to these structural barriers for BME young people and families was also apparent in the contrasting accounts from services where there is more equitable representation of BME young people and families. Participants spoke of services, such as school-based psychological services, that saw more equitable representation through the removal of referral criteria, delivery in non-typical settings and a desire to maximise inclusion and attendance. This is commensurate with the literature where a focus on more locally available and flexible treatment leads to greater uptake (Fatimilehin & Coleman, 1999; Messent & Murrell, 2003), such as in school settings (Hardman & Harris, 1998).

These approaches were also a way of responding to findings that BME young people are more likely to experience coercive mental health treatment, such as through forensic and inpatient mental health services (Lavis, 2014; Malek & Joughin, 2004). Services that provide access in non-traditional settings offer a place in which to support BME young people and families that

is dissociated from institutions involved in the potential for harm, or even death, as seen in a number of high-profile cases of BME individuals in police custody and in mental health services (Hannan, Hearnden, Grace, & Bucke, 2010). BME young people and families are acutely aware of these coercive and onerous pathways to mental health care and talk to its impact on their willingness to access services (42nd Street, 2017; O'Brian, 1990).

Another way some participants responded was their judicious use of language in relation to mental health diagnoses; with more 'everyday' language utilised, so that 'anxiety' became 'stress' and so forth. These attempts were perhaps a way of mitigating the racialisation of particular mental health diagnoses (Fernando, 2017) and the associated stigma and negative perceptions that may be present in some communities (Memon et al., 2016b). Using language that operates in a more 'normative' domain is thought to aid recognition of mental health problems and mediate challenges that come with language associated with stigmatised identities (Arday, 2018), as well as helping with issues relating to language fluency (Cohen, 2000).

#### **4.1.1.2. Contextual pressures**

Accounts frequently referred to how these structural barriers were influenced by wider political and economic factors that impacted upon services and clinical psychologists in myriad and interlocking ways, with consequences that often resulted in reduced access for BME young people. Participants spoke widely about a felt 'pressure' in their work, and that their work with children and young people had been constrained by multiple contexts: service management, the commissioning of services, and by the political arena.

These constraints can on one hand be related to current funding arrangements in local CAMHS. Funding for CAMHS has been recognised as unequal, with just one percent of NHS funding reaching child and adolescent mental health services, and representing just 8.7 percent of the overall mental health budget (Young Minds, 2018b). Even after concerted political



interest by recent governments to increase funding in CAMHS (DoH, 2015), analysis shows less than half of commissioning groups increased their spending in line with the extra money provided to them, with some even spending it on other areas entirely (Young Minds, 2018b). In areas where spending has increased, this is still below that needed to account for increased demand, and these financial pressures have a clear impact on the reality of work clinical psychologists can and are expected to do in the additional contexts of recent policy initiatives and structural changes (see Section 1.2.5.4.). These multiple contextual factors were recognised and referenced by the clinical psychologist whose task it was to navigate these contexts by accepting and resisting the effects on their practice.

This 'pressure' was felt in many forms, one of which was how it manifested in the (un)availability of time, and the extent to which clinical psychologists could adequately 'assess' and 'formulate' the problems of BME young people. Instead, participants talked of expectations that they focus on the 'intervention' portion of psychological work, possibly as a way of mitigating underfunding and providing a reduced service to more people (Young Minds, 2018a). This has implications for BME young people entering services practising with Eurocentric psychological frameworks and moving more quickly to interventive stages of psychological work, as this is contrary to cross-cultural work that often requires more time to adequately meet the needs of BME young people and attend to differences where they occur (Bhui, Christie, & Bhugra, 1995; Messent & Murrell, 2003; Shepherd, Willis-Esqueda, Newton, Sivasubramaniam, & Paradies, 2019).

There are interesting questions raised here. On the one hand, It could be seen that the removal of prejudicial biases in assessment and formulation procedures could provide more equitable psychological services (Hardman & Harris, 1998; Messent & Murrell, 2003), however, it may also pose a challenge to the recognition of mental health difficulties if there is an encouragement to forgo a more detailed assessment and formulation and more quickly undergo intervention. A hasty intervention is more likely to miss factors in the assessment stage that might influence whether a mental health

problem is detected (Commander, Sashidharan, Odell, & Surtrees, 1997; Tervalon & Murray-García, 1998).

It is important to consider the impetus for shortening the time on assessment and formulation, rather than taking it for granted that it is beneficial for improving access to BME young people. Participants frequently cited the wider contextual forces that institute these kinds of changes and that, rather than a meaningful attempt at improving access, such changes might have more to do with increasing productivity and throughput to meet increasing demands on the service. Clinical psychologists are expected to have an awareness of the cost-effectiveness of interventions and meet efficiency targets in therapeutic work, which is regarded as a key area of concern for the profession (Baker, McFall, & Shoham, 2008; Dunn, 2017), and so these outcomes can be more in service to our contexts than BME young people and families.

The concept of the 'therapeutic hour' (Bordin, 1959) and the expectation that within a period of time, often in a singular session, a clinical psychologist might be said to have adequately 'assessed' the young person or family is put into doubt within a context of pressures that treat each young person – regardless of ethnic differences – as assessable within an equal timeframe. This was raised in the talk of participants in instances such as using interpreters, where the therapeutic hour would be constrained by the time available (due to time taken interpreting each other's talk; Jayarajan, 2001), as well as constraints on the greater time and consideration needed to understand each other across other differences, such as ethnicity and culture, which may be taken for granted in therapeutic encounters where both clinical psychologist and client share the same ethnic and cultural background (Bhui et al., 1995; Fernando, 2010; Malek & Joughin, 2004).

There is a risk that these contextual pressures can be disguised in the language of equality (Sardar, 2008), with current trends towards standardisation, manualisation and treatment protocols in clinical psychology flattening the very real differences that can exist between clinical

psychologists and the people we serve. This is observable in the wider context, as initiatives in the name of 'equality' are often seen as preferable to initiatives that act to redress imbalances through the pursuit of equity (Sun, 2014). Reacting to these contextual pressures in an 'equal' way must be viewed as holding the potential to make things more unequal.

#### **4.1.1.3.        *Thresholds***

In an era of austerity for the NHS (Roberts, Marshall, & Charlesworth, 2017), attempts to increase access to services by removing structural barriers may be seen as infeasible given the context of ever-increasing demands.

Participatory research aiming to improve access to services raised concerns from professionals that services would not cope with the increased throughput (Messent & Murrell, 2003). Instead, services might aim to reduce throughput through a process of 'rationing by selection' (The King's Fund, 2017), which is commonly referred to as the enforcement or changing of a service's 'thresholds', which serve to act as barriers to access. Thresholds in these settings act as more than a meaningful gateway to receiving psychological services, but as a way practitioners and managers manage service capacity and meet the expectations of commissioning, political and economic forces on the service.

The institutionalisation of these 'thresholds' is often spoken about as if naturally derived and represents an objective and unchangeable reality of the service. Instead, 'thresholds' might be better represented as partly the result of clinicians', including clinical psychologists, enactment of their professional knowledges and navigation of these aforementioned contextual pressures in order to co-construct 'thresholds' as a seemingly fair and equitable gateway to receiving psychological services.

However, the accounts of participants suggest these 'thresholds' are, in fact, very changeable and that services respond positively to persistent challenges from young people and families to clinical decisions, such as when clinicians place the young person outside of the service's 'thresholds'.

These challenges to clinical decisions were spoken about as more frequently coming from WME young people and families, who were said to often ask for a second opinion and subsequently gain access to services. BME young people and families were spoken about as less likely to challenge clinical opinions in this way, raising questions beyond how ‘thresholds’ might act as a vehicle for perpetuating inequitable access, and the additional barrier of how services and clinicians allow for further opportunities for WME young people and families, who may be more likely to leverage social capital in aid of their preferred outcome (Dixon, Le Grand, & Henderson, 2007; Savage et al., 2015).

