Exploring the Challenges of Commissioning Mental Health Services for Black Men

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ABSTRACT

This research explored the challenges for commissioning services for Black men in Mental Health Services in the UK National Health Service (NHS). More specifically, the focus was on how commissioners conceptualised the structural and social issues in developing services for Black men with the aim of understanding how these issues might translate into service development. The context of commissioning was the focus of the study due to the influence this has on service provision and consequently on supporting the mental health of Black men.

The study involved individual in-depth interviews with eight commissioners who had a role in commissioning adult NHS Mental Health Services. Interviews were analysed using thematic analysis drawing on an Intersectionality framework within a critical realist epistemology. Three main themes were identified, 'Challenges to Commissioning Mental Health Services', 'Reframing Mental Health Services' and 'Black Men and Power Dynamics'. Key findings from the analysis highlighted various intersecting locations such as maleness, 'race', and social context in understanding factors that contribute to the mental health of Black men. These issues were drawn upon to discuss the constrains of service provisions available and explain why Black men were excluded from commissioning processes, leaving them with little power to influence decisions regarding mental health provisions.

Based on the analysis, the limitations of current mental health provisions and processes involved in commissioning are discussed and considered in relation to supporting Black men's mental health. This research indicates that more inclusion and support is required to empower Black men to be involved in commissioning processes in order to address some of the structural and social issues relevant to addressing mental health needs. The implications and suggestions are discussed in relation to considering ways that Clinical Psychologists in particular can facilitate this.

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1.INTRODUCTION

1.1. Overview

Evidence consistently shows that Black men experience a range of inequalities within mental health services (MHS) in addition to discrimination and social disadvantage (Cooper, Morgan, Byrne and Dazzan, 2003; Glover & Evison, 2009; Tarbuk, Topping-Morris and Burnard, 1999). These inequalities and experiences will be outlined and explored within this chapter. Current MHS and provisions are dominated by the medicalisation of distress, although they are questionable in their applicability to supporting Black men's needs and addressing the historical oppression that forms their day to day lives. This will be explored within the chapter to situate the reader to understand some of the literature surrounding this.

Current uncertainty in the UK's social and political situation exacerbates these inequalities through the National Health Service (NHS) and other public services being under increasing pressures with austerity measures and disenfranchisement (Pollock, 2017). Black men are amongst those who are hardest hit by austerity cuts, through marginalisation of policy to address this issue (Salwaymn et al., 2016) and a lack of specifically targeted initiatives despite numerous attempts to highlight their significant overrepresentation in MHS (Cabinet Office, 2018; Department of Health [DOH], 2005).

As a trainee Clinical Psychologist, I continue to feel disconcerted and disappointed that Black men are failed by systems which should protect their well-being. My interest and intentions in conducting this research are drawn from a combination of personal and professional factors which will be discussed within this chapter. I believe as Clinical Psychologists we can utilise our professional position in being committed to promoting social

justice to ensure that provisions of mental health are accessible, adequate and appropriate to all clients (Patel et al., 2000).

In considering the wider context of where some of these highlighted issues sit I will briefly outline the structure of the NHS and provide an overview and rationale for attempting to explore factors which contribute to the inequalities for Black men in MHS with a focus on commissioning. It is hoped that this will orientate the reader to the topic and provide further understanding that contribute to the rational that has informed the research aims.

1.2. Terminology

It is important to define and distinguish between the terms ‘race’, culture and ethnicity as they are often used interchangeably. Despite there being some similarities between them they have distinctions between them, (Odusanya, 2016) and it is imperative to understand these constructs and their relevance to this research project.

1.2.1. Race

‘Race’ is a term that is used to categorise people into imagined communities which has real and material effects (Anderson, 1991, p.6). Socio-political constructions have classed the categorisation of phenotypical characteristics such as skin colour, hair texture and oneself or one’s ancestor’s physical characteristics to mutually exclusive, biologically distinct demographic categories (Helms, Jernigan and Mascher, 2005). However, the concept has been questioned as it’s a term that involves power, domination and subjugation as opposed to biological difference (Patel et al., 2000). Quotation marks are used to demonstrate the contention of this term and indicate my position that ‘race’ is a social construct, this will be discussed further in my introduction.

1.2.2. Ethnicity

'Ethnicity', is considered contextual and associated to a group identity and a sense of belonging to a particular ethnic group (Fernando, 1991). There are suggestions that ethnicity unlike 'race' involves a degree of choice as it is changeable (Fernando, 1991; Jenkins, 1986). Despite everyone possessing ethnicity it is often used in relation to 'minority' groups (for example, the liberal use of African-Caribbean and an absence of say Celtic), where their ethnicity is seen as problematic (Fernando, Ndegwa and Wilson, 1988; Sashidharan, 1986).

1.2.3. Culture

'Culture' is used to describe a set of norms, which includes language, expectations and values shared by a community (Triandis, 1996). It is important to understand culture as evolving, linking past to the present and that it is shaped by our socio-political histories and contexts. Similar to ethnicity it is often assumed by the white majority people that culture only exists in relation to 'the other', whereas culture is both created by and creates individuals (Patel et al., 2000).

Despite the significant differences, 'race', culture and ethnicity are used interchangeably in literature, including the term 'Black and Minority Ethnic Groups' (BME) to refer to people from a range of cultural and ethnic backgrounds. This is problematic as "the homogenisation of people from BME backgrounds can create fertile ground for racism to flourish" (Patel & Fatimilehin, 1999, p.59). Although I use these terms when referring to an author's work, I recognise that it can be a problematic term engendering discrimination and subordination (Feagin, 1984).

1.2.3.1. Black

For the reasons outlined above 'Black' is a contested term with multiple meanings (Paulraj, 2016, p.2). In dominant discourse, it is often conflated with other value-laden, non-neutral, political terms such as 'race' and 'ethnicity'. I choose to use the term Black in reference to people of African

and or Caribbean heritage in recognition that inequalities exist for them in the MHS (Keating, Robertson, McCulloch and Francis, 2002). This is not to denote that constructions of 'race', ethnicity and culture in our social and political system do not exist and are problematic but in attempting to highlight some of the causes of this and utilise it to provide a context for this in the research. Before moving on to present the inequalities to which I refer it is important to recognise the historical context in which Black people reside in the UK.

1.3. Historical Context

Black people have been present in Britain dating back to Roman times (Patel & Fatimilehin, 1999). By the start of the 17th century an African community was established in Britain as a result of the slave trade (Martin, 2011) however, it was not until post-second world war in the 1950s and 1960s that most of the current population of Black people arrived invited by the British government to help re-build the 'mother country' (Patel & Fatimilehin, 1999, p, 51). The colonisation of overseas territories saw the emergence of racist ideas about non-white people who were construed as racially and culturally inferior to white people. This was contrary to the prospects of a better quality of life (presented to Black people) and these ideas continue to be part of the non-white experience in the UK. This is evident in the literature of individual and institutional racism that people from minority ethnic groups experience within several areas such employment, education and racial harassment (Graham & Robinson, 2004; Mistry & Latoo, 2009; Wallace, Nazroo and Bécares., 2016). Experiences of migration and the discrimination faced by immigrants "due to their visible differences are considered to be key in defining, shaping, and limiting one's experiences, opportunities and well-being" (Davidson & Patel, 2004; p.75). In order to provide an understanding of the experiences of Black people in Britain it is important to briefly look at the concept of racism and its impact.

1.3.1. Racism

Racism is a form of discrimination using racial categories and domination which is used by a system to oppress, assigning one group as inferior and another as superior (Bulhan, 1985) and is illegal under the Equality Act (2010). Racism exists, despite a widely-accepted argument that no biological basis exists for differentiating races (Banto, 1967), rather it is a sociopolitical construct. Racism as a set of ideologies and practices is deep rooted in society's unequal power structure and perpetuated by individual and structural practices. Racist ideology was identified in the 18th and 19th century (although it existed before this time) as an outcome of the British trade in the African continent and Indian subcontinent. The British empire was seen as an employer and had to be constructed as 'superior' in relation to the 'other' with African and Asian people being portrayed as savaged in need of 'civilisation'. The term 'Black' emerged as a broad political concept to unite those who faced racism because of the color of their skin as a way of binding those who experienced injustices, racial abuse, and discrimination. This was an attempt to recognise the power, building Black people's own value systems and see themselves as self-defining rather than being defined by others. Political Blackness has been espoused by a number of writers within psychology (e.g. Adetimole, Afuape and Vara, 2005; McKenzie-Mavinga, 2005; Patel et al., 2000).

With the position of power and privilege, racism operates on an individual as well as structural/organisational level (Patel, Bennett, Dennis, Dosanjh, Mahtani, Miller et al., 2000). Individual forms of racism may consist of internalised and interpersonal racism whereas systemic racism includes the less visible forms of institutional and structural racism. Acts of overt racism have abated over the years; however, covert racism in the form of institutional customs and practices disfavoring Black people are still at play. This is supported by evidence that has found distinct ethnic differences in situations that affect Black people in the UK; these systems include the psychiatric system, the policing system and the education system (Berman & Dar, 2013; Department of Education [DOE], 2012; Fearon et al., 2006). This may create and sustain a social status and restrict employment

opportunities and further reinforce the socio-economic inequalities. Keating et al., (2002) discuss the inappropriateness of services that are provided to Black people with regards to how this operates within MHS, several authors have suggested that psychiatric assessment and diagnosis is undermined by negative cultural and ethnic stereotypes which carry power and can perpetuate institutional racism (Fearon et al., 2006; Fernando, 2017; Littlewood & Leipzig, 1982;). Institutional racism in the NHS has been described in the way in which specific models, treatments and care pathways disadvantage people from BME groups (McKenzie & Bhui, 2007). This is because the eurocentricity of mainstream models of mental health service delivery that are centered on bio-medical understanding of needs can be an obstacle to effectively addressing psychosocial needs within this population. Diagnosis in MHS can pathologise behavior which falls outside of Eurocentric norms and result in Black people being constructed as 'mentally ill' leading to them being positioned as the 'other' in whom difference is located (Kitzinger & Wilkinson, 1996) and consequentially being perceived as inferior (Patel et al., 2000). The impact of this can be far reaching, and it is helpful to consider how racism impacts individuals with Black heritage.

1.3.2.Impact of Racism

Racism in the form of discrimination can potentially result in harmful psychological consequences like feelings of powerlessness, rejection, loss, low self-esteem and depression (Gray, 1999). The intersectionality of being from a Black heritage and with mental health problems makes experiencing stigma and discrimination more likely. The values and beliefs of the oppressor can be internalised often referred to as internalised racism (Alleyne, 2004), and can cause people of the same community to view each other as distrustful.

A vast amount of research has found links between experiences (or perceived experiences) of racism, discrimination and poor mental health (Karlsen & Nazroo, 2002; Keating, et al., 2002). Williams et al., (2003)

reviewed studies exploring the impact of racial/ethnic discrimination on health status, and found experiences of racism and racist behaviours were associated with multiple indicators of poorer physical and mental health. Studies have also considered the link between experiences of prolonged day to day experiences of racism and stress responses (Walters, 2003). This extends to the exposure to chronic and daily stressors such as poverty and racial discrimination and differences in health between races over time (Geronimus et al., 2006; Shonkoff et al., 2009). At a societal level, racism within healthcare settings could affect the physical and mental health status through the way services are organised. There is evidence showing how the distress arising from experiences of racism can bring people into contact with MHS (Sanders-Thompson, 2002). However, MHS provision for Black people are insufficient due to the inequalities that exist, which will be discussed in the next section.

1.4. Black People and MHS

Research evidence illustrates that BME communities have notably poorer mental health outcomes from accessing MHS as well as experiences of MHS (Morgan et al., 2006; Sashidharan, 2003). Amongst BME groups Black service users are more likely to be the subject of over-diagnosis of schizophrenia and under-diagnosis of less severe 'illnesses' such as depression (Cochrane & Bal.,1989; Harrison et al., 1989). They are more likely to have more complex pathways (e.g. delayed referrals, access via the criminal justice system) than their white counterparts (Jones & Berry, 1986). They are more likely to receive higher doses of anti-psychotic medication (Lloyd & Moodley, 1992) and more likely to be compulsorily detained and or locked in a ward while in receipt of mental health care (Ferns, 2005; Ineichen, Harrison and Morgan, 1984; McGovern & Cope, 1987). Black people are also less likely to receive or be offered psychological or psychotherapeutic interventions (Ferns, 2005; Little & Leipzig, 1993). Conceptualisations of mental health and views that are held

in relation to Black people lend themselves to preventing engagement in a helpful way. For example, African Caribbean people are less likely to be referred for psychological therapies as they have historically been viewed as “non-psychologically minded” (Bennett & Dennis, 2000, p. 95). Furthermore, once access to services are provided views such as people from BME backgrounds being “culturally backwards, psychologically illiterate, lacking in insight and emotionally unsophisticated” (Wood & Patel, 2017, p.5) further marginalising Black people within MHS.

1.4.1. Black Men and MHS

The picture for Black men in regards to mental health care appears the bleakest and research has highlighted huge disparities in their representation in MHS. The evidence suggests that Black men are more likely to be diagnosed with schizophrenia (Fearon et al., 2006), more likely to be admitted to secure MHS (Jones & Berry, 1986) and Black Caribbean men specifically are more likely to experience coercive care in the form of sectioning (Bebbington et al., 1994; Health Development Agency, 2001). Coercive care in the form of sectioning relates to the use of force or threats in the MHS system through the use of the Mental Health Act (1983) which gives professionals the right to forcibly detain and treat an individual without their agreement under the justification of safety. A number of recent deaths of Black men accessing services within statutory institutions (Mind, 2011; Hemmings, 2012) highlights the detrimental effects of such inequalities and indeed presents another inequality. It also raises questions concerning the use of sectioning, which is subjective in its nature and risks human rights violations under the Equality Act (2010). Such experiences disproportionately affect young Black men (De Maynard, 2007).

The area of access to mental health support is also of concern for Black men for a number of reasons. Firstly, they are less likely to be offered psychological therapy (Grey, Sewell, Shapiro & Ashraf, 2013). Second, due to the intersecting locations of being Black and male (Crenshaw, 2012) Black men are doubly disadvantaged resulting in them being less likely to

seek professional help for psychological distress (Neighbors & Howard, 1987). This can be understood by considering the ways in which exclusion and discrimination can impact on multiple levels; Myrie and Gannon (2013) found constructions of hyper masculinity are intertwined with discourses of oppression and discrimination that can impact on help-seeking. Their study highlighted how Black men are likely to adopt a persona of being in control as a mechanism to protect against societal stressors and negative perceptions that they face in day to day life. Although this demonstrates how constructs of masculinity are intertwined with exclusion and discrimination, it is important to note that Black men are not a homogeneous group and exercising caution against generalisations is important in providing appropriate and meaningful sources of support within services (Cole, 2009).