#### **4.1.2. What do clinical psychologists say about ensuring equitable access to psychology services for BME young people?**

##### **4.1.2.1. *How should we know?***

Participants spoke of two aspects of Whiteness that impact the work of ensuring equitable service provision: firstly, not having the requisite knowledge of these inequalities, and secondly; uncomfortableness in confronting issues of race. Participants’ references to the operation of Whiteness within the profession of clinical psychology were multiple and linked to an awareness of the White-centricity of clinical psychology, which is congruent with recent BPS agendas and demographic statistics (BPS, 2015; Wood & Patel, 2017). The profession was often talked about as if Whiteness was the default, with ethnicity consequently located in the other (Patel et al., 2000) and the acknowledgement of BME clinical psychologists’ contributions minimised (Paulraj, 2016). This is evidenced in the many testimonies of BME clinical psychologists within the profession (Adetimole et al., 2005; Paulraj, 2016; Shah et al., 2012).

The implications of Whiteness could be seen in what participants claimed to ‘know’ about BME young people and families within the profession and their respective service. Accounts from WME psychologists referred to a lack of one aspect of knowledge, personal experience, and remarked on lives where

their ethnicity has not been foregrounded and so rendered invisible (DiAngelo, 2019; Eddo-Lodge, 2017). This lack of personal knowledge was set in contrast to accounts from BME clinical psychologists, who spoke to how the foregrounding of their ethnicity contributed to their knowledge on the topic and increased their capacity to recognise ethnic inequities in service provision. BME clinical psychologists spoke to these experiences aiding them to challenge and raise questions in various contexts and different levels of the service, for example, at the level of managers and commissioners. The responsibility of BME clinical psychologists to see and act upon issues relating to race and ethnicity is just one consequence of the Whiteness of the profession (Shah et al., 2012).

WME participants' accounts of not knowing did not only relate to a lack of racialised personal experiences but referenced the replication of not knowing across all levels of knowledge production; from local, service-level research, through to the wider publication of research on ethnic inequities within clinical psychology. Whiteness here is wound up in knowledge production and has material consequences for the resources available at service level, measurable in clinical psychologists' awareness of inequities to a (lack of) meaningful service-led initiatives and structural support to address discriminatory service provision. The (de)prioritising of inequities in service provision continues at the level of the BPS, where the solution is primarily sought in the diversification of the profession with its implications that awareness and commitment to action is achieved predominantly by BME clinical psychologists, leaving WME clinical psychologists to continue as before (Wood & Patel, 2017).

#### **4.1.2.2. *Whose responsibility is it anyway?***

Participants spoke of overcoming the contextual and structural barriers to improving access to services, persevering through some of these challenges confronting them. What was clearest in my sample was a collective passion to talk more about these issues, and to go beyond what was expected of them towards achieving greater equity in services. This passion resonated

with much that has been written about anti-racist practice in the UK from those within the profession (Adetimole et al., 2005; Fernando, 2017; Howitt & Owusu-Bempah, 1994; McInnis, 2002; Shah et al., 2012). Participants cited how their resolve enabled them to engage with individual-led initiatives, which appeared to surpass any local, service-led initiatives. At times, these individual-led initiatives were spoken about as the only initiatives within whole services, confirming some predictions of the consequence of a lack of policy and strategic direction in recent years (Malek, 2011; Palmer, 2018).

Aiding these feats, participants spoke of the importance of allies – other professionals who shared this passion for addressing inequitable access at all levels of service provision. These could be fellow clinical psychologists, multi-disciplinary colleagues or the encouragement from management to pursue this kind of work. However, these relationships and the cultivation of this passion was hard won, and participants raised the contextual pressures placed upon their capacity for this work, referring to systems that put a greater priority on particular aspects of psychological work, such as therapy, and less priority on initiatives to improve access (see Section 4.1.1.2.). The sense of time, again, appeared in participants' accounts as a metric in their awareness that was representative of their capacity to pursue such initiatives in their context (Messent & Murrell, 2003).

There are important questions around how 'time' is apportioned in clinical psychology services. Participants accounts suggest that 'time' is inextricably linked to relations of power, and it is the task of clinical psychologists to meet expectations of what is constructed as a valuable use of time. These relations of power were most commonly referred to in relationships to managers and commissioners but might be broadened more widely to include the codes of professional practice, agendas of professional bodies, NHS priorities, and governmental initiatives that shape the actions taken by managers and commissioners. This again relates to the lack of policy direction in this area that values local, service-led initiatives (Malek, 2011).

Some of these wider influences may be talked to implicitly as part of participants' descriptions of their relationship with managers and commissioners who, in effect, play a large part in defining the tasks of clinical psychologists within services. Absent in the talk of these participants was any explicit mention of the extensive policy backdrop that places responsibility on services and clinical psychologists to redress social inequalities. These many policies (see Section 1.2.5.) show the expectations according to international and national human rights, which place individual clinical psychologists as 'duty bearers' with responsibility to provide equality of treatment and the highest attainable mental health for BME young people and families. At a more local level, the Equality Act (2010) places further responsibility on the NHS to address cultural diversity and equality in service planning and delivery (Healthcare Commission, 2009).

The NHS has responded to these obligations in previous years and decades by instituting its own policy, however, there is no current meaningful NHS policy that aims to address these inequities (Fernando, 2017; Palmer, 2018), particularly in the context of children and young people's mental health (Malek, 2011). These policy shortfalls have contributed to the lack of collective action in clinical psychology services, instead being left to the individual clinical psychologist to form initiatives through their own determination.

The absence of any current and meaningful policy backdrop might speak to a 'post-racial' United Kingdom (Fernando, 2017), which contributes to the move away from policy focused specifically on issues of race, to policy which professes to be more 'all inclusive' of protected characteristics and is considered generalisable to all (Neckles, 2013). This is compounded further by the specific context of children and young people and the dearth of relevant policy (see Section 1.2.5.4.). Participants' accounts capture the unfortunate consequences of this policy context, and suggest the clinical psychologist, along with the services in which they work, lack an awareness and an encouragement to engage in the necessary work relating to improving access for BME young people and families.

#### **4.1.2.3.      *Whiteness as a barrier***

One of these challenges has been previously discussed as relating to how knowledge of these issues is shared in services, and how the current policy backdrop, lack of local- and service-level research and personal experiences of racialisation contribute to a collective 'unknowing' of inequitable service provision for BME young people and families. One construct underpinning this is 'Whiteness' (Ryde, 2009), which follows from a predominantly White profession and its tendency to reproduce inequalities through the knowledge it pursues (as might be seen in the lack of local- and service-level research). Consequently, this shapes what can be said to be known and influences policy and service-level change and initiatives.

Many participants described overcoming these challenges through the cultivation of personal passion that emboldened them to address issues of inequitable access despite a lack of structural support, and to take heed of the experiences of BME clinical psychologists raising the need for change (McInnis, 2002; Patel & Keval, 2018) and to not ignore these knowledges (Fricker, 2007). However, moving from a place of knowing towards the realm of action and change brought further difficulties for participants. One of these followed from aspects of Whiteness, and can be more specifically referred to as 'White fragility' (DiAngelo, 2019).

White fragility was notable in the discomfort participants felt when talking about issues of race. For WME clinical psychologists, they spoke of the challenges of discussing race with clients from different ethnic backgrounds from themselves, as well as the difficulty in engaging in wider discussions with other clinical psychologists about the ethnic representation of the profession and psychology services. For BME clinical psychologists, their desire to talk to these issues was tempered by an awareness of how uncomfortable it can be for WME clinical psychologists. They spoke of carefully managing when to raise these issues, so as to continue being seen as a professional and protecting the White listener from disenfranchisement. We can also see the operation of White privilege and silencing in how many



of these conversations take place as scheduled and one-off meetings, with discussions around issues of race and ethnicity predominantly limited to these settings, or worse, only occurring within these settings. These findings are commensurate with the literature and manifestations of Whiteness in healthcare settings (Ryde, 2009).

We can now conceive of a number of barriers to equitable service provision, from the clinical psychologist's personal- and context-led awareness of inequity to the challenges of engaging in the candid and discomforting conversations that are needed for meaningful initiatives to be realised. It is not surprising that participants spoke of how tiring it can be to pursue equitable service provision, and that despite the cultivation of this personal passion, in systems in which this is not supported, there is the risk of exhaustion and disengagement. This exhaustion is already prevalent within the profession (BPS, 2019; McCormack, MacIntyre, O'Shea, Herring, & Campbell, 2018). Participants conceptualise individual-led initiatives to improve equity in service provision as 'extracurricular'; outside the scope of a clinical psychologists' typical workload, and there is little to no structural support from their organisation to engage in these issues (Bhui et al., 1995; Messent & Murrell, 2003; Ryde, 2009). These might be seen as the many outcomes of Whiteness, which operate to individually and institutionally maintain the status quo and frustrate any attempts at change.

#### **4.1.3. What do clinical psychologists say about applying psychological theory in the work with BME young people?**

The previously discussed judicious use of language was used by some participants to move away from psychiatric constructs (for example, from depression and anxiety to low mood and worry), with the aim to mitigate some of the effects of negative perceptions and mental health stigma felt by BME young people and families (see Memon et al., 2016b). However, these changes in language use were done through substitution, rather than as a meaningful change to underlying psychological theory and, therefore, are not included here. Participants made attempts at selecting psychological theory

that was felt to be more conducive to greater equity in access to services, but did so with reference to the constraints imposed by the current doctrine of 'evidence-based practice' (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013), which were felt to limit the psychological theory available to them.

Participants spoke to the discourse of evidence-based practice (Baker et al., 2018) and the pressure to draw on psychological theory that primarily meets the criteria of the hierarchy of evidence with empirical studies (Lilienfeld et al., 2013). What is considered 'evidence-based' in the context of the United Kingdom is typically derived from the latest guidance provided by the National Institute for Health and Care Excellence (NICE), which follows this hierarchy of evidence according to psychiatric diagnoses, and makes suggestions on psychological therapies to be used by clinical psychologists. The discomfort practitioners have in relationship to the evidence-base is well documented in the literature (Lilienfeld et al., 2013) and participants in this study spoke of their discomfort at a felt expectation they draw from this limited selection of psychological approaches.

Some participants referred to the dominance of CBT in their service context, speaking to their sense of its inadequacy in capturing the experiences and social context of BME young people and families. Critiques of CBT support this view, and reference its focus on people's interior lives and a tendency towards manualisation that conspire to decontextualise BME young people and families (Beck, 2019; Harper & Iwamasa, 2000). Many participants spoke to their preference for alternative approaches that were seen to sit outside of what was commonly practised in their service contexts, such as Narrative (White & Epston, 1990), Systemic (Dallos & Draper, 2015) and Liberation (Martín-Baró, 1996) approaches.

Participants spoke of these preferences alongside an acknowledgement of the origins of psychological theory and its development in majority White and Western contexts, and the problematic nature of utilising this theory base with people from different ethnic and cultural backgrounds (Bhui et al., 1995; Fernando, 2017; Patel et al., 2000). However, it is notable that these

preferred alternative approaches might be criticised on the same grounds to those referenced as inadequate. How Narrative, Systemic and Liberation approaches might differ, however, is in their attention to issues of context and power in their understanding of psychological distress, and so place a greater importance on experiences and environments associated with racialisation. These approaches may offer a greater focus to the 'exterior' of people's lives and their social and material circumstances (Smail, 2005). Greater attention to the social contexts of BME individuals is one of the ways CBT is adapted; encouraging the practitioner to better address and integrate these aspects to CBT formulation (Beck, 2019). One participant remarked on their desire to use psychological theory free from these Eurocentric origins, however, was unable to refer to an awareness of any alternative theories to draw upon (Fernando, 2010).

Participants again raised the wider contextual pressures impressing upon their practice, speaking to the challenges in their respective service contexts and the importance of attending to expectations at multiple levels – the client, the colleague, the team, the manager, the commissioner, the NHS, the professional body. The pressure of time is again relevant here, with implications on the kinds of work clinical psychologists can practice. To make the necessary adaptations to practice that are 'culturally competent' (see Section 1.2.4.), such as addressing BME young people and families' social contexts, there is a need for practitioners to have more time with clients (Shepherd et al., 2019). This is necessary when the clinical psychologist differs on axes of ethnic and cultural background to the young person and family, and so must do more to understand their particular context and talk across difference (Chandra, 1996; Kirmayer, 2012). If time is constrained for the clinical psychologist, as has been spoken about in these excerpts, it holds that their capacity for practices that are sensitive to difference are similarly constrained. The effects of limited time would, therefore, disproportionately disadvantage BME young people and families accessing services.

## **4.2. Limitations**

### **4.2.1. Participants**

Whilst invitations to take part in this study were open to all, I was struck by the interest and commitment of participants to achieving greater equity in access; evident in their talk during interviews. The clearest example of this is within the subtheme on the passion involved in the pursuit of equity of access. I also note that, despite current Clearing House demographics of 13% acceptance of BME candidates, my sample had a representation of 25% BME clinical psychologists. It is likely that my recruitment strategy has encouraged those with an interest or lived experience related to the topic, inevitably talking to this knowledge in their accounts.

There is, of course, great value in this. I was particularly appreciative of the ability to analyse my data with these different ethnic identities in mind, which proved invaluable for interrogating aspects of Whiteness in the profession from multiple perspectives. This was most notable in the subtheme around White fragility, where this phenomenon was observable in participants accounts when speaking both from and to White identities.

I am left thinking of the kinds of participants that are not represented in my sample. What of the many WME clinical psychologists who perhaps saw my invitation and thought 'I don't have anything to say about that', or 'I don't have any expertise on that'? My invitation may have even involved some turning away; perhaps seeing the topic was too difficult or painful, and a desire not to implicate oneself. It is this 'group' of clinical psychologists that would be wonderful to capture, so that this study can speak more widely about the profession as it currently is. Research will always involve an opting in, but I wonder if these anxieties could be diffused somehow through more general or gentle invitations to take part, or by promoting the input of those that might have felt they have little to add to this piece of research.

### **4.2.2. Methodology**

My decision to use thematic analysis also raised some limitations for a number of desired features of this piece of research. Namely, I hoped to adequately attend to the specific contexts from which participants spoke out of, and to appreciate issues of intersectionality within their accounts, rather than view their accounts solely through the lens of race and ethnicity. This was made challenging due to the nature of a thematic analysis, and that individual accounts are collectivised and make situating participants' talk difficult to achieve when compared to more idiographic approaches (Bryman, 2012).

Thematic analysis also had the inadvertent effect of rendering some accounts less prominent, particularly for those working in contexts that were different to the majority of participants or had views that diverged from the overall themes in accounts. This left some interesting opportunities for analysis untapped that may have offered unique insights into particular mental health contexts; something that might be addressed in future research (Section 4.5.4.).

### **4.2.3. Epistemology**

Choosing a critical realist epistemology allowed me to take a moderate position where I could theorise both material and discursive factors in participants' accounts. However, I found it challenging to position myself in this epistemological arena and I was often drawn to more of the solely discursive aspects of participants' talk. I found myself particularly interested in the way clinical psychologists utilised language and what available opportunities were allowed or disallowed in these constructions, as well as how the wider context impacted on this process. There may be value in pursuing a more social constructionist epistemology that might better interrogate these aspects of clinical psychologists' talk, rather than doing so alongside and within a non-discursive realm, as a critical realist epistemology does.

### **4.3. Reflexivity**

In line with my critical realist epistemology is the importance of the researcher's own influences on the knowledge produced and claims within it (Willig, 2013). I first look at the personal, before turning to what Fairclough (1995) termed critical language awareness.