Taking the aforementioned points into consideration, it is not surprising that Black men report negative experiences of the MHS and express discontent with services (Sandamas & Hogman, 2000). Consequently, this exacerbates the existing reluctance to seek professional help compared to their white counterparts (Ayalon & Young, 2005). Moreover, there is a suggestion that a barrier to accessing help is fueled by an expectation of racial mistreatment (McLean et al., 2003). Keating et al., (2002) have documented ‘circles of fear’ between Black communities and MHS to illustrate the spiral that can form as a result of services not offering the appropriate care in the form of specific support and care pathways. The institutions are seen as dangerous and untrustworthy by the Black community and the mental health staff view the Black communities as dangerous. Racial stereotyping and discrimination by healthcare staff (Bhui, 2003; Commission for Health Improvement, 2003; DoH, 2003; Nadirshaw, 1993) can also be heightened through problematic societal discourse such as those communicated through media coverage in terms of the so-called knife crime epidemic and how it disproportionately effects young Black men in England (Alexander, 2008; Gunter, 2017). This in itself is a racist rhetoric which associates knife crime as located amongst Black

men. This can result in Black men being reduced to stereotypes, positioning them as ‘trouble makers’ or in the limelight of conflict, drama, controversy, violence and deviance (Halloran, 1974; Hartmann & Husband 1974; Troyna, 1981). This spiral can lead to a reluctance to seek help and in turn increases the risk of coercive treatment and contact when it is ‘too late’ resulting in more coercive treatment leading to a further reluctance to engage with MHS (Keating et al, 2002). This is problematic as MHS utilise western modes of psychiatry in the form of ‘treatment’ (Grey, Swell, Shapiro & Ashraf, 2013) and can be attributed as a causal factor for the inequalities in MHS. The focus on individual psychopathology with little or no attention to the socio-economic factors renders psychiatry and MHS racist institutions (Fernando, 1991). The practices employed in MHS can fail to attend to the socio-economic contexts of Black people through the focus on individual psychopathology (Williams, Turpin & Hardy, 2006) perpetuating fears around accessing MHS which is fueled by diagnosis and has been argued to be a mechanism of social control which can result in disempowerment (Fernando, 2017).

1.4.2. Attempts to Address Institutional Racism

The Stephen Lawrence inquiry (The Stationary Office, 1999) and the MacPherson Report (1999) highlighted the existence of institutional racism in the police force defining it as:

"The collective failure of an organisation to provide an appropriate and professional service to people because of their color, culture, or ethnic origin. This can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantages people in ethnic minority groups" (Macpherson, 1999, p.49).

Institutional racism was also highlighted in the NHS following the enquiry into the death of David (Rocky) Bennett in 2003, with an emphasis on examining its structures and services to eradicate racism (Blofeld, 2003).

Collectively, these reports have framed the changing story of race relations in the UK and led to different national policies like Inside Outside (DoH, 2003) and Delivering Race Equality [DRE] (DoH, 2005) being developed. These attempted to specifically address the issues of race and ethnicity in the NHS. Nevertheless, since these reports little has emerged at an institutional level to address change for Black men. Evaluations of DRE highlighted political obstacles that prevented meaningful change and failure of a coordinated systemic response was suggested to contribute (Fitzpatrick et al., 2014, p. 12). In spite of these attempts the Count me in Census (CQC,2010) showed an overrepresentation of young Black men in MHS and a disproportionate percentage in inpatient admissions were from BME communities. The only substantive acknowledgement of disparities for BME groups was highlighted in the "No health without mental health" policy, a "cross-government and all age strategy" for all mental health services (Fitzpatrick, et al., 2014). The Equality Act (2010) marked the beginning of issues of race becoming subsumed under a national Equality and Diversity remit. The Race Disparity Audit (Cabinet Office, 2018) reflected this and highlighted that inequalities for Black men in the MHS remain an area of concern. As well as higher rates of coercive care they also pointed to several wider inequalities that Black people experience, demonstrating how the intersectionality of oppressive practices can result in exclusion and discrimination on multiple levels. The conceptual framework of intersectionality considers how overlapping categories of identity (such as class, race, gender and health status) can impact on an individual and the oppression they might experience (Crenshaw, 2012). I will now turn to explore these inequalities.

1.4.3. Black Men's Social Context

People from BME backgrounds are disproportionately affected by social inequalities; (e.g., income, housing, education, social isolation, social disadvantage) (Mangalore & Knapp, 2012; Morgan, et al., 2008) increasing the likelihood of psychological distress (Bhugra & Kamaldeep, 2001). African Caribbean communities are noted to have a larger proportion of

families living below or just above poverty compared to other ethnic groups (Barnard & Turner, 2011), with Black African and/or Black Caribbean people being more likely to be in persistent poverty (Cabinet Office, 2018). Difficulties securing employment can restrict young Black men's ability to escape from poverty often prolonging intergenerational economic struggles. African and Caribbean men are 10-20% more likely to be unemployed (Berthoud, 1999) and three times more likely to be excluded from school (Barnard & Turner, 2011) compared to their White counterparts. In England, 14% of all homeless households were identified as Black (Cabinet Office, 2018). In England, Black people are more likely to experience extreme levels of disadvantage amongst all levels of community disadvantage and are more at risk of being involved in violent crime (Laurence, 2015). Trauma is discussed as an experience that can disproportionately affect people from BME backgrounds (Allen, 1996; Briere, 2004), but absent from most conceptual and research analyses of trauma is the experience of historical disadvantage and discrimination resulting from causal or aggravating factors in the development of psychological distress or poorer quality of life (Helms, Nicolas and Green, 2010; Wallace, Nazroo and Bécares, 2016). Such experiences can cause real threats to personhood, sense of self and well-being (Bryant-Davis & Ocampo, 2005). Overall life satisfaction of Black people has been reported as lowest within BME groups including low ratings for overall happiness (Cabinet Office, 2018). Whilst this research demonstrates social disadvantage experienced within a range of people from Black and BME communities' experiences of social disadvantage are considered to be key in defining, shaping and limiting "one's experience's, opportunities and well-being" (Davidson and Patel, 2004, p.75) and are applicable to understanding the systems in which Black men are situated. The multidimensional nature of disadvantage that Black men have experienced which is rooted in discrimination and arguably can lead to contact with MHS can be seen to be further compounded by wider social inequalities and social exclusion (Bhui, Nazroo, Francis, Halvorsrud and Rhodes, 2018). Moreover, the most recent audit by the government highlighted that

little has been done to address the inequalities for Black men in the MHS. Their audit revealed that Black people were more likely to have been sectioned under the Mental Health Act (1983), with Black men more likely to have been given a diagnosis of psychosis compared to their white counterparts along with worse outcomes in psychological therapy (Cabinet Office, 2018). The audit set out a mission to “tackle the burning injustices” (Cabinet Office, 2018, p.5) and demonstrated that the inequalities for Black men is an area of continual concern that needs to be addressed.

Black men’s social context is discussed to provide the environments they might find themselves in as an oppressed group. Social dominance theory (Sidanius & Pratto, 1999) can be applied to understand how the inequalities for Black men in the NHS can be maintained through dominant models of distress and service structure. The conceptualisations of ‘mental health’ fail to address and reflect Black men’s socio-political contexts and can thus maintain dominant hierarchies in society which serve to favor Western conceptualisation of well-being (Mills and Fernando, 2014). With strong correlations between disproportionate overrepresentation of Black men in MHS (Bebbington et al., 1994; Fearon et al., 2006) and high rates of social inequality (Bhui, Nazroo, Francis, Halvorsrud & Rhodes, 2018) Black men can be in a complex position of disempowerment once they enter MHS.

Given that the NHS is set up under the principle that it provides a comprehensive service to all (NHS England, 2015) with the intention of health restoration (Patel & Fatimilehin, 1999), this calls into question the lack of progression in addressing institutional practices which can maintain the status quo within MHS (Fatimilehin, 1989; Howitt & Owusu-Bempah, 1994; Husband, 1992; Morgan, 1998; Nadirshaw, 1992). The Western model of psychiatry has been implicated for the maintenance of the institutional practices prompting an exploration of its cultural relativeness in aptly meeting relevant ethnic, cultural, spiritual and religious needs (Williams, Turpin & Hardy, 2006).

1.5. Western Model of Psychiatry

Most Western models of care stem from the idea of mind-body separation or dualism, introduced by the French Philosopher Rene Decartes. This idea represents a metaphysical stance that mind and body are two distinct entities, each with a different essential nature (Mehta, 2011). This dualistic stance which formed the basis of the biomedical model of health with a diagnostic focus on psychological distress, fails to consider context and emphasises individualism and universality. Mills and Fernando (2014) also argue that this method of thinking has been institutionalised and transported to non-Western countries, ignoring the different ways of conceptualising psychological distress that exist in populations with different cultural traditions. For instance, in non-western cultures, the mind and body are considered inseparable (Sue & Sue, 2003) and the understanding of the 'mind' in 'Asian' and 'African' psychologies are very different in fundamental ways to those in Western psychology and psychiatry. Since the discipline of psychiatry has developed in the context of the Western world drawing on few or no other cultural traditions it questions the validity of the framework employed within MHS (Fernando, 2017). MHS fail to take the cultural aspects of mental health into account and services are organised around a reductionist approach where mental health difficulties are constructed as illness. An example of this comes from the label of 'depression' reflecting culture-specific connotations that echo the history of emotions in Western countries (Kitayama & Marcus, 1994; Shweder & Haidt, 2000). Services are shaped through psychiatric diagnosis, which relies upon the expression of emotional distress through the product of white European culture (Sashidharan, 1990) and fails to address the different context and history of Black people. Renaming people's emotional distress using Eurocentric psychiatric tools and criteria (Rogers & Pilgrim, 2001) which are lacking in scientific and objective measures, is problematic and questions psychiatry's role and function within society as a larger social control apparatus that has influence over

the lives and experiences of Black people (Francis, 1989). Diagnosis can therefore serve as a mechanism of locating the 'problems' in people (Boyle, 2006) and overlook the concerns for Black men which are interpreted within their social context, family environment, acculturation process and influence of stressful life events (Watkins, Walker & Griffith., 2010).To conclude, research has evidenced that inequalities in wider society negatively impact Black men, yet service developments on addressing this are limited which questions the evidence based rhetoric embedded in mainstream MHS (Williams & Garner, 2002). The hegemony of biomedicine fails to acknowledge the interpersonal, cultural and real disadvantages that Black men experience. Moreover, the imposition of the application of inherit bias models questions the validity of MHS and has been described as 'secondary colonisation' (Patel & Fatimehin, 1999, p.65).

As such, rather than viewing Black men in this way, it has been suggested that MHS should adopt a holistic approach to supporting the "whole of the person and their contexts in order for their issues to be taken into account and seen as legitimate areas of inquiry and action" (Patel & Fatimilehin, 1999, p.67). The literature also paints a thin picture of Black men which is deficit focused based on "predetermined deficiencies" (e.g. Darwin, 1959; Jensen, 1969) overriding the rich stories of strength and resources that Black men might hold (Khan et al., 2016).

1.6. Alternative Approaches

A need to take into account socio-political context has been discussed as pertinent in improving the well-being of Black men who are systematically disadvantaged within and by society (Myrie & Gannon, 2013). Ideas from Liberation and Community Psychology offer interrelated theoretical frameworks to support Black men's needs by recognising the role of power within socio-political contexts on well-being (Kagan, Burton, Duckett, Lawthorn and Siddigue., 2019; Martín-Baró, 1994). By positioning clients

as experts in their own lives and psychologists as part of the emancipatory process for, and with oppressed communities through; consciousness-raising, social orientation, consideration of and siding with the “oppressed majorities” and deideologising reality (Martín-Baró, 1994). Byrne et al., (2011) developed and used this framework drawn from liberation psychology to support the well-being of African and Caribbean men within her local service (e.g. Trailblazer Project) which employed a creative, strengths based and social action-orientated approach recognising the role of power within socio-political contexts on their well-being. Another example of practice that has employed principles of community psychology theory has provided evidence for the importance of utalising principles of empowerment to position Black men as the expert in their life. This was achieved through the understanding that empowerment is linked to the sharing of power in co-producing activities to enhance employment opportunities (Hodgson, Stuart, Train, Foster and Lloyd., 2018). This example of practice pays attention to concepts of power by moving away from expert-led individualistic interventions (Fryer, 2008) through working alongside those who are marginalised and oppressed through strengths-based approaches acknowledging that people are active agents in relation to their context (Fogg-Rogers, 2017). Although these ways of working have demonstrated opportunities for empowerment which can contribute to addressing Black men’s needs which are intricately linked to disadvantage and discrimination a more coordinated response is required systemically within the NHS (Fitzpatrick et al., 2014). This is because MHS are situated within broader structures such as policy and politics (Smail, 2005) and these systems have an influence on service provisions. Highlighting structural causes of inequalities can be complex and challenging and suggestions of focusing attention on commissioning have been discussed (Harper, 2005). Since commissioning sits within the broader structures that influence service provisions available in the NHS this can open up possibilities to address some of the limitations of existing service provisions for Black men. In the next section, I will briefly set the context of the NHS system in relation to commissioning.

1.7. Commissioning in the NHS

The NHS is a large complex system; therefore, it is firstly important to understand the structure of the NHS in England including core organisations, their roles and how these ties together with commissioning in order to understand the context (see fig.1).

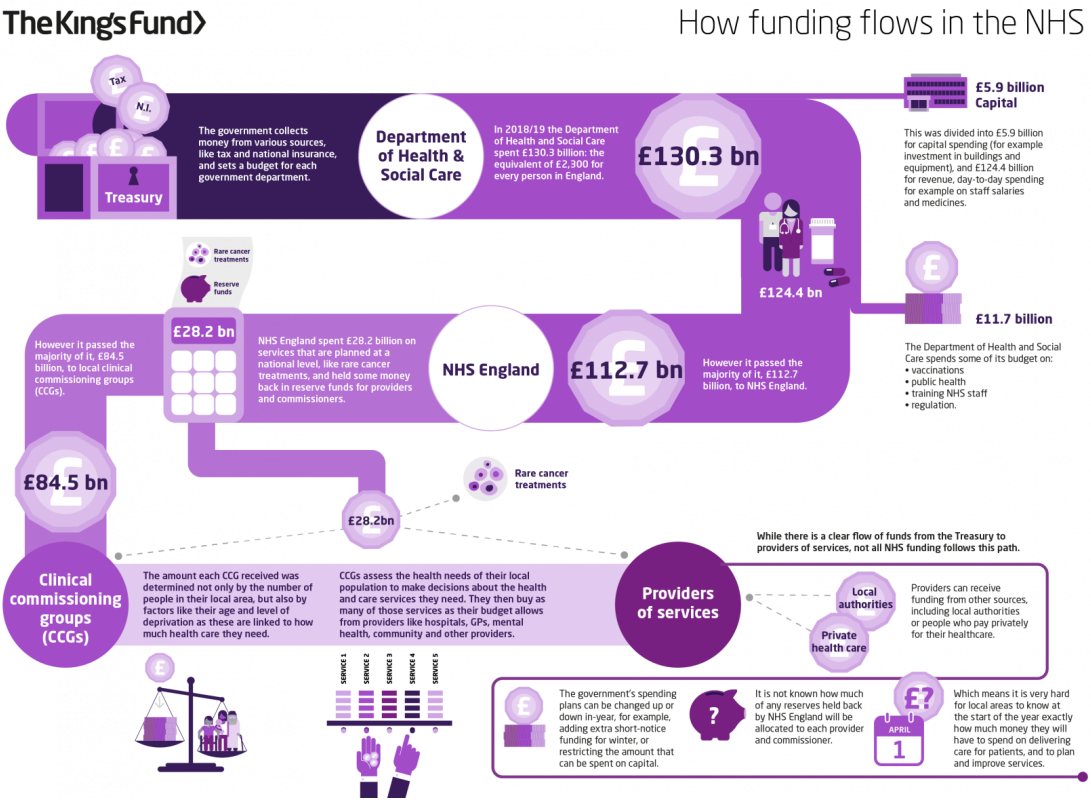


Fig.1. NHS England Structure and links to commissioning (The Kings Fund, 2020 [1])

In summary, overall responsibility for how money is spent in England is held with the secretary of state for Health and Social Care, who provides strategic leadership for public health, the NHS and social care. NHS

[1] Permission to reproduce diagram sought and written confirmation available in appendices A.