#### **4.3.1. Personal reflexivity**

My own identities, values, experiences, interests and beliefs have no doubt shaped the completion of this research. I am a White male trainee clinical psychologist, and so across many axes I am privileged and hold positions of relative power with many other identities. Throughout the process of this research, I have felt a great deal of uncertainty about the usefulness of this pursuit and whether I should even go ahead with it. At times, I have wished I had chosen another topic altogether; something less overwhelming and easier. This uncertainty has been something I have tried to unpick.

A question I ask myself a lot, and is asked of me a lot, is why am I interested in exploring this topic? What has it got to do with me? I do not have a satisfying or coherent response to answer these questions. However, this process has helped me to question the question: 'why are they asking me this?'.

I know I ask this question of myself for many reasons. For one, this pursuit is in contradiction to many of my other beliefs, such as a desire to give greater voice to marginalised communities such as those racialised as BME. Why am I giving further voice to clinical psychologists? Particularly, clinical psychologists who are predominantly from WME backgrounds? Should someone else, other than a WME clinical psychologist, be doing this research? I am clearer now on how to respond these questions, to start I ask, 'why not?'. Does the profession not have something to contribute to this issue, or should we look elsewhere? And should a WME clinical psychologist

not attempt to redress these inequalities, or should we place the responsibility elsewhere?

There is value in research that looks at each component of such a complex issue, and so there is value in the perspective of the clinical psychologist. I see some of these questions coming out of existing racial hierarchies, asking whether (and why) I am betraying my own privilege and the privileges of others. The pursuit of this research has been hard because it involves beginning to scrutinise and possibly relinquish some of this power and begin to see myself as fallible and complicit in these hierarchies. This is painful, and all too easy to want to look away from or try to obstruct (Morgan, 2014).

#### **4.3.2. Critical language awareness**

To critically consider the kinds of language used in this research project, and how they have impacted on the research process, is to be engaged in a kind of reflexivity termed critical language awareness (Fairclough, 1995). A sensitivity to language and terminologies has been an important part of this research. Perhaps the most contentious is my usage of the construct of 'BME'. This category has greatly influenced many components of this research, from the literature review to its findings. Throughout, there is reference to the idea that this category describes a homogenous group, and this frames the language of my invitations to interview and interview questions.

This category then primes and limits what can be spoken about by participants, often with little acknowledgement of the many differences and heterogeneity of those racialised as BME. This language usage further impacts on my interpretation, for example my subtheme around the narrative of empowerment, and how the talk of my participants is interpreted as a broad statement over the way my questions were constructed. Further, this research now sits alongside literature that reproduces ideas of a BME monolith and that clinical psychologists must use these categories in theory and practice.

#### **4.4. Evaluating Qualitative Research**

There is considerable debate about the best methods in which to assess qualitative research on its 'quality'. Applications of similar methods to those used to evaluate quantitative research are recognised to be problematic (Ritchie & Lewis, 2003). Spencer and Ritchie (2011) propose the principles of contribution, credibility and rigour as tools of evaluation.

##### **4.4.1. Contribution**

The contribution of research refers to its value and relevance to the areas in which it relates, such as theory, policy, or practice and impact on the lives and circumstances of individuals. This piece of research aims, at the least, to offer an original understanding of the area of access to services and is the only study I am aware of that has explored clinical psychologists' perspectives. This contributes towards understandings that place more of the onus on practitioners and services to identify and address barriers to equitable access, which they may be uniquely able to do. In terms of the impact of this research, I discuss this further in Section 4.5.

##### **4.4.2. Credibility**

Credibility refers to the plausibility of the claims within, something that has been supported by sharing the findings with my supervisor who has worked within the field of improving access for BME communities in adult mental health settings and confirmed the many similarities in the findings of this research with their experience. In addition, my supervisor offered credibility checks on my coding and interpretations through reviewing a transcript and the coding process.

##### **4.4.3. Rigour**

Rigour refers to the transparency of the research process and the extent to which aspects of the research process are revealed to the reader. Chapter



Two contains detail on the procedure, with Chapter Three presenting direct quotations of participant's accounts alongside themes and interpretation. I followed the guidelines for thematic analysis (Braun & Clarke, 2006) attentively, however, in line with my epistemological position I view my interpretation as one perspective on the data, influenced by my own contexts (see Section 2.2.2.).

#### **4.4.4. Epistemology**

In line with this, Willig (2013) proposes that evaluation of qualitative research should be aligned with the epistemological position of the research. Madill, Jordan and Shirley (2000) introduce criteria for contextual constructionist approaches, such as the critical realist position taken in this research, that assesses research on the degree of consideration given to the contexts influencing participant's accounts and the researcher's interpretation. I have attempted to do this by including aspects of participants' relevant identities and work contexts in my analysis, as well as including my own context in reflective accounts and how this impacted on the research process (Sections 2.2.2. and 4.3.). However, as previously acknowledged in Section 4.2.2., it has been difficult to connect participants' contexts and identities in meaningful ways, partly due to my use of thematic analysis.

#### **4.5. Implications**

Apparent in participants' accounts are the multiple implications across different levels and contexts. Already clear is the capability and desire of many clinical psychologists to improve the equity of access for BME young people and families, and here I consider the implications across different levels in order to support this. The following is not proposed to be an exhaustive list of possible outcomes following the literature review and this piece of research, as this would be beyond the scope of this thesis and the research questions. What follows are some possibilities, with a more comprehensive overview of possible changes available elsewhere (see Bhui et al., 1995; Dwivedi, 2002; Fernando, 1995; Malek & Joughin, 2004).

#### **4.5.1. National and local strategy**

##### **4.5.1.1. Policy**

Through my literature review, I became increasingly aware of the scale of legislation that directly promotes race equality that is applicable internationally and nationally. However, there is little sense of the weight of these legal instruments in everyday practice and I am in agreement with what Palmer (2018, p.129) concludes is 'an absence of strategic direction'. This is particularly true of the child and adolescent context and recent governmental strategy not including initiatives relating specifically to ethnic inequality (see Section 1.2.5.). Without a strategic direction or effective monitoring by services, action to redress these inequalities is made more difficult. Mental health trusts must expect clinical psychology to engage in promoting greater access and should form an explicit part of the expectations in the role, rather than the responsibility of the impassioned clinical psychologist.

There was a great awareness of the impact of reduced funding and resources on the capacity of clinical psychologists to engage in equality practice. Alongside improved strategic direction, an acknowledgement of the consequences of austerity and the underfunding of child and adolescent services is needed, which recognises the harmful impact on clinical psychologists' priorities in these contexts. Such contexts are less conducive to practices that redress issues of inequitable access, as there is an increased push for greater therapeutic contact hours and the discouragement of structural changes that are needed to change rates of access. This process must be seen as an act of institutional racism, with greater value placed on practices of equality that go beyond an analysis of throughput and therapeutic hours. Funding should be provided to manage the potential 'increase' in referrals as a result of providing fairer access, rather than current (under)funding which may stifle structural change due to claims of an inability to cope with increased demand; a justification for the maintenance of the status quo and an act of institutional racism.

#### **4.5.1.2.      *Community partnership***

This kind of work need not start from scratch, and despite my recommendation that services do more to initiate equity initiatives, this need not be siloed and disconnected from the many resources already extant in the community. Strategic models that recognise and utilise existing community knowledge through greater collaboration with non-governmental organisations and charities can provide a mutually supportive environment to achieving greater equity. Innovative approaches to addressing underserved groups have often been associated with the voluntary sector, and Chandra (1996) highlights some of the features available to these organisations that lend to their success: the provision of services that are language and culture specific; knowledge about local communities and their unique circumstances; user-friendliness and accessibility, and; a vital link with alternative voluntary and statutory services.

Research with local BME communities is an important part of assessing needs, with evidence suggesting this kind of knowledge is not up-to-date, is not regularly reviewed, and is not used systematically in the planning of service provision by commissioners (Malek & Joughin, 2004). In addition, BME communities are under-represented in assessments of need and processes of decision-making in their localities (Bhui et al., 1995; Rawaf & Bahl, 1998). A commitment to greater local research and strategy could draw on the principles of action research (Kagan, Burton, & Siddiquee, 2008) and encourage a mutual exchange of learning, co-production and joint working. Importantly, action research promotes practical change through participative processes. These approaches have been successfully implemented in adult services (Griffiths, Byrne, & Nolas, 2010) and services for children and young people (Dwivedi, 2002), and is characterised by meaningful local research that considers the unique contexts of the communities they serve, alongside a willingness to adapt to better meet these needs (e.g. 42nd Street, 2017).

Specific campaigns of awareness can be delivered that follow from what is already indicated in the literature, for instance Messent and Murrell (2003)

conducted a piece of action research in relation to the local Bangladeshi community that led to the suggestions of improved signposting to increase visibility through information at health centres and mosques; CAMHS staff attending open days at local schools and mosques, and; advertisements in local media. Similar findings with African Caribbean parents found a similar lack of awareness campaigns from local psychology services (Fatimilehin & Coleman, 1999). Further local-level research would need to be conducted to meet the needs of each community that are up-to-date and not based on different times and contexts (Ramchandani, 2004).

#### **4.5.1.3.        *Improving access to psychological therapies***

Children and young people's improving access to psychological therapies (CYP-IAPT) aims to improve the availability and effectiveness of mental health services for children and young people through the transformation of existing service provision (CAMHS Press, 2014). To achieve this, one of its aims is to increase training available to staff that follows a 'standardised curriculum of NICE approved and best evidence-based therapies' (CAMHS Press, 2014, p.3). This key tenet brings the potential for opportunities and costs to greater equity in services. The costs are already apparent from the findings of this research, with the risks of standardisation and an over-adherence to the 'evidence base' contributing to services that provide for the particular needs and evidence as it relates to WME young people, potentially excluding BME young people. Such a direction has the potential to further constrain clinical psychologists in their current contexts; limiting possibilities for the development of creative approaches to improving access.

There are also opportunities that come with a nationally recognised and funded training programme such as CYP-IAPT. Commitments could be made to acknowledge the enactment of Whiteness and embed anti-racist practice, model culturally appropriate services, use systems of outcome monitoring that disaggregate based on ethnic identity, actively pursue local research with under-represented groups, decolonise therapeutic practices and promote cultural humility, to name but a few. These are not small tasks,

and would require concerted efforts, but in CYP-IAPT there exists a ready-formed network for the dissemination and development of these ideas. The CYP-IAPT initiative also holds the principle of participation and strategic collaboration in service planning and delivery, which could be further utilised to improve access to services through recruitment and culturally relevant training (CAMHS Press, 2014).

#### **4.5.2. The profession**

Whilst organisations such as the BPS no longer have regulatory power, they still accredit training courses and wield influence through guidelines and initiatives such as the Inclusivity Strategy (BPS, 2015). The BPS could certainly do more to include anti-racist practice into clinical psychology training and teaching on the limitations of psychological knowledges as applied to BME young people and families (Patel et al., 2000). Work towards this end previously existed in the 'Race' and Culture Special Interest Group within the BPS, however, this group was met with opposition and criticism from the BPS since its inception; being first disallowed the status of a 'Section' and later dissolved in 2014 without consulting its members (Wood & Patel, 2017). The knowledge and achievements of the 'Race' and Culture faculty should be returned to and continued, as to see the issues of the profession's history and practice in relation to 'race' and ethnicity as being addressed by the current diversity agenda is plainly inadequate.

This is not to say the profession should not aim to improve the representation of workforce demographics, but that this should happen in parallel with the decolonisation of psychological knowledge and practice (Paulraj, 2016). This can be supported with research directed at the profession towards this goal, with teaching during clinical training that acknowledges the Whiteness of the profession and acts to deconstruct its many manifestations (Wood & Patel, 2017). Clinical psychologists, particularly from WME backgrounds, would benefit from continuous conversations around these issues, so that they might be integrated into everyday conversations and beyond 'one-off' occurrences.

In addition, competency frameworks used by the profession might be updated to better include working with difference, as well as informing clinical psychologists of their legal duties to promote equality as part of the role. Furthermore, updated and alternative models to prescriptive competency frameworks might be developed that move away from an acontextual, static and individualistic view of competence to the skills needed to work with communities and across difference that are typified by andragogical forms of learning, collaborative practices, sensitivity to power, and a commitment to social justice (Kagan & Lawthom, 2014).

Clinical psychologists' legal obligations could be further strengthened as part of HCPC regulation and Continuing Professional Development (CPD) requirements that are embedded in cultural relevancy and humility (Cowan, 2009; Tervalon & Murray-García, 1998). This would meet the needs of the large proportion of clinical psychologists already trained and practising in the UK and could be institutionalised by structures already in place, such as the availability of a curriculum of training that is widely advertised and accredited as CPD by the BPS, for example through supervisor training workshops already provided by university programmes. These CPD opportunities could be further supported through the HCPC auditing process to encourage their attendance.

Evidence-based practice (EBP) was often spoken about as a constraint to the preferred therapeutic approaches of participants, however, EBP is often mischaracterised as based solely on research evidence, and it is instead best understood as the synthesis of three components: research evidence, clinical expertise, and client preferences and values (Lilienfeld et al., 2013). These latter two components may offer clinical psychologists opportunities to apply their preferred psychological theory in their context towards the goal of more acceptable therapeutic interventions for BME young people and families, and could be better supported by the profession to do so.

In contexts where theoretical plurality is less possible, for example, due to commissioning arrangements and national transformation plans (e.g. CYP-IAPT), clinical psychologists could be encouraged to move towards adaptations that might be more appropriate and acceptable to BME young people and families, such as culturally-adapted CBT (Beck, 2019). Alternatively, clinical psychologists can advocate at the level of service management and commissioning for the unsuitability of Eurocentric practices and the need for more culturally acceptable service structures and ways of working (Bhui et al., 1995; Rawaf & Bahl, 1998).

#### **4.5.3. Teams and services**

In common with the wider lack of strategic direction, management in teams and services must do more to address disparities in access to psychology services by placing expectations and capacity to engage in local research and structural changes to service delivery. This would need to place real value in enabling clinical psychologists to take part in this work and go beyond the level of mere agreement of these practices to substantial action. Such teams and services would share a collective responsibility to monitor and improve access to services for BME young people and families and move away from a reliance on the individual passion of employees.

In meeting these ends, the principles of co-production and partnership (see Section 4.5.1.2.) can be utilised and underpinned by community psychology (Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011). Such approaches would be consistent with wider agendas in CAMHS, such as a commitment to 'strategic collaboration' (CAMHS Press, 2014, p.10) that includes young people and families in the designing, planning and delivery of services. Meaningful involvement of BME young people and families would contribute to teams and services that are more culturally acceptable.

#### **4.5.4. The practitioner**

Many of the changes made at the aforementioned levels will influence the practitioner, but there remains much to be done as individuals. This begins with an awareness of their own racism and capacity for harm, a difficult but necessary step towards committing to anti-racist practice, but one that must be achieved through a personal motivation (Moodley, 1995; Patel & Keval, 2018). It also entails an openness to learning about differences between cultures, which may be facilitated through consulting with relevant members of the community and engaging with a broad literature (Fatimilehin & Hassan, 2010; Tervalon & Murray-García, 1998).

Participants spoke to preferred practices and psychological theory, citing Narrative (White & Epston, 1990), Systemic (Dallos & Draper, 2015) and Liberation (Martín-Baró, 1996) approaches. A commitment to practising in ways that attend to the context was a common theme, with psychological intervention linked to a detailed understanding of the particular context in which the young person and family reside (Fatimilehin & Hassan, 2010). For example, Systemic approaches have been used to attend to the importance of context as well as the different family structures and multiple significant relationships that might be present in certain cultures (Fatimilehin & Hassan, 2010). For example, Krause and Miller (1995) detail their use of systemic ideas in the delivery of cross-cultural family therapy service to better meet the needs of a Bangladeshi community.