England is an independent body which sets priorities and directions of the NHS. Following the NHS Five Year Forward view (DoH, 2015) primary care co-commissioning was introduced, which includes the role of clinical commissioning groups (CCGs). CCGs replaced primary care trusts in April 2013, and are clinically led statutory NHS bodies responsible for their local area. CCGs includes various professionals such as GPs, nurses, consultants and clinicians who are responsible for approximately 60% of the budget and, among other various services they commission MHS (NHS England, 2015; The Kings Fund, 2017; The Kings Fund, 2020).

1.7.1. NHS Commissioning Process

In the NHS system commissioning has been described as "the set of linked activities required to assess the healthcare needs of a population, specify the services required to meet those needs within a strategic framework, secure those services, monitor and evaluate the outcomes" (Woodlin, 2006, p. 203). Commissioners are encouraged to use evidence based practice to support decisions regarding service provisions, guidelines encourage the utilisation of sources such as The National Institute of Clinical Excellence (NICE) and the Cochrane Centre (UCC) to support their commissioning decisions (Wyne, Brangan, Cameron, Gabbay, Klein et al., 2015). Evidence based practice is an empirically based approach which aims to identify and appraise the best available scientific data in order to guide the implementation of assessment and intervention practices within MHS (Frueh et al., 2012, p.2).

1.7.2. Limitations of Process

Sources such as NICE and UCC draw on principles of evidence based practice and favor 'scientific and medical approaches' despite these having been criticised for favoring particular forms of knowledge (Glasby & Beresford, 2006). Hierarchical organisation of research, valuing systematic reviews, which include randomised control trials as 'gold standard' research and practice based evidence/case studies as the least valued

source of information. Likewise, this structure places expert opinion at the top of the knowledge hierarchy and service users at the bottom. The validity of this evidence based rhetoric embedded in the approach can be questioned for a number of reasons (Williams & Garner, 2002). For example, sources such as NICE and the UCC include studies that typically do not reflect diverse populations (Gupta, 2007) and are based on individualistic notions of the person (Kirmayer, 2007) which can reinforce and shape medicalised models of service provision locating socio-economic problems within the individual (Blackman, 2007). Although there is evidence for alternatives to the medical model such as social prescribing; which seeks to address people's needs in a more holistic way recognising economic and environmental factors that contribute to people's mental health problems (Kings Fund, 2017). This approach rarely gets featured in NICE guidelines despite evidence for improving general health, quality of life and reducing the use of NHS services (Kimberlee, 2013; Dayson & Bennett, 2017).

Despite locally based information being favored by commissioners in their decision making, an emphasis has been placed on researchers and policy makers to develop relationships with local communities in order to 'co-produce' evidence-base which informs decision making (Wyne et al., 2015). A way of addressing some of these dilemmas could involve the application of 'knowledge-based practice' (Glasby & Beresford, 2006) which utilises the knowledge of people with lived experience to shape health and social services. Such an approach can challenge power imbalances in research and MHS towards change through concepts of empowerment.

1.7.3. Empowerment within the Commissioning Process

Empowerment is a multi-level and dynamic construct, linking individual wellbeing with larger social and political environment. Through empowerment, individuals develop a critical understanding of their environment and strengths to access valued resources and decision-

making capabilities (Zimmerman, 1990; 1995; 2000). Empowerment involves critical reflection on our context allowing for greater control over resources and participation (Rappaport, 1987). Empowerment can help provide people from BME backgrounds with some hope that they do not need to give up responsibility for their lives and health once in contact with MHS (Patel & Fatimilehin, 1999). Empowerment has been found to be positively related to quality of life, income and community activism amongst service users and linked to a reduction in the use of MHS (Rogers et al., 1997). In addition to the benefits of empowerment it is presented as a specific goal for community psychology interventions, being key to improving mental health and wellbeing (Harper & Speed, 2012) Therefore, empowerment can be a way for 'knowledge-based practice' (Glasby & Beresford, 2006) to emerge by allowing Black men to shape service provisions through meaningful engagement in the commissioning process to shape MHS provisions that have otherwise been subjugated.

1.7.4. A Need for Involvement

Co-production has been discussed as an integral part of the NHS Five Year Forward View (NHS, 2015) in establishing new relationships with service users and communities. Co-production is expressly conceptualised with more equal sharing of power and decision-making between 'service-user' and service provider (Mayer & McKenzie, 2017). Co-production can be a way of involving Black men to develop a critical understanding of their environment and draw on strengths to contribute to decisions regarding service provisions through an equal sharing of power. This involves a need to change the discourse and language that suggest that Black communities are the cause of their own misfortune, recognising communities' assets and resilience within concepts of co-production (Vernon, 2011). Furthermore, in order to make any real progress in addressing some of these inequalities it has been recognised that a holistic approach, which tackles systemic social factors that perpetuate the problem is what's needed (CQC, 2011). In 2014, the DoH published the crisis care concordat which acknowledged the overrepresentation of Black men in MHS and a need for commissioners to

identify and address this, through the involvement of service users in the commissioning cycle. This coincided with a report by Mind (2013) which proposed that consultation and engagement is required with diverse communities in an attempt to provide person-centered care which accounts for cultural differences. Whilst these documents highlight that race equality is being held in mind, it seems there is still a way to go for the inequalities for Black men in the MHS to be addressed in a timely and meaningful manner. Likewise, an independent review of the Mental Health Act (DoH, 2018) highlighted that little progress has been made to address the inequalities for people from BME groups, particularly Black African and Caribbean men who remain subject to compulsory powers under the Mental Health Care Act (1983). The Disparity Audit (Cabinet Office, 2018) also clearly demonstrated that little progress has been made to address the inequalities in MHS for Black men. Despite recommendations for commissioners to consult with service users and Voluntary, Community and Social Enterprises (VCSE's) a report published by the NHS revealed wide variations in engagement (NHS England, 2018). It is evident that there are challenges in addressing inequalities for Black men from a commissioning perspective, such challenges will be explored in the following in section.

1.8. Literature on Challenges to Commissioning Addressing Inequalities for Black Men

Literature Search Strategy

Selected databases were searched including: PsychINFO, CINAHL Plus, Academic Search Complete, and Science Direct. Reference sections of journal articles, books, Google Scholar as well as 'grey' literature of unpublished research and articles were reviewed to ensure the search was thorough. Key search terms used were derivatives of: "inequalities", "overrepresentation" "Black men", "ethnic minorities", "BME", "BAME", "commissioning", "National Health Service", "NHS", "challenges", "obstacles", "United Kingdom", "Britain", "mental health" and "MHS". The

decision to widen the search to include BME groups and data drawn from some literature outside of the UK due to the lack of literature available that was focused specifically on Black men in the UK within NHS MHS and commissioning. The literature search was limited to English and no date ranges were implemented, in total 30 articles were considered relevant. Further relevant literature was located through using reference lists in articles of interest.

1.8.1. Context of User Involvement

People from a range of disenfranchised groups including people from BME groups have been seen historically to be providing collective challenges to poor care and discriminatory services (Brown & Zavestock, 2004). Such campaigns have been reinforced by wider arguments against the biomedical model in promoting models of treatment and decision making (Freidson, 1970), including concerns around a need to address poorer and unequal access to health care for people from ethnic minority groups (Townsend, Davidson and Whitehead, 1988). Ocloo and Matthews (2016) discussed how models of patient and public involvement (PPI) can be rooted in “mechanistic, controlled and professionally dominated approach, based upon a very practical and theoretical way to getting someone’ s input” (p.626). The models are discussed in relation to their roots being embedded in narrow models drawn from consumerist ways of working developed in market research (Tritter, 2009). Using such models can shift focus away towards more generic engagement, leading to detrimental effects on service users say and how services are commissioned (Kalathil, 2011). These are in contrast to wider democratic rights and values-based approaches which emphasise the need for direct involvement and empowerment of users of services in decision making (McLean, 1995). This can be problematic when translated into the practice of involving Black men in the commissioning process, as narrow models that PPI are rooted in can lead to less or greater level of involvement or influence of power in decision-making processes. This is evident in research which demonstrates that service user representatives are struggling to influence

decisions working within existing systems, where they are provided with little opportunity to influence decision making (Tritter, 2009). This can maintain professional and system interests and power (Rutter et al., 2004). In practice, this favors organisations or systems and maintains the existing balance of power rather than partnership working with users of services (Donaldson, 2008).

1.8.2. Challenges Concerning Policy

Marginalisation in attention to ethnic diversity within NHS agenda as well as in the national commissioning infrastructure has been discussed as a challenge for addressing the inequalities for BME groups (Salwaymn et al., 2016). The approach of 'parity of esteem' which is described as valuing mental health equally with physical health fails to address the relationship between mental health, stigma and discrimination in shaping experiences of well-being (The Health Foundation, 2012). This is perhaps concerned with national healthcare policy being poorly aligned with other more dominant agendas, which can be a way of indifference or resistance of those in power to marginalise populations (Connell, 2007). This reflects suggestions that the multi-ethnic reality of English society being largely unacknowledged within many areas of policy (Anionwu & Atkins, 2011) and can result in central policy makers failing to articulate clear, detailed commissioning expectations in relation to ethnic diversity and equity. Issues relating to inequity, racism and ethnicity can be an uncomfortable topic within policy making circles (Bhui et al., 2012). Moreover, approaches to racial and ethnic equality can remain in a narrow interpretation of legal compliance rather than being something integral to understanding and meeting the healthcare needs of their diverse populations (Ahmed, 2007).

1.8.3. Uncertainty in Addressing 'Race' Equality

Literature which explored the obstacles to achieving race equality within health care revealed that commissioners have expressed a lack of confidence and uncertainty regarding their role in addressing equality (Salwaymn et al., 2016). This is echoed by literature that has found an

expression of concerns regarding privileging particular groups and uncertainty regarding appropriate responses amongst social support provisions in addressing equality within healthcare (Atkin & Chatto, 2007). Common fears amongst healthcare professionals include descriptors of 'fear' and 'professional uncertainty' in response to taking action on such issues (Johnson, 2009; Kai et al., 2007). Findings of such literature point to a need to support professionals particularly commissioners, including a need to enhance and support the skills and confidence of individuals as well as organisational systems to enhance the facilitation of attention to ethnic diversity and inequality (Salwaymn et al., 2016). An important aspect of facilitating such action includes the need to collaborate with minority ethnic communities in order to stimulate and facilitate mutual learning to tackle some of these dilemmas' (Connell, 2007).

1.8.4. Challenges in Collaboration

Recommendations for addressing obstacles for this call for a 'systems-based approach' (Salwaymn et al., 2016) include enhancing meaningful engagement with minority communities, a clear national direction with an integrated approach with commissioners working alongside provider, communities, service users and researchers. Despite an emphasis on the importance of professionals and commissioners to engage with service users on the development of services, this activity can be seen as tokenistic because user involvement involves no real power in setting the agenda or decisions within hierarchical structures (Kalathil, 2011). A lack of representation from minority groups can be driven by notions that they are 'hard to reach' despite their overrepresentation in mental health care systems (CQC, 2010; Stuart, 2008). Moreover, reluctance of BME communities to get involved can be fueled by experiences of discrimination and the unequal terms with which they are asked to be 'involved' particularly where no space is allowed to acknowledge and discuss these issues (Kalathil, 2009). Exclusion from decision-making groups and commissioning processes reinforces the peripheral positioning of knowledge, experience and needs relating to people from BME

backgrounds and can result in a lack of involvement (Boote, Wong & Booth, 2012). These groups present with greater needs with their capacity to be involved affected by social disadvantage (Wait & Nolte 2006). A lack of workforce diversity and lack of ethnic minority representation within the commissioning workforce likely adds to these dilemmas (Dreachslin, 2007).

1.8.5. Benefits of Involvement

There is an acknowledgement that more space needs to be created to explore emotional journeys, negative and difficult experiences that people have faced (Blakey, 2006). Meaningful engagement of minority communities within decision making processes has been shown to be beneficial (Cacari-Stone et al., 2014; Wilson, 2009). This is particularly so in relation to commissioning; the involvement of community members highlighted the benefits both to commissioners and community members, emphasising a need for a greater voice for BME communities independent of statutory sector boards (Bhat, Kaur, and Kauser, 2009). Involving BME communities outside of statutory sector boards might allow for those who have had difficult or negative journeys to participate in voicing their concerns and suggestions for service provisions.

1.8.6. A New Voice for Knowledge Production

The emphasis remains on policy makers and MHS systems to work more collegially with communities prior to service design and delivery. An approach to empower and go beyond seeing the focus on individuals can help to recognise the systemic nature of health inequalities and how different groups can be excluded (Ocloo & Matthews, 2015). A “politics of change” has been proposed by Connell, (2007, p. 222) whereby an engaged relationship exists between commissioners and minority ethnic communities, permitting mutual learning and creativity to be stimulated. Empowering communities and the third sector to challenge and support commissioning is a way of remodeling relations between marginalised and dominant actors and forms of knowledge (Connell, 2007). In order for there to be meaningful and sustained involvement structural changes in

power and hierarchies, organisational practices, assumptions about people, the location of decision-making and the way people are treated within and outside of them need to be addressed (Kalathil, 2009). Models of co-production at an organisational level can be a way of addressing power imbalances within reciprocal relationships (Boyle, Slay and Stephens, 2010). This can also allow the emergence of alternative knowledge to inform service development through the inclusion, practice and wisdom of lived experience and human testimony (Collins, 2000; Lindow, 1999) as a way of producing 'knowledge-based practice' to support the shaping of MHS (Glasby & Beresford, 2006).

1.8.7. Critical Reflections

I encountered a number of concerns whilst carrying out this research, one of which was the paucity of literature that explored the relationship between commissioning and user involvement within MHS specifically focused on Black men. This made me both question to utility of such knowledge in understanding the challenges relating to commissioning services for Black men and was a contrast to rhetoric embedded in 'user involvement' and over-representation of Black men within MHS (Cabinet Office, 2018). This made me curious whether there were other mechanisms at play such as a lack of diversity within hierarchical structures (Kline, 2014; Fernando, 2017) which can perhaps add to these challenges.

1.9. Relevance to Clinical Psychology

My experiences prior to and during clinical psychology training working in a wide range of inner city adult MHS highlighted the impact of social inequalities on mental health. I became aware of overrepresentation of BME groups, in particularly Black men in the more coercive end of MHS such as inpatient services or underrepresentation in primary care services. Overwhelmingly, statistics depicted a broken system in which Black men are disadvantaged by statutory MHS. Following this, studying at the University of East London (UEL) which encourages critical approaches to

psychology has influenced and enabled me to further question society, practice and my values in this research. Learning from experience and developing a critical understanding of contextual factors with regards to mental health provision I am committed to actively raising awareness about inequality leading to distress in my practice, and research.