Alternatively, community (Kagan et al., 2011) and Liberation (Afuape & Hughes, 2016; Martín-Baró, 1996) approaches allows for practices that recognises the importance of context and actively intervene to reshape the social circumstances of young people and families. Fatimilehin and Dye (2003) drew on these ideas, along with social materialist understandings (Smail, 2005), to intervene in an economically deprived area of Liverpool in ways that emphasised prevention, social and material context, community participation, and creative ways of practice. This creativity is often cited as a helpful way to approach work with BME young people and families (e.g.



Hughes & Afuape, 2016), as it often has the effect of shifting the reliance on taken-for-granted concepts that may be unhelpful (Cecchin, Lane, & Ray, 1994).

However, the approaches suggested here should not be seen as an easy way of providing equitable access or mitigating the potential for harm in therapy. To use these approaches in a way that becomes dogmatic risks homogenising BME young people and families further. The practice of the practitioner must remain self-critical and open to change if they are to meet the evolving needs of the young person across difference.

#### **4.5.5. Future research**

A comprehensive quantitative analysis of ethnic variations in access to psychological services has not, to date, been published. Research that has been done has been limited to the level of whole service (such as CAMHS) and multi-disciplinary effects, rather than psychological services (e.g. Daryanani et al., 2001). The literature, and the profession of clinical psychology, would benefit from research that explores many of the differences in accessibility that have been referred to in the talk of this study's participants across CAMHS, forensic, schools-based, social care and hospital settings. Such research would allow for comparisons between these services with respect to their differing practices and contexts. With this knowledge, many more questions can follow, and many more actions taken on structural and individual levels as these differences are identified.

Further studies taking on different epistemological and methodological positions would add great value. I was very interested in the ways in which clinical psychologists spoke about BME young people and families that might be better understood by more discursive approaches. This could be across different levels, such as the use of conversational analysis to elucidate the moment-to-moment communicative interaction between interviewer and clinical psychologist, looking beyond verbal speech to the non-verbal layer of communication – such as the pauses and silences that may hold important meanings as clinical psychologists interact with this topic (Bryman, 2012).

Other levels of analysis, such as discursive analysis, may offer insights into how people use discursive resources to achieve interpersonal outcomes, with Foucauldian discourse analysis possibly offering an understanding of the kinds of objects and subjects constructed by clinical psychologists through discourse and the associated consequences (Willig, 2013). These avenues for research might further implicate the clinical psychologist in the current predicament and further encourage profession-wide changes.

#### **4.6. Concluding Reflections**

Completing this piece of research was one of the most difficult things I have done. Confronting all that has been written, all that has been known, and all that has been tried often left me demotivated and hopeless. This research has forced me to confront how little I can hope to know, and how little I can hope to change in regard to the present situation. However, after all this, I am more at ease with this reality than I was before.

As I go forward into my professional life as a clinical psychologist, I wonder what I can do to contribute to the change that needs to happen in the profession? What does this change look like on the ground, as I begin in to work within the time-pressured and changing priorities of NHS settings? At the least, I hope to (re)start conversations about these issues, again and again with an understanding of the need to look inwards.

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## 6. APPENDICES

### 6.1. Appendix A – Information Sheet



#### **Barriers encountered by young people from Black and Minority Ethnic communities accessing psychological services: Clinical psychologists' perspectives**

**Principal Investigator:** Jack McKellar

University of East London

School of Psychology

**Email:** [u1622888@uel.ac.uk](mailto:u1622888@uel.ac.uk)

Stratford Campus

Water Lane

London, E15 4LZ

#### **Information Sheet**

##### **Consent to participate in a research study**

This page is aimed at providing you with the information you need to consider whether to participate in this study.

##### **Project description**

The majority of research looking at access to mental health services for Black and Minority Ethnic (BME) individuals has tended to focus on these populations for explanations of barriers to accessing services. This research project aims to explore the perspective of clinical psychologists in practice and their views on barriers to access for BME young people during the assessment process. This study will use qualitative interviews to explore clinical psychologists' views and data analysed using thematic analysis.

### **What will be asked of you**

If you decide to take part in the research, you will be interviewed about your experiences as a clinical psychologist. The interview can take place face-to-face, video call (Skype) or telephone at a time and place convenient to you. The interview will last around an hour in length. The principal investigator will be with you at all times if you have any questions about the interview or research, and you are able to take as many breaks as you require during the interview.

### **Confidentiality of data**

During the interview your responses will be audio-recorded on a Dictaphone. This audio recording will be transferred to an encrypted, password-protected laptop where it will be transcribed and anonymised, so that any unnecessary identifiable information is removed. Some information, such as your ethnicity, will not be anonymised as these will be relevant to the research study. The transcript will then be analysed by the principal investigator. No other researchers will have access to the unedited transcript and your information will only be presented in anonymised form to other researchers.

Due to the nature of qualitative research, full confidentiality cannot be assured, and the participant will agree to having excerpts of their anonymised transcript published. If, during the interview process, you talk about you or others being at risk of harm, this information will need to be disclosed in an appropriate manner. If you have any questions about this, please ask the lead investigator.

### **Disclaimer**

Your data will be kept anonymously for 2 years after the interview for potential use in future publications, after which it will be destroyed. You are free to withdraw at any time during the study. If you choose to withdraw your data, simply contact the researcher on the details provided within 3 weeks of the interview. Should you choose to withdraw you may do so without disadvantage to yourself and without any obligation to give a reason.

### **Contact Details**

If you have any questions or concerns about how the study has been conducted, please contact my supervisor:

Dr Angela Byrne, Psychology Department, 1st Floor, Burdett House, Mile End Hospital, Bancroft Road, London E1 4DG  
(Tel: 020 8223 8076. Email: [angela.byrne7@nhs.net](mailto:angela.byrne7@nhs.net))

**or**

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.  
(Tel: 020 8223 4465. Email: [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk))

## 6.2. Appendix B – Invitation Flyer

### **CALL FOR ALL CLINICAL PSYCHOLOGISTS WORKING WITH YOUNG PEOPLE & FAMILIES**



Are you a clinical psychologist involved in assessing young people and families for psychological services?

Can you offer an hour of your time for your perspective on the barriers Black and Minority Ethnic young people and families encounter when accessing psychological services?

Interviews can be done at a time and place convenient to you, either via a face-to-face interview, video call (Skype) or telephone.

You can be working in any service providing psychological services: CAMHS, primary care, third sector organisations, physical health settings, etc.

For more information: <https://goo.gl/iLFvaG>

Please contact me on [u1622888@uel.ac.uk](mailto:u1622888@uel.ac.uk) if interested.

Thank you for your support.

### **6.3. Appendix C – Interview Schedule**

#### **Interview Schedule**

##### ***Opening Statement***

As you are aware, I'm interested in your experiences as a clinical psychologist and I am particularly interested in your experiences of providing services to young people from ethnic minority communities.

*(Clarify understanding of 'ethnic minority' terminology)*

Do you have any questions about the project before we start?

##### ***Context Questions***

It would be useful to hear a little about yourself, how long have you been in the service? How do you identify in terms of ethnicity and other identities you may feel to be relevant? Can you tell me a bit about your service context and the role of clinical psychologists within this team? What is the process for accessing psychology?

Can you briefly describe the demographics of the young people in the service? What groups are over- or under-represented in the service compared to the local population? Do these demographics differ for young people accessing psychology?

Does the service and/or psychology team have any initiatives or resources to support access for BME young people?

##### ***Main Questions***

How do you assess young people for psychology? What psychological theories or ideas do you draw from? Do you have a preferred way of formulating the problems/difficulties reported by young people?

Are there aspects of the assessment process that might present barriers for BME young people? When assessing a BME young person, do you adapt your assessment in any way? Do you place a greater or lesser focus on a particular area of the assessment?

Why do you think there is an over- or under-representation of BME young people in the psychology service? Are there any barriers to accessing

psychology that you think particularly affect BME young people? If there isn't a difference in representation, what do you think accounts for this? What has the service done to achieve this?

How do you think psychology services could improve access for BME young people? Do you think there are ways of assessment, formulation and theory that might better meet these ends?

Have you ever discussed any of these difficulties with other clinical psychologists in the service? Do these issues come up in clinical supervision? Are these issues spoken about in your team?



#### 6.4. Appendix D – Consent Form



### **Barriers encountered by young people from Black and Minority Ethnic communities accessing psychological services: Clinical psychologists' perspectives**

**Principal Investigator:** Jack McKellar

University of East London

School of Psychology

**Email:** [u1622888@uel.ac.uk](mailto:u1622888@uel.ac.uk)

Stratford Campus

Water Lane

London, E15 4LZ

### **Consent Form**

Please tick the box to indicate your understanding and agreement to each statement. Only by ticking all of the boxes will this be taken as consent to participant in the research study.

1. I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

• Please tick box ☐

2. I understand that my involvement in this study, and particular data from this research, will remain anonymous. Only the researcher involved in the study will have access to identifying data.

• Please tick box ☐

3. I hereby freely and fully consent to participate in the study which has been fully explained to me.

• Please tick box ☐

4. Having given this consent, I understand that I have the right to withdraw from the study at any time up to the point of write-up, without disadvantage to myself and without being obliged to give any reason.

• Please tick box ☐

## 6.5. Appendix E – Ethics Approval Form

### School of Psychology Research Ethics Committee

#### NOTICE OF ETHICS REVIEW DECISION

##### For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

**REVIEWER:** Tim Lomas

**SUPERVISOR:** Angela Byrne & Matthew Jones Chesters

**STUDENT:** Jack McKellar

**Course:** Professional Doctorate in Clinical Psychology

**Title of proposed study:** TBC

#### DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before

any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

**DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY**

*(Please indicate the decision according to one of the 3 options above)*

Minor

**Minor amendments required *(for reviewer)*:**

On the documents for participants put Tim Lomas instead of Mary Spiller as chair of SREC

**Major amendments required *(for reviewer)*:**

**Confirmation of making the above minor amendments *(for students)*:**

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (*Typed name to act as signature*): Jack McKellar

Student number: 1622888

Date: 22/11/2018

*(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

**ASSESSMENT OF RISK TO RESEACHER** (*for reviewer*)

Has an adequate risk assessment been offered in the application form?

YES

**Please request resubmission with an adequate risk assessment**

If the proposed research could expose the ~~researcher~~ to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

/

HIGH

**Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.**

/

**MEDIUM** (Please approve but with appropriate recommendations)

/

LOW

**Reviewer comments in relation to researcher risk (if any).**

**Reviewer** (*Typed name to act as signature*): Tim Lomas

**Date:** 21.11.18

*This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee*

**RESEARCHER PLEASE NOTE:**

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

## 6.6. Appendix F – Debrief Sheet



### **Barriers encountered by young people from Black and Minority Ethnic communities accessing psychological services: Clinical psychologists' perspectives**

**Principal Investigator:** Jack McKellar

University of East London

School of Psychology

**Email:** [u1622888@uel.ac.uk](mailto:u1622888@uel.ac.uk)

Stratford Campus

Water Lane

London, E15 4LZ

### **Debrief Sheet**

This page is aimed at providing you with the information you need after the study and relevant contacts should you wish to withdraw your data.

#### **Confidentiality of Data**

During the interview your responses will be audio-recorded on a Dictaphone. This audio recording will be transferred to an encrypted, password-protected laptop where it will be transcribed and anonymised, so that any unnecessary identifiable information is removed. Some information, such as your ethnicity, will not be anonymised as these will be relevant to the research study. The transcript will then be analysed by the principal investigator. No other researchers will have access to the unedited transcript and your information will only be presented in anonymised form to other researchers.

Due to the nature of qualitative research, full confidentiality cannot be assured, and the participant will agree to having excerpts of their anonymised transcript published. If, during the interview process, you talk about you or others being at risk of harm, this information will need to be disclosed in an appropriate manner. If you have any questions about this, please ask the lead investigator.

### **Disclaimer**

Your data will be kept anonymously for 2 years after the interview for potential use in future publications, after which it will be destroyed. You are free to withdraw at any time during the study. If you choose to withdraw your data, simply contact the researcher on the details provided within 3 weeks of the interview. Should you choose to withdraw you may do so without disadvantage to yourself and without any obligation to give a reason.

### **Contact Details**

If you have any questions or concerns about how the study has been conducted, please contact my supervisor:

If you have any questions or concerns about how the study has been conducted, please contact my supervisor:

Dr Angela Byrne, Psychology Department, 1st Floor, Burdett House, Mile End Hospital, Bancroft Road, London E1 4DG

(Tel: 020 8223 8076. Email: [angela.byrne7@nhs.net](mailto:angela.byrne7@nhs.net))

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Chair of the School of Psychology Research Ethics Sub-committee: Dr. Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4465. Email: [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk))



## 6.7. Appendix G – Example of Coded Transcript

[P2]: No no I've come, early on I've come to basically try to I mean to formulate what is in the line, what led up to this person diagnosed or labelled with conduct disorder, basically where I put way more emphasis now is to understand where that came from and almost have to admit almost in a very sceptical manner, for almost everyone, the White boy who almost never is, to the White girl who actually never happens with these girls. And try to understand when that was picked up and try to understand what was going on and to really focus on, instead of the label the formulation, it's just a little bit more taking, you know, I have resorted to doing an extended assessment and doing more than one session now and you know that has implications for the work and time and feeling quite tired yes, but it's for my understanding a bit more and there was an experience working and discussing in an MDT that really opened my eyes to it, and it was my MDT is quite mixed in terms of the clinicians as well, and it was actually quite powerful experiences when somebody, a psychiatrist who her herself is Bangladeshi was bringing up this case um and in a very more typical way okay, this kid was taken by police, talking about a 13 year old, this boy was you know have had stolen, had done this and done that, you know this looking like a conduct disorder kind of thing and you know we were like it was a bit uncomfortable, you know she was saying things about this client that seemed pretty minor you know like, he has stolen £2 I remember, and you know it was this, and everything seemed like, and you know it, nobody was actually saying anything and I remember as was the one, I felt a little bit bold that day and I said well by any chance is the kid Black, you know, and she said why, and other Black, Black members of staff started speaking and they actually wanted to say something but as a Black person you know I'm sure they were feeling quite uncomfortable bringing that up you know because of what people would think, and I guess it's a matter of I could imagine they were going through a process of thinking I don't want everyone to think I'm milking everything about being Black, but in reality what led up to the discussion is that perhaps that boy before predicted things to him and assigning some thing that you know might be overlooked in treatment, and for many of us that day was actually quite you know eye opening experience it what, some of this what we're doing here might be a bit sketchy we really need to be a bit more careful about yeah.

I: can you tell me a bit about that, you talked about being bold that day, what helped you be bold and are there other situations where you feel less bold?

[P2]: I think that I think that day I was just feeling a bit more I can also fall into that thing of not inhibiting myself for fear of what other people might say, and it's weird because of course this is very clearly psychologists can understand this you know but the idea of what others might think is pretty minor compared to whereas in reality you might say it right, but I did not say anything controversial that day, but again a White person might be in a very different position to say things like that you know because because some of the comfort that probably comes from being a White group you know and also because that person doesn't have the fear that he's saying something because it's personal and I guess it's like that and that day I was feeling a little bit more like I don't care what they think, which is sometimes, I wish it was more of the time, but oftentimes we inhibit ourselves because we're thinking that, it's basically that that we're making it personal, that's really it, in a profession like this you don't want to seem that way you want to seem very objective and cold and you have a very good boundary and therapeutic stance you know, you understand.

I: So could you say a bit more about that, that kind of professional identity there of boundaried, objective, coldness, um, and I'm wondering about your own personal identities there in terms of might that have informed that boldness? Is that in contrast with that objectivity?