Clinical Psychologists have been active in the area of racial inequalities in mental health since the 1980s. Wood and Patel (2017) have been attempting to tackle some of the issues of inequalities within the profession in order to:
“see clinical psychology to be transformed to acknowledge and examine its historical and current racism and euro-centricity in order to be better skills to work with multi-ethnic populations and raise the goal of health services for all, and one which does not reproduce institutional racism” (Wood & Patel, 2017, p.3.).

Statutory requirements, health authority recommendations, and discipline specific recommendations (e.g. from the British Psychological Society, [BPS]) compel us to ensure provision of MHS are accessible, adequate and appropriate to all clients (Patel, et al., 2000, p.23). In addition to this Community Psychology highlights that psychology can and ought to concern itself with pressing social and political concerns (Kagan, Burton, Duckett, Lawthorn and Siddigue., 2019). Terms such as 'activist-practitioner' (Zlotowitz, 2013) have raised awareness that clinical psychologists, through social action, can address societal issues such as inequality that affect the overall mental health of the population.

In recognition of this and the inequalities Black men experience within MHS as discussed within the literature, my hope is to contribute by exploring the challenges to providing appropriate service provisions through a focus on commissioning. This can contribute to the profession of psychology by supporting new ways of working beyond the therapy room (BPS, 2010; Harper, 2005) by utalising its power and access to resources within the

profession through leadership to pay attention to ensure the needs of oppressed groups are adequately being met. In adopting this approach it will be important to ensure the facilitation of local and national action that promotes wellbeing of the population.

1.10. Why am I Doing This Research

My experiences working in several inner-city statutory services and being part of BME representative' groups that met to think about marginalised communities who were often described as 'hard to reach', often left me with feelings of frustration. This included frustration at the lack of flexibility to work outside of the constraints of 'traditional' systems where decisions were often influenced and dictated by hierarchical structures which frequently excluded the voice of those who were marginalised and oppressed. Developing awareness of wider complex social, political and cultural structures has helped me adopt perspectives and practices aligned with the view that 'the person is the political' (Dillion, 2011). Acknowledging that our experiences, feelings and possibilities of our personal lives are not just private matters of personal preference and choices, enables us to recognise these as limited and defined by the broader political and social context (Dillon, 2011).

In considering my personal history, I do not view my 'identity' as easy to categorise, but to situate myself I can be described as having multiple ethnic and cultural influences (Turkish, Cypriot, British) born and brought up with Muslim affiliations. I grew up in inner city London where experiences of racism were the norm, born to working class parents who had immigrated from Turkey and Cyprus. Growing up my parents strongly advocated the importance of securing opportunities that they grew up without such as education, secure employment and housing. However, access to many opportunities were difficult to obtain due to cultural, language and economic barriers. Growing up I felt faced with various obstacles to achievement and as I grew so did my awareness of difference and inequalities, which strengthened my determination to achieve and

represent diversity within professional realms. My personal experiences of feeling like the 'other' coupled with personal contextual challenges that I have experienced growing up have both motivated and strengthened values of equality and social justice in both my personal and professional life. It is my hope that I can utilise both my personal and professional experiences and critical approaches in psychology to highlight some of the ways in which Black men are being disadvantaged. I also hope that this will facilitate a change which encourages meaningful involvement to support services to be better equipped to provide equitable and appropriate services for their needs.

1.11. Research Aims and Questions

1.11.1. Summary

In summary, the above has provided an overview of the inequalities Black men experience within MHS and has situated the findings in a broader social, political and historical context as to why they exist. In reviewing the literature, it is evident that this is a complex picture entangled with social disadvantage, individual and institutional racism which sit within a socio-political context. Moreover, the fact that despite continuous rhetoric that this issue needs to be addressed in literature, research and policy, and in an NHS system where principles underpinning it are based on providing a comprehensive service to all (NHS England, 2015), very little progress has been made to address these issues, prompts investigation. It is clear that commissioners face challenges in providing adequate MHS to people from BME communities, however no research exists which specifically explores the challenges of commissioning services for Black men in the UK, despite them being disproportionately affected by current service provision.

1.11.2. Research Aims

In attempt to understand the issues summarised above further this research aims to explore commissioning within MHS in the NHS to consider some of the challenges of addressing the limited appropriate

provisions available for Black men. Furthermore, given the existence of multiple social inequalities for Black men, the research aims to provide further guidance to move beyond the rhetoric of providing equal service provision in policy and guidelines, to ways in which service provision can be shaped to better provide a comprehensive service to Black men.

1.11.3. Research Question:

The main research questions are:

How do commissioners conceptualise the structural and social issues that are relevant when developing services for Black men?

How do these issues get drawn upon in commissioning NHS services?

2. METHODOLOGY

Overview

In this chapter I will provide an overview of the research methodology. Epistemological issues will be outlined and considered in undertaking research and why a qualitative design was selected to answer the research questions described above. I shall also describe the process of undertaking the study, including the collection of the data and analysis.

2.1. Defining Knowledge

2.1.1. Epistemology in Psychological Research

Epistemology can be defined as the exploration of what counts as knowledge, how we obtain it and what its limits are, meaning that research is always implicitly commenting on the way in which we know things (Willig, 2008). Clinical psychology has established itself on the premises that similar to psychology and sciences generally knowledge is gained by discovering 'truths' in a particularly systematic and 'scientific' fashion. Typically, the epistemological position used to strengthen this stance is the idea of positivism. A positivist stance center's around the idea that objectively there are facts that one can know about the world that exist in themselves', independent of the role of the 'discoverer'. Therefore, in the discipline of psychology methods of knowledge striving to gain objective understandings of the world were afforded privileged positions. The terming of this method is called empiricism- the process of developing hypotheses which are tested, accepted or rejected in order to develop theories.

2.1.2. The Shift from Positivism to Social Constructionism

Social constructionism advocates a disengagement from the idea of objective knowledge. Although there is no definitive definition of social constructionism and it is seen as more of an 'approach', key factors are emphasised by Burr (2003). Shifting from ideas of objective knowledge social constructionism aims to highlight the cultural and historical processes which operate to influence what we know about the world. This approach attempts to move away from positivist reliance on quantitative data to an alternative of using language due to the importance placed on discourse as a source of knowledge (Avdi & Georgaca, 2007). Social constructionism also aims to address relationships between social processes and knowledge that posits that what we know is a result of our interactions with others and society at large. Consequently, different positions of truth on what is accepted and what is not varies between social and cultural groups, and also changes over time. This view posits that there are no objective truths, rather there are multiple truths depending on what context and by whom information is shared by.

2.1.3. Critical Realist

Although language alone can inform the way in which social reality is made meaningful, it has been argued that an exclusive focus on it has led to a failure in theorising extra-discursive influences on human experiences (Willig, 1999). Therefore, language alone cannot be seen as unproblematically representing reality. Critical Realism combines positivist and subjectivist approaches in one philosophy, acknowledging the existence of an external world as well as a socially constructed world (Willig, 1999). This approach acknowledges that wider social contexts impact on our meanings through a degree of 'reality' that exists. This position recognises the importance of studying qualitative data by going beyond the 'text' to include broader historical, cultural, and social contexts (Harper, 2011). Moreover, provides a framework to choose and apply methodological approaches as opposed to being wedded to a set of

prescribed methods and thus aims to determine what is objectively real and what is subjectively accepted as truth (Abdul, 2015).

2.1.4. Epistemological Stance

For this research, a critical realist approach was adopted. This approach acknowledges that broader social and historical context impinges on how people make meanings of the provisions available for Black men within MHS, while retaining an attitude that we can and should investigate 'reality' in itself, doing so cautiously and critically. This position enables the current analysis to explore the challenges to providing appropriate service provisions within the NHS for Black men from a commissioning perspective. Adopting this position in this study enabled consideration to go beyond the text in analysis (Harper, 2011), to incorporate the wider historical, social and cultural contexts constituting various understandings that impact on provisions available for Black men in MHS. This position is underpinned by the assumption that an individual's 'reality' exists, it is material and has 'real' effects (Maxwell, 2012, p.8). Thus, regardless of my or anyone else's perceptions of 'race', 'ethnicity', there are observable inequalities in the MHS for those who label themselves (or are labelled) as Black men and has real effects on their experiences. Furthermore, this assumption remains that it is possible to capture data that can verify these inequalities concretely. This position can allow for researchers to make ontological claims about pre-existing material practices that can influence service provisions (Harper, 2011) such as service structures, policies and procedures used in MHS and the commissioning process. In order to enable change, there must be an acknowledgement of 'reality' and a critical realist position can highlight pre-existing accepted practices that work to distort realities (Glesne, 1992).

2.1.5. Epistemological Dilemmas with Critical Realism

Adopting a critical realist position can be argued as 'sitting on the fence' as such providing researchers with an approach whereby interpreting data maintains the illusion of objective reality (Elder-Vass, 2012). However, in

any study the knowledge being researched exists independently outside of the study but the research process cannot independently assess all the external knowledge of the phenomena (Abdul, 2015). Similarly, Harper (2012) notes that holding this position could lead to inconsistency and selective relativism, choosing to question some knowledge claims whilst ignoring others (Speer, 2007), leading to a form of ontological gerrymandering (Woolgar & Pawluch, 1985). However, failure to interpret beyond the transcripts of talk might mean the various factors that influence how service provisions are commissioned cannot be fully explored (Nightingale & Cromby, 1999). To acknowledge and manage this dilemma, I consider 'real' and 'socially constructed' as neither homogenous nor dichotomous (Burr, 1998). Therefore, the factors that participants might draw on are both 'real' and 'socially constructed', and together with material structures and the influence of power, have 'real' embodied or subjective effects on Black men (Burr, 1998).

2.2. Research Design

Qualitative methodologies are adaptable to a range of epistemological positions (Willig, 2013) and are concerned with providing "illumination and understanding of complex psychosocial issues and are most useful for answering humanistic 'why' and 'how' questions" (Marshall, 1996, p.522). Through my review of the research literature I was aware that evidence consistently shows inequalities within MHS for Black men (Khan et al, Centre for Mental Health, 2017). Focusing to explore this from a commissioning perspective would allow for a novel perspective on the issue (Salwaymn et al., 2016). Therefore, it was relevant to use such an approach to try and understand *why* and *how* commissioners understand the challenges of providing services for Black men and how this informs how service provisions are developed, which indicates the suitability of qualitative methodology.

2.2.1. Reflexivity

'Reflexivity' can be understood as the researcher's consideration of their influence on the research process and the knowledge produced (Willig, 2013; Nightingale & Cromby, 1999, p.228). A critical benchmark of qualitative research includes a shifting of the researcher from the objective to the subjective of the study, therefore the decisions regarding what is chosen to be researched, assumptions drawn based on person contextual positions and epistemology as well as what is analysed are largely influenced by the researcher (Parker, 2005). As such they are a reflection of who is doing the studying as well as who is being studied. I approached this research self-identifying as first generation Turkish-British female with no personal experience of receiving MHS. Therefore, a number of my life experiences are in direct contrast with both the area of focus in this research and study participants. While I do not see this as inherently negative, I conceive it possible that contrasting experiences could lead me to make assumptions. In order to reflect on my own assumptions and potential influences on data I maintained a reflective journal, engaged in personal linguistic and epistemological reflexivity (Willig, 2008) throughout the research and discussions with my research supervisor. Reflective comments are included within the research report and a more detailed account is discussed in the evaluation part of this research report.

2.2.2. Recruitment

I used the general principles of qualitative sampling and aimed to recruit participants who have a role in commissioning NHS services for adults. The rationale for choosing London was based on the premise that it is the most ethnically diverse region of the United Kingdom (UK) with a large percentage of people identified from Black ethnic groups which is relevant to the focus of this research. My initial approach to recruitment was to create a database of London based CCG's which included contact details such as telephone or email addresses of the various boroughs within London. Using this data base, I contacted everyone on the list to invite them to participate (details of the email is included in appendix B) along

with an information sheet of study (available in appendix C). Individuals who took part in the study were also asked to inform others they knew who were appropriate and might be interested in the study, a process known as 'snowballing' (Faugier & Sargeant, 1997). The snowballing was used to generate more participants through the people I had already interviewed. I also tried to utilise colleagues and professionals who had contacts with commissioners to ask them to participate.

2.2.2.1 Inclusion and exclusion criteria

In order to be eligible to take part in the study participants had to be working in an NHS setting in London with a role in commissioning MHS.

2.2.3. Participants

Eight participants were recruited from across NHS London CCG's, a mixture of five people identifying as a male and three as female were interviewed. Although I attempted to recruit more participants, I respected people's choice not to participate if they did not respond to the email or phone enquiry. During the analysis, it appeared that many of the themes that emerged from the data overlapped and related to one another, this could be a reflection of the complex multilayered nature of the inequalities.

Although I am aware of the importance placed on the presentation of peoples 'demographic' characteristics in qualitative research in order to contextualise the analysis. I chose not to collect such information to maintain anonymity and confidentiality due to the sensitive nature of the research topic.

2.3. Data Collection

Data was collected using semi-structured interviews. Although a focus group might have promoted discussion between participants (Kitzinger, 2005) which might have been useful in understanding how meanings are disputed negotiated and socially constructed (Bryman, 2008; Wilkinson, 1998) this had to be ruled out due to both the sensitive nature of the topic

and time restrictions on participant's availability. Semi-structured interviews were used as they offer flexibility with a balance to focus on emerging topics allowing a space for participants to discuss their understanding of the research topic. I constructed the interview schedule in collaboration with my research supervisor whilst bearing in mind the literature I had reviewed. It is worth noting that whilst I used the literature to consider questions that might elicit some understanding as to why there might be challenges to commissioning services for Black men, this did not include the direct views of Black men.

Interviews, however are not without fault (Potter & Hepburn, 2005). Although interviews can adopt different levels of structure, all interviews are 'conversation with a purpose' (Burgess, 1984) and what is heard from participants' responses will be based on my 'theoretical project', influenced by my research question, rationale for asking the question and epistemological stance, thereby forming a structure (Mason, 2003, p.225). Therefore, as discussed in section 2.2.1. I have attempted to maintain reflexivity and make explicit the influence I have had throughout the process of the research project.

2.4.Location

All participants requested for the interviews to take place within their work context due to an expression that time within their job roles was constrained. Therefore, interviews took place in a variety of NHS settings within the participants' work bases within London.

2.4.1. Procedure

All interviews were conducted in a meeting room within the participants' work base, organised at a time of their convenience. Before the interviews begun participants were offered a chance to review the information sheet and ask any questions regarding the research. They were reminded that they could withdraw at any time during and after the interview and that their responses would be kept anonymous and confidential. Permission was

then sought through the signing of the consent form (appendix D). Interviews lasted between 40 to 68 minutes.