[P2]: I mean, I mean that the whole idea of being you know detached and I and boundaried you know I guess my experience in training is that we really need it to be like that, you see, I've been doing this long enough to know that times are changing I'm in a different country

Commented [IC1]: Diagnostic discrimination, White people not being diagnosed and alternative pathways for BME YP

Commented [IC2]: Going beyond diagnosis

Commented [IC3]: Time pressure

Commented [IC4]: Self-directed, personal passion, stepping outside of service expectations

Commented [IC5]: Diagnosis as racialised

Commented [IC6]: Personal effort and passion

Commented [IC7]: Tension of speaking to these issues

Commented [IC8]: White fragility

Commented [IC9]: Psychology as complicit in discrimination

Commented [IC10]: Tension of talking to these issues

Commented [IC11]: White blindness, White fragility

Commented [IC12]: Identity as a resource

Commented [IC13]: Psychology knowledge, objective and cannot bring personal

and I can see how psychologists are bringing quite different things especially you know places like UEL or people are coming up with different ideas about how to do stuff but I guess in many ways not so much. I again, this thing which make the distinction that as a person I can be quite open, this is my culture we are very open expressive people, whereas when a psychologist or a clinician tends to be a little more reserved and there have been tensions around that at times because you know, it's quite a distinction right, it's got different stances you know, but what you then I guess it's a matter of learning to experience that and these whole ideas are just ideas right and something like boundary work that's actually very very flexible and you know there's not a clear differentiation of what that is and it depends on the you know the idea that distance it depends on the context and how you're feeling on the day or what the client needs so there's also all those things you know and I guess I'm in a situation like that I'm bold, what we talked about before, I guess I think I just came out from from something really really seemed very very off, that perhaps it was not possible to not say something, you see, I guess that's it.

Commented [IC14]: Psychology as objective, boundaried and detached

Commented [IC15]: Identity as a resource

Commented [IC16]: Psychology knowledge as objectivism

Commented [IC17]: Personal passion

I: I'm just going to quickly check the time because there's not a clock here, okay, so all right then I want to now think then about how do you think then your service context, how do you think then they can improve access for BME young people, you've mentioned the representation of it, are there other things you think might help, or are there other kind of obstacles you might think could be changed?

[P2]: Are you talking about the services in general or psychology in particular?

I: I'm talking about psychology in particular.

[P2]: Okay, yeah, it's I think, because in terms of accessing services, it's just not an area I have researched so I'm not, I think from what I see of people coming in it's pretty diverse, but I do think there's probably a very big problem that most psychologists have not been from BME groups and and I, and the future of that alone I think it would be good that that diversity is more represented in psychology but everybody knows that now I mean it's pretty much something that everybody talks about here as well you know it's a thing about psychologists and trainees, oh trainees they're all White you know so.

Commented [IC18]: Diversity of the profession

Commented [IC19]: Diversity as a solution

Commented [IC20]: Psychology as White

I: So people talk about that do they? Here? Do they? And you're saying that it's quite that they, is it taken for granted now that that is something that would be helped if it was changed?

[P2]: I don't think so.

I: You don't think so still?

[P2]: No, no, I think it would help, I don't think it is talked about, I don't think, I mean I think it's more that people come and it's a matter of fact that it's the way it is, you know, that's what I think you know, so I don't think, kind of, I mean, activities or initiatives in terms of promoting the service for more people from those groups to come, I'm not sure, I mean that's that's really not I I haven't thought about that too much, you know, but in terms of psychology being more representative of the actual community we're working with, how do you go about that? It's very complicated, you know. I mean because psychologists are extremely competitive in this country and the whole process by which people end up in clinical training is quite long and arduous and you could imagine that there has to be some disproportion somewhere you know and then, not so much because diversity is one thing but it's social class, social class social standing, so it's really the interplay of things right, it's a big question, I wish I had the answer.

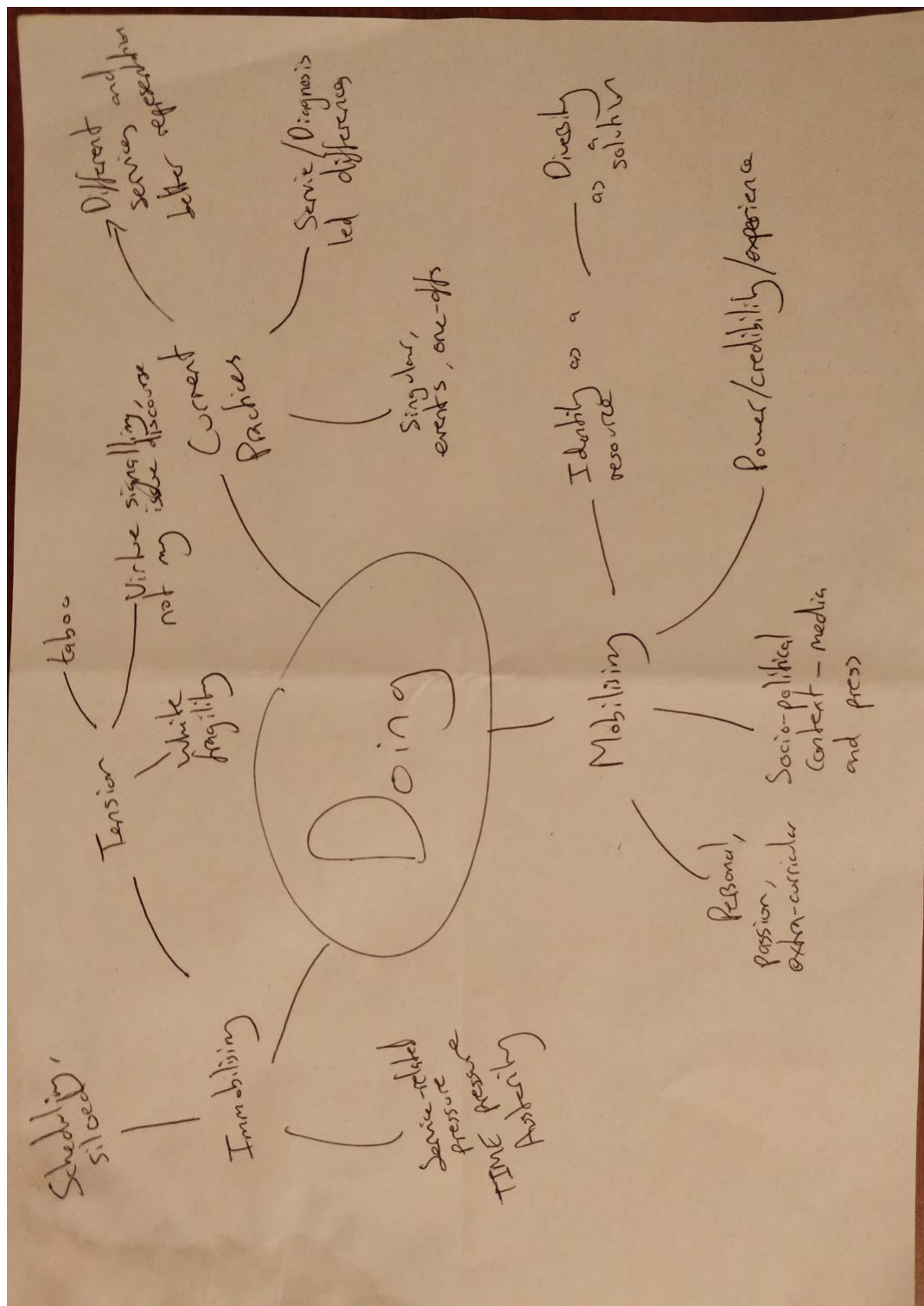
Commented [IC21]: Tension talking about these issues

Commented [IC22]: Unchangeable, matter of fact

Commented [IC23]: No initiatives to recruit diverse staff team

Commented [IC24]: Complexity of the issue

## 6.8. Appendix H – Example of Initial Thematic Mapping of Codes



## 6.9. Appendix I – Example of Mapping the Developing Subthemes