A context of providing a rationale for the study was offered at the beginning of the interview. This was done by briefly verbally sharing literature that I had explored on the inequalities for Black men as discussed in my introduction (section 1.4.). This was done in order make my intentions explicit and invite an open space to explore the issues in a non-confrontational way. This was discussed with my supervisor as important in an attempt to avoid making the interview seem like a personal interrogation of why they had not made changes for service provisions. In discussing and co-creating the questions with my research supervisor we decided it was important to start the interview with a general question on the experiences of being a commissioner in an acknowledgement that it can be a complex role. The line of enquiry that followed included questions about why the inequalities existed for Black men and factors that might contribute, gradually working towards exploring the challenges more specifically to commissioning services for Black men. Questions also included a chance to explore positive practise that had been implemented. A copy of the interview schedule is available in appendix E. On completion of the interview, participants were debriefed with a space for them to ask questions, reflect or make additional comments. Participants were also informed that findings and recommendations would be provided following the completion of the thesis as a way of both making participation useful and relevant to their role.

2.4.1. 1. Transcription

All interviews were transcribed by myself, the lead researcher. Transcription is seen as an interpretative process in itself (Willig, 2013) and included the conversation of spoken material to written material. Transcription included all verbal and noticeable non-verbal material (significant pauses, laughter, silence) that were deemed as significant. Basic punctuation was added in order for readability. Once transcription

was complete, I checked all transcripts against the recordings to ensure accuracy amending where appropriate.

2.4.5. Ethical Issues

Ethical approval was granted from the school of Psychology Research Ethics Sub-Committee at UEL (Appendix F). As the population recruited were from NHS staff settings, NHS ethical approval was not required.

In order to adhere to issues of informed consent (e.g. Patel, 1999) within research, an information sheet was provided to individuals who expressed an interest in the study, in order to help them make an informed decision about whether to take part. The information sheet highlighted that data obtained from the study would be anonymised and participants were able to withdraw from the study at any point. The information also outlined that the research was part of the requirements for a Doctoral in Clinical psychology, which would be written up as a thesis with the possibility of being prepared for publication in a journal article.

2.4.5.1. Confidentiality

All participants were informed that their personal information such as name, role, place of work would be kept confidential and their responses would remain anonymous. Access to the transcribed material was limited to supervisors and examiners, all participant data was stored on a computer accessed only via a password and log-in details. The recorded interviews will be erased after the thesis has been examined. Research materials (including consent forms and transcripts) will be kept securely in a locked cabinet, only accessible to the researcher, for a period of three years after completion of the study to allow the possibility of developing the research for publication. After this time data will be destroyed in accordance with the Data Protection Act (1998).

2.5. Data Analysis

I recorded the interviews using a digital voice recorder. In keeping with issues of confidentiality, participants were assigned a participant number and any actual names were kept separate from the raw data.

2.5.1.Thematic Analysis

Thematic Analysis (TA) is positioned as independent theory, therefore it can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006). TA from a critical realist epistemological position was chosen as a method to organise the data (which I have detailed in section 2.1.4.) and an Intersectionality Framework as a set of ideas drawn upon to understand the responses. An Intersectionality framework (Crenshaw, 2012) was drawn on to support the data interpretation, this is in recognition that social identity such as gender, 'race' and social economic status can interact with each other to determine outcomes. Considering the novelty of this research it was important that the method of obtaining participants responses allowed openness and flexibility which is also why TA was chosen. The flexibility offered by TA is considered a significant strength, but this encouraged me to consider the philosophical and ethical concerns around different ways of approaching the participants' responses. I have been guided by Braun and Clarke (2006) in using TA to arrive at a pattern in the data and outline below the stages I went through during my analysis and write up.

2.5.2. Data Analysis Process

Analysis of the eight interviews followed the six-phase approach defined by Braun and Clarke (2006):

a. Familiarisation with the data

I began by listening to the interview recordings and noted my reactions to the first hearing of the conversation after the interviews. I then transcribed the interviews, read through the transcripts and noted my initial thoughts.

An excerpt of a transcription that I have analysed is available in appendix G.

b. Generating initial codes

TA can focus on either the sematic level (what is said explicitly) or the interpretive level (e.g., on underlying assumptions). As recommended by Frosh and Young (2008) and Joffe (2012), I chose to code on both levels to obtain different layers of information, highlighting small segments of text that I found to be relevant and of interest. In line with my epistemological stance and the exploratory nature of the research question, my analysis was data-driven (inductive), meaning my coding was closely linked to the content of the text.

c. Searching for themes

I organised the codes into potential initial themes, first within and then across the transcripts. This was done using large tabled word document which mapped out the development of the themes (for an example, see appendix H), checking back repeatedly to the original coded data extracts to ensure that the codes were representative of what was said and related to the different levels of initial themes they were being placed under. This enabled me to review the initial themes further and condense them into themes and subthemes (appendix I). These were once again checked against the original extracts for representativeness. It has been suggested that individual researchers decide what constitutes a theme and in the results section I have attempted to qualify them by their distribution across the interviews.

d. Reviewing themes

To decrease repetition and increase distinctiveness I collapsed the initial thematic graphs further, leading to some themes being merged, split or combined with other subthemes, resulting in the final thematic map (appendix J). At this stage, the transcripts were re-read to check that the themes represented the data

e. Defining and naming themes

I organised the themes and considered how they related to each other and how they related to the research question with the aim of developing a coherent narrative around the data. This involved re-naming some main themes, adapting from participants' talk and to reflect the meaning within each theme (appendix K).

f. Producing the report

During both the analysis and write up, I have aimed to ensure quality by following the guidelines for a good TA (Braun & Clarke, 2006, appendix L). I have presented numerous data extracts, referring to participants using pseudonyms, to allow for the evaluation of the relationship between the analysis and the data. As already mentioned I aim to share a summary of the findings along with recommendations with the participants once the thesis has been examined. It is important to note that participants were keen to receive this to help support their role of attempting to address the inequalities described.

3. CHAPTER THREE- RESULTS AND DISCUSSION

3.1. Overview

This section presents themes derived from the data analysis of the eight interviews. Using TA, initial codes were grouped into three main themes, each with sub-themes (see table one). Readability of data extracts is enhanced through the use of information in [square brackets] to help make sense of quotations and maintain confidentiality of participants, service names or locations. Extracts from the transcripts have been provided to support the findings and participants have been numbered to maintain participants' anonymity. Where words have been omitted to shorten quotes, a dotted line within brackets (….) is indicated.

-How do commissioners conceptualise the structural and social issues that are relevant when developing services for Black men?

-How do these issues get drawn upon in commissioning NHS services?

The analysis was inductive and codes and themes were aligned according to a combination of the transcription data and research questions. The table below outlines the themes and sub-themes which emerged during the analysis;

Table 1; Themes and Sub-themes

THEME	**SUB-THEME**
1. Challenges to Commissioning Mental Health Services	Sub-theme one; Identity, Mental Health and Engagement Sub-theme two: Narratives Influencing Mental Health
2. Reframing Mental Health Services	Sub-theme one: Trusted Ways to Engage Sub-theme two: Joining Together Sub-theme three: Creating Opportunities
3. Black Men and Power Dynamics	Sub-theme one: Power Imbalances in Commissioning Sub-theme two: Power from Wider Influences

3.1.1. Overview Wider Context of Interviews

I include this section in order to set the scene in helping provide a wider context for the participant's role and the tone of the interviews that took place and in linking with the findings and analysis that will follow. This section includes a combination of reflections on what was said as well as information from the process of data collection. Participants were asked about their role and challenges that they face within their roles as commissioners. Participants generally showed a keen interest in the

chosen topic area and discussed how they were interested in receiving findings from the study, perhaps suggesting they were somewhat isolated within their roles. Due to feeling slightly stuck and frustrated within their role they expressed curiosity in finding out about practices that were being employed elsewhere in order to support and stimulate their learning and generate ideas to use within their role. Participants shared feelings of frustration in terms of being open and willing to make changes, but feeling stuck within a system in which change is difficult to achieve. This was due to a combination of time constraints, pressures of the multifaceted nature of the role and a sense of being powerless in a role which seemingly holds power. Despite their role ostensibly holding the power to make service development changes they considered that the power to make those changes were located within a wider system. They appeared to see themselves as often knowing what the right thing to do was while feeling overwhelmed and restricted in what that could say and do within their roles.

3.2. Theme One: Challenges to Commissioning Services for Black Men

This theme encapsulates several factors discussed by the participants associated with commissioning services which can create challenges to providing appropriate services for Black men, as well as their engagement with services. Such factors include conceptualisations of mental health employed within services, which is discussed in sub-theme one 'identity mental health and engagement'. The second sub-theme 'narratives influencing mental health' discusses the relationship between perceptions and the treatment of Black men within services.

3.2.1. Sub-theme One; Identity Mental Health and Engagement

This sub-theme discusses issues that were outlined by participants which relate to conceptualisations of mental health, identity and engagement, which are bound by constructions of masculinity and 'race'. Participants identified gender and 'race' as aspects of a service user's identity, questioning the applicability of service provisions for Black men. They also

drew on these aspects to consider how this translates to help-seeking and engagement amongst Black men and MHS including institutional practices employed within NHS services, that can be limited in serving their well-being needs. Participants framed some of the issues involved in mental health identity and engagement within an intersectionality context (Crenshaw, 2012). They drew on constructions of masculinity, which are linked to identity associated to being male and from a Black African heritage and how this can impact on help seeking as demonstrated in the extract below;

Participant 2 "Last but not least you've got all the issues of maleness so you've got men don't like to be seen as weak and won't go to therapy….."

Participant 8 "There's a number of things that are interconnected, so it's not just the issue of ethnicity and Black African heritage it's the fact of maleness, these two things are associated in the engagement process, so it's important to think about how this can impact on less engagement in therapy and ending up in the acute end.."

Participant 5 "… Black men often, you know, don't go to seek help it's been a part of the culture, tradition, what have you, typically won't seek help, they have to stand up on their own, be mature and show outwardly that they can handle things and seeking help from health care provisions can be seen as a form of weakness."

Participant 3 "….and finally we've got the double stigma issue so if you think maleness if there's a fragile ego who feel they have to be strong um and therefore can't be seen as weak then we say Black men identity is increasing that because they already feel perhaps stigmatised for being Black for how they are perceived and won't confess to having a mental health difficulty so that's double stigma."

Participant 3 refers to "double stigma" which draws on how aspects of transecting identity can restrict help seeking for Black men. Constructions of being male and Black can act as a mechanism to protect against societal stressors and negative perceptions resulting in reluctance to seek help (Myrie & Gannon, 2013).

Participants drew on the intersect between the constructions of 'race' and masculinity to show awareness that the Black community are not a single homogenous group of people, as demonstrated in the extracts below;

Participant 7 "… the issue is for African heritage is not one community where as those communities are homogenised, if we talk about African heritage we talk about Afro-Caribbean Black so many different cultures…."

Participant 5 "… there's an issue with saying Black men because there are quite a lot of cultural differences…"

Participants expanded on the issues connected to the heterogeneity of the Black community and the effect that linguistic variations have on the conceptualisations of mental health that are available within MHS, which derive from non-western cultures (Sue & Sue, 2003) and are disconnected to people from Ghana as demonstrated in the extract below:

Participant 8 "…one of the interesting things are for example in Ghana they don't have a word for depression…"

Participant 8 echo's how current MHS are organised by concepts and constructs that originate in the West as discussed by research (Kitayama & Marcus, 1994; Shweder & Haidt, 2000) which are not recognised in different cultures or applicable to Black men.

Participant 2 "I do think you know there are some cultures where the word mental health is not recognised you don't talk about it…"

Participant 5 "Different cultural norms and stigmas are constructed different in different communities and different histories…"

Participant 6 "for some would have a view that our services might not be culturally tailored to certain communities Eurocentric etc….."

The extracts by participants 2, 5 and 6 demonstrate how they drew on various concepts of language and culture and the degree to which they align with those employed in services. This raises questions regarding how accessible MHS provisions are for Black men since their language and cultural norms vary to those of the majority population. Participant 8 below builds on the varying ways in which services fail to meet Black men's needs, by drawing on the problematic nature of MHS being organised around a medicalised model of understanding mental health and engaging those who are in need of services:

Participant 8 "…so to engage in the statutory system is quite problematic particularly if you're talking about diagnosis and labels and tests so I think there's a nervousness around engagement…"

Participants expanded on the limitations of how current MHS use conceptualisations of well-being to respond to behaviours displayed amongst Black men which can locate the problems within the individual (Boyle, 2006), as demonstrated in the extracts below from participants 6 and 7;

Participant 6 "One I think there's an issue about diagnosis, there's a view that those over diagnosing particularly readily disposed Black men...a sizeable proportion is through some form of coercion…"

Participant 7 "well some would argue that for example in the mental health system that people can represent might be quite vocal, agitated who wouldn't be in the context of many scenarios where the police are introducing you to a doctor who's attempting to assess you and people might in quotes act out and that's deemed to be a symptom of poor mental health…."

Such an individualised conceptualisation of well-being can serve to draw attention away from recognising the social context of Black men (Watkins, Walker & Griffith., 2010). Participant 5 provides an example of how methodologies embedded in service provisions (such as IAPT), which delivers Cognitive Behavioural Therapy (CBT) can prevent engagement with Black men as it does not fit with their conceptualisations of well-being and social context.

Participant 5 "in IAPT its still seen as quite a white methodology and practise in the NHS can be seen as not understanding of Black culture and history and the issues… people just try and cope themselves and don't turn to services for support."

Similarly, Participant 6 refers to how services are aligned in a Eurocentric way which is formed through a dualistic stance (Sue & Sue, 2003) which is limited in considering the various intersecting locations that might form Black men's identity and well-being. Participants question such a framework which suggests that Black men are being systematically

disadvantaged as a Eurocentric framework can be more applicable to the identity of the White majority.

Participant 6 "for some would have a view that our services might not be culturally tailored to certain communities Eurocentric etc….."

Participants drew on social context from the intersectionality framework (Crenshaw, 2012) such as poverty, social economic status and trauma to conceptualise how wider factors within Black men's context can impact on well-being. This is demonstrated in the extracts below;

Participant 4 "I think poverty and that's a key factor to young Black men are more likely to be out of work not educated involved in drugs and gangs all of those things have an impact on people's lives"

Participant 3 "...if you break down the factors its, and I am being cautious about saying if you're Black you're also deprived and not educated as clearly that's not the case but as a population there are more hot spots and both of those things are poor risk factors for mental health or conversely if you have protective factors against mental ill health it's those multi influential things that are difficult to unpack."

As participant 3 and 4 point out overlapping categories of identity such as poverty and education increase the likelihood of psychological distress (Bhugra & Kamaldeep, 2001. This is echoed in the research, which highlights high rates of African Caribbean communities living in poverty (Barnard & Turner, 2011) with African Caribbean men being more likely to be unemployed (Berthoud, 1999) and three times more likely to be excluded from school (Barnard & Turner, 2011) compared to their White counterparts.

Participant 6 expands on the factors that can impact on psychological well-being to include trauma and the effects of migration:

Participant 6 "...many of the people who access our services are second third generation erm and you know so experiences of migration etc. for many communities are particularly for some of the newer communities that have arrived is equally traumatic."

Truma is discussed by Allen (1996) and Briere (2004) as disproportionately impacting on people from BME backgrounds and this combined with other social disadvantage highlights how such experiences might impact on the

well-being of Black men. Participant 4 goes on to describe how factors such as poverty, and lack of education can have an impact on Black men's well-being:

Participant 4 "It has a massive impact on all walks of life, your ability to go onto a job, retain a job, to look after your family, your ability to keep social services from your door you know there's becomes a vulnerability…"

Participant 7 expands on the intersect between 'race', and mental health status and how conceptualisation of well-being through a diagnostic lens can serve as a double-edged sword for Black men in creating further barriers in accessing employment;

Participant 7 "...the issue again is the whole stigma element and going to an employer and saying by the way I have a mental health issue give me a job and then being a Black man as well it doesn't sort of tick the employers box..."

Although participants were able to identify issues relating to the way well-being is conceptualised and its disconnection to Black men's identity, they expressed uncertainty around how to tackle these issues:

Participant 3 "…but if we are only commissioning services that people don't feel are appropriate in some way then its discrimination then we are making a conscious choice to close down options, I struggle a bit with how we square that circle…"

Participant 3 highlights how commissioning services that are not appropriate for Black men is discriminatory, which has been discussed by Fernando (1991). The expression of "struggling to square the circle" depicts an acknowledgement of this and suggests support is required by commissioners to tackle some of these issues.

3.2.2 Sub-theme Two: Narratives Influencing Mental Health

This sub-theme explores issues that participants discussed in relation to perceptions amongst staff, and more widely in society that can play a role in the way in which Black men are treated within MHS. They discussed how negative narratives can play a role in people's experiences that might

bring them into contact with MHS and how this can be perpetuated by discriminatory experiences that Black men face in society as demonstrated in the extract below:

Participant 5 "The things that make you feel safe make you feel paranoid like being at risk of the police umm experiencing racism and discrimination in your life those are really powerful factors that I do think drive the higher rate of psychotic presentation."

Connected to this participant 1 discusses how perceptions held more widely in society, which have been suggested as a factor that contributes to racial stereotyping by healthcare staff (Bhui, 2003; Nadirshaw, 1993), can be heightened by negative stereotyping of Black men in the media (Alexander, 2008; Gunter, 2017):

Participant 1" because it has to do with perceptions and there is a perception in society that Black men are dangerous and that perception I think influences how people respond to a Black man in crisis…. Because if you have a young Black man who's that tall [indicating height with arms] shouting and screaming and how you might respond to that will be different to how you respond to an 80-year old with dementia screaming at you."

Participant 1's comparison of a "Black man in crisis" to "an 80-year old with dementia" draws attention to the difference in treatment that a Black man might receive once in contact with MHS. The comparison demonstrates how negative stereotypes heightened by the media can play a role in how a Black man might be treated in MHS.

Participant 6 goes on to discuss the impact that such negative perceptions can play on Black men's experiences, which is supported by evidence that discusses discontent that Black male service users have expressed with services (Sandamas & Hogman, 2000). This, combined with barriers to accessing help being fueled by expectations of racial mistreatment (McLean et al., 2003), can perpetuate the circles of fear documented by Keating et al., (2002).

Participant 6 "particularly for Black men their first experience of mental health services is the coercion, being picked up by the police, crisis so therefore we get feedback that the experiences are just not good…."

Participant 1 expands on how such negative experiences can feed into the risk aversive culture embedded in NHS services. Such experiences can reinforce difficult experiences that Black men might face more widely in society and prevent meaningful engagement impacting on how they might be treated once in contact with services.

Participant 1 "…. we have become a more risk averse culture and being risk averse also has a very negative impact…"

Participant 2 expands on the notion that the culture of risk in the NHS feeds into differential treatment of Black men compared to say a "white man" through the influence of "conscious or unconscious associations".

Participant 2 "..it's the consideration well higher percentage of Black men in the criminal justice system over reflective of Black men in the community…. It's the same in prison and is there's a conscious or unconscious association of risk and therefore there is a threshold of risk that would get a different response for a Black man than say a white man and its interesting and good at helping us challenge our unconscious biases and perceptions."

Participant 7 discusses how it is important for professionals to consider how they build relationships with Black men, incorporating how they might challenge perceptions by opening dialogue moving away from diagnostic notions of well-being to explore their well-being:

Participant 7 "it's about having a worker having a relationship with the person so perception is really important so how you perceive somebody so yeah that was my experience as a social worker working in inner city [location] and I had a whole range of people and I'm white and was young… and how do you make those relationships with Black men and engage them and you know saying let's talk about things because their viewpoint will be different to mine."

Participant 8 similarly discusses how the conceptualisation of Black men's well-being through a diagnostic lens, influenced by negative narratives of dangerousness can elicit a response by professionals that justifies the "management of symptoms":

Participant 8 "..so with young Black men there's a tendency to see them as dangerous so do they get therapy or do they get management of their mental health, there's a tendency to suppress the symptoms and management.."

Participant 4 highlights how professionals, who predominantly represent the 'white' majority, are in a position of power in the context of MHS, where Black men are in receipt of care from those in power, to treat Black men in a way which criminalises them.

Participant 4" I'm not trying to point the finger but historically again it is a matter of diagnosis. Black men come in psychotic, they are dangerous because they smoke what have you and that brings psychosis so they must have issues so there's a range of deep seated issues in regards to how Black men are seen from the indigenous population and I must say most of the clinical assessors ermm are not Black men."

Participant 3 suggests that the tool of labelling people as having "serious mental health" issues can, perhaps further reinforce perceptions of Black men within wider society as being "threatening compared to others" as outlined below:

Participant 3 "A lot of people feel very threatened by people with serious mental illness… and um that can feel more threatening from some people compared to other people"

Participants discuss possible solutions to challenging the perceptions of professionals, and negative narratives entrenched within MHS through the utilisation of a strength based approach as a way of empowering Black men within MHS.

Participant 2 "We should be doing everything towards strengths based approach recognising people with their assets and treating them as equals, which is absolutely key rather than professional knowing all expert and lonely person in need of service, I think they are equal collaborators and people need to be given the opportunity to help empower."

Participant 2 draws on aspects of power within relationships in MHS that can be observed between service users and professionals. The contrasts made between "professionals knowing all expert" and "lonely person" highlight how MHS can perpetuate power imbalances, by viewing service users as not having anything to offer which can fuel disempowerment.

Participant 3 expands on the notion of utilising a strength based approach when engaging Black men, as outlined below by discussing how a sense of optimism is necessary:

Participant 3 "I think a sense of optimism is necessary, I don't feel despairing about them [referring to Black men] I sometimes meet people who are despairing; oh its a Black problem...we are not a million miles away from a solution I don't think Black men are difficult to engage."

The sense of optimism discussed by participant 3 draws on concepts of narrative therapy (Epston & White, 1990) recognising that people's lives are multi-storied. The optimism refereed to reflects this acknowledging that positive narratives can help challenge the dominant negative narratives that MHS can encompass, opening up new possibilities for Black men's lives that are fostered in hope and strengths.

Participant 1 expands on notions of power and strengths based approaches to discuss how MHS should move away from narrow approaches of CBT, which can be problem saturated to models such as the Tree of Life.

Participant 1 "I think they need a service that is not stigmatising that gets away from describing mental health as problems or as a weakness, so moving away from narrow approaches of CBT it means things like the Tree of Life and other forms...changing the offering you know like sports, arts etc.…"

Such a framework has been developed and used successfully to support the well-being of African and Caribbean men which recognises the power within socio-political contexts on well-being (Byrne., et al 2011).

3.3. Theme Two: Re-framing Mental Health Services

This theme incorporates factors related to some of the solutions participants discussed to the challenges in the conceptualisations of the identity of Black men. Discussions were centered around engaging in an alternative way of supporting them within services that draws on principles

of trust, partnerships and systemic ways of working. Participants discuss how drawing on these principles can provide a more holistic service which allows for opportunities to address Black men's needs incorporating the socio-political context of their lives. This includes important aspects of trust which are relevant to engaging Black men within MHS, captured in sub-theme one 'trusted ways to engage'. Linked to this are discussions around the importance of partnering up systematically, captured in sub-theme two 'joining together. Sub-theme three captures the importance of creating opportunities that participants discussed in sub-theme three 'creating opportunities'.

3.3.1. Sub-Theme one: Trusted ways to Engage

Participants discussed principles of trust that are important in engaging Black men with services acknowledging the legacy of distrust which has contributed to the historical and current mistreatment of Black communities. The importance of building connections with Black men through creating trusted places and spaces are discussed by participants as a way of addressing this.

Participant 5 and 8 highlight how MHS can perpetuate the distrust that Black men might experience. This is shown in the extracts below when discussing how service users in their borough might typically have been sectioned and treated for a 'condition' requiring management of treatment. Such a conceptualisation of mental health fails to address Black men's social-political context. This is discussed in terms of how it can serve to create barriers to engagement fueling distrust between Black communities and service providers;

Participant 5 "...so there's an undercurrent of distrust of statutory services, the council, the police and the NHS, so people getting sectioned in [acute MHS provision] umm and yet there is a body of trauma in that community that is not acknowledged or talked about very well so…"

Participant 8 "...the experiences of Black people getting into the system I think it's overly bureaucratic, I think they're suspicious of the system because the system failed them and you know they might not feel the offer is attractive as its about insight into diagnosis."

Participant 4 develops the concept of trust to consider, how often engagement with MHS can perpetuate complex power dynamics amongst Black men and people in positions of power who might predominantly be represented by “white middle class people”:

Participant 4” Do you trust because if you’re brought up in a system where white middle class people are seen as the people who put you in prison or punish you in some way or they come from a position of authority of power, then I think for someone to go and walk in to see a psychologist who is likely to be white and middle class then you know straight away you’ve got a barrier because you’re not the same, your base from where you’re starting from is different.”

This extract highlights how perhaps barriers to engaging with MHS can be intractably linked to power, and differences in intersecting social locations between professionals and Black men which can fuel disengagement. As highlighted by Keating et al., (2002) trust is an important aspect of engaging people from the Black community and participant 7 refers to how trusted organisations can help provide opportunities to bridge people in with services:

Participant 7 “...I support earlier points I made about trusted organisations and how they are acting as signposting...”

Similarly, participant 8 and 1 refer to the importance of MHS being situated in the community to enable trust;

Participant 8 “The focus needs to be on engagement building trust and reaching them in their communities and having those community links, so because communities make people stronger.”

Participant 1 “Well I think it's trying to go back to those grass roots organisations and communities to build on trust...so outreaching into those communities and the people who know most about them are the people who have been in them...”

Participant 1 used an example of an alternative service provision that was offered within the local borough which engaged local barber shops in conversations around well-being. This example demonstrated the power of building services alongside Black men and the community to have a lasting positive impact;

Participant 1" It kind of snowballed and they started doing creating football teams together doing physical activity and are still doing it now. It's not a particularly innovative project but you know it's just one example of how you can get into a community that is hard to access and get people talking about mental health, these kinds of things will have long term impacts."

Alternatives to MHS which incorporate well-being support through a holistic lens have been discussed by Patel and Fatilmilehin (1999). The example discussed by participant 1, supports practice which pays attention to concepts of power moving away from expert-led individualistic interventions (Fryer, 2008) through the use of trusted members of the community being active agents which can contribute to the empowerment of Black men (Fogg-Rogers, 2017).

Williams, Turpin & Hardy (2006) question how institutional practices in MHS fail to meet relevant spiritual, cultural and religious needs. Similarly, participant 3 discussed examples of how Black men had engaged with alternatives to MHS that were outreach based incorporating faith and sports. Such an example suggests that a way to provide more trusted ways of engaging could lie in providing access to help, that is embedded in the community offering non-traditional provisions of assessment and treatment:

Participant 3 "...with this group of people they were coming to first appointments and then deciding it wasn't for them, and that was a lost opportunity but lots of engagement with faith groups, and this kind of boxing group outside of services."

3.3.2. Sub-theme two: Joining Together

This sub-theme builds on notions of trust to consider how participants highlighted the importance of providing systemic interventions, which joined together with communities and community organisations could support intersecting social disadvantage as a way of addressing Black men's well-being.

Participant 6 described how progress can't be made in addressing the inequalities observed within MHS for Black men unless systems, such as local government, NHS, etc. work with local communities:

Participant 6 "So we are never going to make progress in addressing the inequalities unless the system, so you know local government, NHS, Police, others, education etc., work hand in glove with local communities."

The emphasis on the need to incorporate the multiple levels of oppression and discrimination that impacts on help-seeking amongst Black men has been suggested by Myrie and Gannon (2013) prompting systemic and community interventions.

Research by McLean et al., (2003) has indicated that barriers to accessing help for Black communities can be fueled by expectation of racial mistreatment. Participant 6 drew on the importance of systems being aligned to work with Black men to address the multiple social inequalities they might experience. Substantial research has demonstrated that Black men are more likely to experience social inequalities in a wide range of settings such as education (Barnard & Turner, 2011), the NHS (Cabinet Office, 2018) and the Police (Berman & Dar, 2013) prompting a need to offer systemic interventions that address these inequalities.

Similarly, participants 4 and 2 emphasise that tackling the inequalities observed within MHS for Black men requires a joined-up system for tackling the multitude of social inequalities that Black men experience across the lifespan:

Participant 4 "People only end up in the NHS because they have become unwell, so you've got to think from the beginning how do you stop people becoming unwell in the first place and lots of those things are about the social statements of health like jobs, housing, good relationships and you can't tackle them in isolation… it has to be a joined-up system."

Participant 4 draws on the links between multiple social disadvantage that Black men experience within housing and employment (Bhui, Nazroo,

Francis, Halvorsrud & Rhodes, 2018., Cabinet Office, 2018) and the need for systems to be connected in order to address the various social locations that impact on their lives (Crenshaw, 2012). This is because social disadvantage is linked to an increased likelihood of psychological distress (Mangalore & Knapp, 2012; Morgan, et al., 2008; Bhugra & Kamaldeep, 2001).

Participant 2 "So I think that kind of you know trauma informed culturally competent approach needs to run as a thread through pre-child, parenting, early years' services, childhood services, education services emotional well-being services…"

Participant 2 draws on the intersect between 'culture' which links to the identity of Black men and how this should be embedded in systems which support well-being across statutory services such as education, childhood services etc.

Participant 5 went on to describe how the need for a systemic intervention does not lie within commissioning, instead locating the responsibility to make change within the system:

Participant 5 "It's a system issue not a commissioning issue… we have to think and start from every layer. We have to start in schools etc."

Literature by Salwaymn et al (2016) suggested addressing obstacles for race inequality call for a system based approach which incorporates meaningful engagement with minority communities and statutory services however fear and uncertainty on how to do this were key within some of the barriers to change. The externalising by participant 5 could perhaps reflect the uncertainty expressed, which has been discussed by previous research that proposes that those in power can be resistant to change as a way of marginalising minority populations (Connell, 2007).

Participant 5 provides an example of a partnership service that was commissioned between the local authority and third sector organisations as demonstrated in the extract below:

Participant 5 "so this individual service [project name], award winning but keeps a low profile, works with young people with some gang affiliation connection fairly multidisciplinary... It's not exclusively for Black men but it's got a high use for Black men and they partner up with a whole host of organisations. So, statutory, grass roots and it's got better reach into the community."

The example provided by participant 5 highlights that change is possible within a commissioning framework, with partnership working being successful for better reach into the community, particularly with Black men. This was an alternative to solely providing services with statutory agencies that could provide a platform for empowerment, allowing for critical reflection on context and consequently greater control over resources and participation with MHS (Rappaport, 1987). This can act to both benefit people within the community participating in the partnership in enhancing well-being (Harper & Speed, 2012) as well as providing an anchor to engage Black men whom might already be distrustful of services.

Participant 7 described how one of the key factors to align services more systematically involves working towards the same set of outcomes, which would create a culture change that brings on a sense of responsibility between services which is more closely aligned;

Participant 7 "It's important that all providers are working towards a single suit of outcomes rather than multiple and I suppose the culture that we put into place is that my problem is your problem."

3.3.3. Sub-Theme three: Creating Opportunities

Connected to the previous sub-theme 'joining together', participants discussed how opportunities to address social inequalities could provide solutions to addressing engagement between professionals and Black men. They also highlighted how these opportunities could also help increase the proportion of Black men in positions of power, which might allow greater sensitivity towards circumstances and experiences they face.

Participant 8 highlighted the importance of workforce diversity relating to the links it has to engage Black men with mental health interventions;

Participant 8 "...also there's an issue when we talk about role models and engagement having mental health interventions with people they can see relate to..."

Such issues are echoed in research by Keating et al., (2002) which highlights distrust with MHS can act as a barrier to engagement therefore seeing people they can relate to might support engagement with MHS.

Similarly, participant 4 described the importance of workforce diversity in general, and the relevance of teams of staff reflecting the community they serve. Workforce diversity particularly within hierarchical structures has been discussed as one of the contributing barriers to addressing race equality within MHS amongst BME groups (Fernando, 2017; Kline, 2014).

Participant 4 "I am a massive believer of your workforce reflecting your community and my team has always been made up of a diverse group of people…and I do that consciously..."

Participant 1 expanded on workforce diversity in describing how the further up in the hierarchical structures you go the less likely there is to be representation from Black people, which is linked to the inequalities observed within MHS and in leading to a lowering of aspirations for Black men:

Participant 1 "So it's all of those things that perpetuate the inequality [in response to a question about why the inequalities exist for Black men in MHS] there's no aspiration there because even when you look at our big mental health trust we know all the senior managers are mostly white and the junior care workers are Black."

Participant 5 expanded on the notion that workforce diversity amongst hierarchical structures can influence the power to prioritise issues relating to the needs of Black men:

Participant 5 "You have overrepresentation in health care assistants and junior nurses and as you go up the ladder and more and more white and I think a lack of representation going up the ladder represents structures affects how services are designed and shaped."

A lack of diversity amongst hierarchical structures such as commissioning has been highlighted by research as contributing to the obstacles for addressing race inequality (Dreachslin, 2007). As participant 5 suggested, the lack of representation can lead to a lesser awareness and sensitivity towards the circumstances and experiences of Black men which can impact on what provisions are made available. The lack of representation from Black men in hierarchical structures pointed out by the participants, could perhaps reflect the limited opportunities to access material resources across intersecting social context such as education, housing and employment.

Both participant 2 and 7, discussed the importance of creating opportunities systemically by tackling social inequalities through opportunities in education and how this in turn can provide a platform to progress within MHS and hierarchical structures;

Participant 2 "...you know that relates to why very few people are trained in certain professions, if all your judges are white middle class but yet all the defendants are Black men you've got a disconnect straight away… that judge doesn't know that community or why they are standing in front of them… if you think about education then it's the same story and that needs to be tackled, and you can't do that unless people from a young age are given opportunities like the rest of the world."

Participant 7 "...you know the other thing is to encourage more Black men to be clinicians and to be at the front door so they can see likeness, that could start with identifying people also starting at school or university you know identifying groups of Black males that will be able to take on these roles encourage motivate them to be in the mental health arena."

3.4. Theme Three; Power Dynamics and Black Men

This theme explores concepts of power in relation to commissioning. In the sub-theme, 'Power Imbalances in Commissioning' participants provide examples that demonstrate the lack of power Black men hold within these structures. The second sub-theme 'Lack of power to prioritise' draws on the

links that participants made between systems such as policy, politics and evidence based practices, which influence their ability to prioritise the needs of Black men within commissioning structures.

3.4.1. Sub-Theme one: Power Imbalances in Commissioning

This sub-theme explores issues relating to commissioning that participants described which replicated power imbalances that Black men might experience with MHS, leaving them with little or no power to influence the systems in which they operate. Resistance to this was demonstrated through concepts of sharing power, which are linked to principles of co-production and how this can be incorporated into commissioning frameworks to support the empowerment of Black men.

Participants highlighted how many service user forums or feedback groups embedded within commissioning were typically represented by “white females” and rarely involved Black men;

Participant 1 “...but you know thinking about the makeup of that group [referring to a SU group who feeds into commissioning] most of them are white females, I don’t think we have or have ever had any Black men.”

Participant 5 “So in commissioning when you decide on a new service most of the time there will be SU involvement and we tend to use established groups...but in my experience, they tend to have poor representation of Black men. So, it’s easy to do co-production, co-design and not really notice that you’ve not got the right people in the room.”

The lack of involvement within commissioning structures could perhaps be explained by the intersect between ‘race’ and gender which prevents engagement with statutory services. Participant 5 refers to “co-production and co-design” which has been discussed as an important aspect of the Five Year Forward View (NHS, 2015) in establishing relationships with service users and communities in addressing some of the limitations of MHS for Black men. The lack of involvement from Black men within commissioning could be perpetuated by a gender bias which leads to little power to get involved in decision making. This could result in maintaining complex positions of disempowerment which serve to favour western

conceptualisations of well-being embedded within MHS (Mills and Fernando, 2014).

Participant 3 suggests that there is a need to get out into the community in order to support relationship building with a wider range of people, including Black men, as a way of breaking down some of the barriers to engagement in commissioning processes:

Participant 3 "I think there's something in the process of asking what they want and not just relying on the few representatives we need to get out there and get a solid input from a vast range of people"

Participant 4 describes how some of the processes involved in participating in service user feedback groups within commissioning can restrict opportunities for Black men to be involved:

Participant 4 "So we have a service user and career group but it's quite formal so you have to apply to be on it, go through an application process have a DBS check and people do a year and they have a work plan and can you help us with this…"

Using such formalised ways of involving Black men in commissioning groups mirrors narrow models of PPI which are drawn from professionally dominated approaches rooted in consumerist ways of working (Tritter, 2009; Ocloo & Matthews, 2016). Using such formalised ways of involving Black men can create barriers to engagement, particularly when there is already an existing sense of distrust towards MHS (Keating et al., 2002). Such an individual and professionally dominated approach embedded in processes to involve service users in commissioning can fail to attend to the socio-economic contexts that exist for Black men (Williams, Turpin & Hardy, 2006; Wait & Nolte, 2006). Similarly, as highlighted by participants 7 and 2, this creates barriers to engagement within commissioning processes whilst reflecting the reasons why Black men might not engage with statutory services;

Participant 7 "...but you know some of the same barriers exist in feeling that they [Black men] can get involved in helping design services, the same issues apply across the board..."

Participant 2 "...you know if people are voting with their feet to not use the services or they've not had great experiences, they're not going to turn up at your consultation and tell you what needs to be in a service specification."

Despite there being forums that included people from BME SU groups the input they provided remained tokenistic because resources or money being held by hierarchical structures prevented the implementation of ideas or voices being taken forward;

Participant 4 "[referencing a BME SU group that commissioning uses to consult with] they get together and we tend to consult but it feels a little bit tokenistic you know like here they are again asking questions but you're not willing to fund up so it exists but it's not perfect..."

Such findings echo research that has found that often involvement entails little or no power in setting the agenda or decision making within hierarchical structures (Kalathil, 2011).

Participant 6 suggested solutions to address some of the barriers to engaging Black men within commissioning groups, by highlighting the relevance of opening up conversations around racism and identity:

Participant 6 "...we need to start having identity conversations in these schemes and we need to do the same about racism in a non-threatening way and understand its relationship to needs and I can't commission that..."

Participant 6 draws on the links between conceptualisations of identity which has been discussed in research highlighting the need to acknowledge and discuss people's experiences of discrimination within service user involvement forums (Kalathil, 2009). The positioning of this outside of the commissioning role suggests that support is required to manage some of these dilemmas, which has been discussed in previous literature (Kai et al., 2007; Johnson, 2009).

Participants described some instances of taking action towards tackling the inequalities observed with MHS for Black men:

Participant 5 "...bridging in people from outside particularly people with lived experience to engage with service users on the wards to talk to them about how services should be delivered and designed..."

Such action in the example by participant 5 involved principles of co-production that were values based (Vernon, 2011) and centered on concepts of empowerment (Zimmerman, 1990; 1995; 2000) incorporating the direct involvement of service users in decision making (McLean, 1995). As participant 5 outlined, involving "people with lived experience" to discuss how services should be designed creates opportunities to break some of the barriers in power between professional and service user relationships. Similarly, participant 6 discussed the involvement of people with lived experience in designing services as a co-produced activity, this supports notions of co-production that recognises equal sharing of power in decision-making between 'service-user' and provider (Mayer & McKenzie, 2017).

Participant 6 "..we are currently in the throes of co-designing services with careers, family members so looking at the crisis team and involving people with lived experience to obtain their view on how to shape access.."

As participant 4 outlined below, creating roles for people with "lived experience" can be fueled by fear which is perhaps conceivably exacerbated by their diagnostic label or assumptions based on negative narratives. This not only calls for a need to advocate more strongly to challenge some of these misconceptions but also highlights a need for 'people with lived experience' to have catered support to navigate some of the complexities involved in working within hierarchical systems:

Participant 4 "I battled for a co-production lead, so someone with lived experience and they said oh we don't have those kinds of posts...and there were loads of fears around what if they have a break down and I said that could happen to you and I and then they said okay let's do it..."well it's been a bit tricky we have had a few different people in post which tells me its a stressful post as its dealing with lots of people, politics and lots of hoops to jump.."

3.4.2. Sub-theme two: Lack of Power to Prioritise

This sub-theme outlines the power situated in wider influences such as policy, politics and research which participants discuss as a challenge in addressing the needs of Black men within commissioning infrastructures.

Participants situated power to influence decisions and MHS within wider systems such as policy, as demonstrated by participants 1 and 3 below;

Participant 1 "In the NHS you prioritise what NHS England tell you to do, so the five year forward for mental health that's keeping us pretty busy at the moment..."

Participant 3 "Well changes at the moment are very much based on the five year forward view of mental health so much developments are in response to that..."

Both participants situate changes to address the challenges to commissioning services for Black men in the Five Year Forward view (DoH, 2015). Although the policy highlights the need to address the inequalities for Black men it is subsumed under catering to services for the majority. This is, perhaps, reflected in the way that services are delivered, which serves to marginalise the needs of people from minority groups as discussed by participant 6;

Participant 6 "The NHS is firstly a national service so we get dictates from national what to do and what to prioritise and they are poorly attuned to local populations and using big clinical organisations to deliver make it very difficult to consistently have things that are more adapted to different groups..."

Marginalisation of policy attention is an obstacle which has been discussed by Salwaymn et al., (2016) in addressing the needs of BME groups within commissioning infrastructures. Little attention within policy to make changes to services for Black men can perhaps lead to commissioners having less power to make changes locally within services.

Similarly, participant 5 discusses how wider political issues within society, such as Brexit [1] takes precedence within government which results in little or no power to concentrate on the needs of Black men within MHS;

Participant 5 "I mean in the NHS a clear message from the central a national and Theresa May has been talking about race and mental health but obviously, the government is tied up in Brexit …"

The extract demonstrates how the power to make changes is situated in needing a clear message from central government, resulting in little authority for commissioners within their roles to make changes to service provision for Black men. Participant 2 expands on this notion of power being tied to self-interest and politics which is echoed in the literature (Rutter, Manley, Weaver., et al., 2004; Tritter, 2009). The lack of influence by wider systems such as policy and politics affords little power to prioritise Black men's needs which perpetuates the disempowerment that already exists within MHS:

Participant 2 "Millions and millions of pounds is tied down to conventional ways that people are married to do things, because of self-interest and politics..."

Many participants drew on the "equality impact assessment" as a formalised process which is embedded in the Equality Act (2010) that is intended to assess how any changes to service provision could negatively impact on any group or persons that have protected characteristics;

Participant 1 "any changes we do you have to do an equality impact assessment and think about how this will adversely impact on one group with protected characteristics..."

Participant 4 "...there is a formalised process and a format so you have to do an equality impact assessment, how meaningful is it well it depends on how well it is done and if you turn over every stone and speak to everyone..."

Such a formalised process can perhaps lead to a fragmentation of priorities following a narrow legal interpretation of how to address the challenges to commissioning services for Black men, which is complex and situated within a socio-political context. The emphasis on complying with the legality

of equality for all which has been discussed by Ahmed, (2007) can prevent changes being seen beyond this, to an approach which draws attention away from understanding how to transform services in a more holistic way.

Similarly, participants referred to research and evidence bases which hold power to influence how services get commissioned or not and the tensions between how this restricts changes being made for service provisions for Black men.

Participant 3 "I guess the whole thing of cultural sensitivity of services does come in and we struggle with that, so we know there's good evidence for a service and it's something that people want. It's a really difficult funding conversation to have."

Participant 4 "There's something interesting about our duty to deliver some evidence based services and how that tension between being evidence based and culturally sensitive sometimes clash..."

Both participants 3 and 4 discussed the dilemmas between the validity of evidence base which favour scientific and medical approaches (Glasby & Beresford, 2006). They drew on how the evidence base clashes with 'culture' which has been highlighted by Gupta, (2007) in how it typically does not reflect diverse populations, questioning the process of this method in its influence in making decisions within commissioning structures.

Participants call for some freedom from structures to be able to make changes to decision making with regards to commissioning services for Black men;

Participant 6 "I think one thing we need is to have some form of evidence base delivering services however social prescribing although it has a limited evidence base we know from experience it works so allowing commissioners to deliver more social prescribing and things like that..."

Participant 7 "I think you need to be granted some independence from centrally targeted initiatives some more genuine local approach you know localism and believe in the greater good"

As participants 6 and 7 outline some flexibility within their role would allow commissioning to cater services more locally which could open up possibilities to genuinely ‘co-produce’ services that are aligned with local community’s needs.

[1] During the period of data collection, Brexit was still unresolved politically within the UK and Teresa May was the Prime Minister in the UK.

4. FURTHER DISCUSSIONS EVALUATION AND IMPLICATIONS

4.1. Overview

This chapter builds upon the analysis and discussions in the previous chapter through further reflections which evaluate this research and consider implications with recommendations.

4.2. Revisiting the Research Aims and Further Discussions

The research aimed to explore how commissioners conceptualise the structural and social issues that are relevant when developing services for Black men, and how these issues get drawn upon in commissioning MHS in the NHS. The analysis revealed that participants conceptualised some of the limitations of current MHS using an intersectionality framework (Crenshaw, 2012). They highlighted the structural and social issues to understand how Black men's mental health might be conceptualised and how this might impact on engagement with services. These issues are discussed within theme one 'challenges to commissioning mental health services'. This incorporates intersecting locations that participants drew upon such as; gender, 'race', and social disadvantage which they described as being linked to Black men's identity and how this can interact with engagement which is captured within sub-theme one 'identity mental health and engagement'. Intersectionality provides an understanding of how constructs relating to maleness and 'race' can disadvantage Black men in seeking professional help for psychological distress (Neighbors & Howard, 1987). Research which explored constructions of hyper masculinity provides evidence to support how Black men adopting a persona of being in control to protect against societal stressors and negative perceptions can help explain why Black men might be less likely to seek professional help (Myrie & Gannon, 2013). Participants drew on these ideas, highlighting how conceptualisations of mental health for Black men are bound by discourses of oppression and discrimination (Myrie &

Gannon, 2013) which play a role in understanding the inequalities observed amongst Black men in MHS (Bebbington et al., 1994; Bennett & Dennis, 2000) and some of the challenges in providing MHS. Although it is helpful to understand how these conceptualisations might guide thinking about identity and mental health for Black men in considering some of the challenges of providing MHS, it is important to exercise caution about generalisations framing Black men as a distinct group. As the analysis highlighted assuming homogeneity between Black men can fail to take into account distinct differences in language, histories and culture that form people's experiences. Therefore, it is important for services to incorporate this understanding in order to develop and provide well-being support that accounts for these distinct differences in people's experiences as discussed by Cole, (2009). Issues relating to the homogenisation of people from BME backgrounds have been echoed by many researchers (e.g. Patel and Fatimilehin, 1999; Feagin, 1984), highlighting how this can engender racism, discrimination and subordination. It is therefore important that distinct cultural differences between Black men are understood when applying the learning from the findings. This is because assuming universality between Black men can fail to pay attention to the different language, contexts and histories that form their experiences. For example, a man from Ghana might have a varying linguistic description for his well-being compared to say a man from Barbados due to the differences in the language they speak, as well as the different experiences in their historical context. Therefore, adopting a homogenous viewpoint can fail to acknowledge the diversity between the varying languages and histories that form part of their experiences. The failure of services and professionals in detecting subtle differences between Black men can lead to broad genralisations being drawn propagating racism and leading to unhelpful sources of support being developed. The intersectionality framework (Crenshaw, 2012) could be useful in providing professionals with principles that draw on various aspects of Black men's experiences and social locations to provide an understanding of how various factors such as 'race', gender, and social disadvantage can impact on well-being.

In line with the intersectionality framework (Crenshaw, 2012) participants also drew on wider social disadvantage, as highlighted in research showing that Black African and/or Black Caribbean people are more at risk compared to their White counterparts of being in persistent poverty (Cabinet Office, 2018) and 10-20% more likely to be unemployed (Berthoud, 1999). Studies such as these are integral to understanding how such social locations can impact on identity and well-being needs. More recently a review from The Public Health England (PHE) has published findings that mortality risk from Covid-19 is higher amongst Black, Asian and minority ethnic (BAME) people compared to their white counterparts (PHE, 2020). The review highlights that the impact of Covid-19 replicates existing health inequalities and in some cases exacerbating them. These experiences of disadvantage have been discussed by Bryant-Davies & Ocampo, (2005) as causing threats to personhood and to a sense of self and well-being. However, the biomedical model is limited in terms of attending to any social or contextual factors that impact on well-being through the focus on diagnosis and deficit-based understandings of mental health. This calls into question the focus on biomedicine embedded within MHS and its applicability to supporting Black men's needs, as discussed by Williams & Garner (2002). The biomedical model which frames mental health from a limited perspective, categorising sets of behaviors through diagnosis can fail to attend to the wider disadvantage that can impact on well-being. The treatment options available within MHS, such as medication and talking therapies such as CBT, which focuses on changing unhelpful thinking patterns related to behaviours and emotions, can draw attention away from addressing wider social context. Crenshaw's (2012) framework of intersectionality can be applied to understand how categories of identity, such as poverty, race, gender and education, can overlap with health status for Black men thereby impacting on well-being. Such conceptualisations are important for services to consider in relation to how they can adopt practices that are exclusionary through the focus on western conceptualisations of well-being which favour diagnosis (Mills &

Fernando, 2014), leaving Black men in a position of disempowerment once in contact with MHS (Fernando, 2017).

Building on the challenges to commissioning MHS participants also drew on perceptions amongst professionals, and more widely in society, that can influence the way Black men might be treated once in contact with services, which are captured within sub-theme two 'Narratives influencing mental health'. Discrimination and racial stereotyping by professionals have been linked to problematic societal discourses featured in the media (Alexander, 2008; Bhui, 2003; Gunter, 2017) and can lead to a spiral of either being reluctant to seek help or increasing the risk of coercive treatment (Keating et al., 2002). This, married with current mental health provisions being disconnected from conceptualisations of identity for Black men, can be argued to be a mechanism of social control (Fernando, 2017), overlooking the sociopolitical context which can serve to maintain dominant hierarchies which favour western conceptualisations of well-being (Mills & Fernando, 2014). Participants identified a need to adopt a more holistic approach which is strengths-focused drawing on ideas from liberation psychology (Martín-Baró, 1994), which has been shown to be effective in supporting the well-being of African and Caribbean men (Byrne et al., 2011). Participants identified issues that would fit into a narrative therapy approach (Epston & White, 1990) that could be relevant for us within mental health services as a way of acknowledging strengths-based narratives that could provide Black men with a different way of thinking about themselves. This could open up new possibilities to challenge the deficit focused models that are entrenched within MHS that could enhance well-being. Allowing strengths-based narratives to emerge could also support professionals and wider society to perceive Black men in a way which moves away from the dominant negative stereotyping frequently featured in the media (Alexander, 2008; Bhui, 2003; Gunter, 2017).

Participants spoke of some of the potential solutions to addressing the structural and social issues that impact on Black men's lives, which require a need to 'reframe mental health services'. These are captured in Theme

Two. This theme incorporates important principles of trust that participants described that would enable Black men to engage with MHS, included in subtheme one ‘trusted ways to engage’. Trust as a concept has been discussed by Keating et al., (2002) in understanding its relationship to preventing help-seeking amongst Black communities, participants echo an undercurrent of distrust that they suggest Black men might hold concerning services, including MHS, the police and social services and how professionals representing the ‘white majority’ in positions of power might perpetuate disengagement. Participants suggested that in order to enable Black men to rebuild their trust with services they will require the help of the community and trusted spaces. Such discussions are echoed in research by Salwaymn et al. (2016), which identifies a need for commissioners to enhance meaningful engagement with minority communities. Their findings also suggested a need for more systemic interventions in partnership with community organisations, which is echoed in sub-theme two ‘joining together’, building on notions of trust discussed by participants as being important to incorporate with community organisations as a solution to providing MHS for Black men which address some of the intersecting social disadvantages that create barriers for accessing wellbeing support. This includes a need to address multiple social inequalities across various systems that span across the lifespan. Such a joined-up approach could provide opportunities for empowerment for Black men, providing hope once in contact with MHS and allowing critical reflection on their socio-economic context (Rappaport, 1987), enabling a greater sense of control over resources and participation. Despite this, a report published by NHS England in 2018 highlighted that little progress had been made by commissioners in consulting with VCSE’s, suggesting that there is a wide variation in engagement which points to other factors potentially contributing to the lack of a joined-up approach. One of these factors could be related to a lack of diversity within the workforce in the NHS in relation to Black men and positions of power within hierarchical structures captured in sub-theme three, ‘creating opportunities’. Participants spoke of how opportunities to tackle some of the wider social inequalities can provide

opportunities for Black men to hold more positions of power which could influence decision making within services, opening up possibilities for incorporating socio-economic context into service provisions. Developing opportunities for Black men through providing access to resources in order to support structural changes in power and hierarchies within the NHS could provide meaningful and sustained changes, as discussed by Kalathil (2009). Increasing diversity within hierarchical structures could also provide opportunities for 'knowledge-based practice' (Glasby & Beresford, 2006) to emerge as a way of shaping MHS, which are often dominated by individualistic notions of the person (Kirmayer, 2007), thereby locating socio-economic problems within the individual (Blackman, 2007).

The final theme 'Black men and Power Dynamics' highlights concepts of power embedded in processes within commissioning as well as in wider systemic structures such as policy, politics and evidence based practices, which can serve to maintain the interests and power of professionals and the wider system (Rutter, Manley, Weaver et al, 2004; Tritter, 2009). Under the sub-theme 'power imbalances in commissioning' participants described processes in commissioning structures, as well as constructions of 'race' and gender intertwined with complexities of social disadvantage which can prevent Black men from being involved in decisions regarding service design and delivery. Although co-production as a concept can be a way to support Black men to be more involved in commissioning by sharing power and decision making between 'service users' and providers (Mayer & McKenzie, 2017) the analysis revealed that this is, in reality is a lot more complicated to achieve. Firstly, progress in addressing the lack of participation from Black men would need to be focused on tackling systemic and social factors, which perpetuate the problems of participation in commissioning forums (CQC, 2011). Secondly, the models of PPI which are often embedded in narrow models of consumerism (Tritter, 2009) would need to be reviewed, in order to avoid any further detrimental effects on Black men (Kalathil, 2011). Such narrow models of engaging Black men in commissioning structures can serve to reinforce notions that they are 'hard to reach' (CQC, 2010; Stuart, 2008) which can not only serve to fuel

experiences of discrimination with the ‘unequal’ terms they might be asked to be involved in (Kalathil, 2009).

The sub-theme ‘lack of power to prioritise’ builds on concepts of power embedded within wider structures that can serve to privilege particular groups (Atkins & Chatto, 2007) and that exclude Black men. The analysis revealed that participants situated power within wider processes such as; policy, politics and evidence based practice. Neglecting policy related to ethnic diversity has largely been acknowledged in literature (Salwaymn et al., 2016; Anionwu & Atkins, 2011), which echoes the findings that reveal Black men are being marginalised from getting involved in commissioning structures. Failure to involve Black men consequently affords them little power to have any input in developing MHS provisions. Similarly, evidence based practice which relies on randomised, controlled studies often excluding diverse populations from their samples (Gupta, 2007) can serve to negate the needs of Black men in service development. As the analysis revealed, participants situated power in evidence based practice to support their commissioning decisions, but this method can be questionsed as the samples that are generally used in the studies rarely feature diverse populations including Black men. This can serve to reinforce individualised notions of a person (Kirmayer, 2007), which can fail to address the intersecting locations of Black men’s experiences that are linked to structural and social inequalities that impact on their lives (Kimberlee, 2013; Kings Fund, 2017). Further research that involves building on the evidence base to support more systemic and community interventions could be helpful in developing appropriate service provisions for Black men. The analysis also revealed that there is a need to recognise ‘knowledge-based practice’ (Glasby & Beresford, 2006) which values the expertise that Black men hold in providing input on how to develop appropriate service provisions. Increasing roles such as ‘expert by experience’ and supporting relationships with community organisations could provide valuable opportunities to empower Black men within commissioning structures to contribute to decision making processes. This approach could help enable and facilitate change by recognising assets

and resilience (Vernon, 2011) amongst Black men to support the integral part of the NHS Five Year Forward View (2015) achieve some of its goals of establishing co-production within commissioning processes.

4.3. Methodological Limitations

I acknowledge that a weakness of this research is the omission of participant characteristics or 'demographic' information, which might help 'situate the sample' (Fischer & Rennie, 1999). Gathering such information did not feel fitting with my research questions, which were focused on understanding how commissioners conceptualise the structural and social issues relevant in developing services for Black men. The demographic information might have provided some understanding of how certain characteristics, such as gender or ethnicity might have influenced what the participants said, it was beyond the focus of the questions taken in this research. Additionally, commissioners spoke about sensitive topics such as 'race', racism and issues within the context in which they work in, given the small sample it felt appropriate not to include 'demographic' details in order to maintain anonymity.

The flexibility of TA allowed for an exploration of conceptual issues using an intersectionality framework (Crenshaw, 2012) related to challenges commissioners reported in developing services for Black men. Thematic analysis aims to generate an understanding of patterns across data (Braun and Clarke, 2006). However, the use of this might have resulted in a loss of subtlety; an attempt was made to account for the similarities as well as differences in participants accounts. Despite this it is important to acknowledge that due to the focus on the research question and process of analysis, subtle data on the challenges and dilemmas commissioners reported might have been missed. In particular, the challenges that commissioners reported in relation to their role (as outlined in section 3.1.1.). Highlighting challenges to the role and frustrations that are experienced with juggling a multifaceted position which seemingly holds power could have provided some insights into the barriers to addressing

changes to service development for Black men within the MHS. Further research could explore some of these issues focusing on commissioner's experiences of their role and the challenges they face in implementing change within the wider system.

The decision to apply thematic analysis was with the aim of gaining a general understanding of the shared challenges that may be experiences by commissioners within NHS settings. While it may be useful to consider alternative forms of analysis, it was felt that thematic analysis was appropriate in answering the research questions for this study.I acknowledge that using a critical realist position may not be sensitive to how power flows through systems and how language can serve to construct sets of relationships and how this might in turn position people and their ability to make changes.

While presented as naturalistic, interviews are not the same as conversations that occur naturally (Howitt, 2010 p62), which means that often people are more likely to develop ways of speaking that may portray themselves in a positive way. In particular, because participants were asked to talk about their attempts at tackling the inequalities for Black men, they may have had a tendency for positive self-portrayal. However, despite the limitations discussed above, there were strengths in this method as it allowed for common themes to be drawn together, through a semi-structured interview schedule which complemented existing literature relating to some of the conceptual issues surrounding mental health provisions. In addition, it permitted recommendations to be made that participants could take forward into their role to facilitate meaningful engagement with Black men within commissioning processes.

I have reflected on the process of interviewing up, so the process of interviewing people in a position of seeming power to influence service development within the MHS. I have considered how this might have influenced my ability to probe during the interviews which could in turn

have influenced the richness of the data obtained. For example, I recall initially feeling quite intimidated when contacting commissioners for the study, and consequently when approaching the interviews. This was perhaps exacerbated by messages I received from others, such as my supervisor, peers and colleagues at my work placement who I had informed about the research. Reactions included a range of being surprised, impressed and curious about the outcome of the interviews due to ideas they held about the responsibilities commissioners held with regards to decision making within MHS. These reactions often included messages that reinforced power being held within the commissioning role. After completing the initial interviews I was surprised at how I had changed my viewpoint on the power that commissioners held especially, as descriptions and messages about who held power varied greatly from my initial thinking process. Therefore, the impressions and assumptions that I had formed initially might have influenced the data obtained.

In recognising that the inequalities for Black men in MHS is situated in socio-political context involving a lack of power once in contact with services and involvement of commissioning, I acknowledge that failure to include Black men within the research project can serve to replicate existing power imbalances. Although the decision was rooted in attempting to explore challenges of commissioning services for Black men, from those who have a role in decision making I acknowledge that the agenda and direction for the research was selected by myself as a Trainee Clinical Psychologist whom is in a position of power. Therefore, the limited input that Black men had within the research project might replicate some of the power imbalances that already exist for them within services and commissioning structures. This has made me consider how such exclusion might play out in many different contexts within Black men's lives as discussed in the findings including employment, the education system and social care. This has made me reflect on the importance of both acknowledging my position of power as a 'white psychologist' and the need

to create ‘allyship’ with Black men in order to ensure their input is incorporated into the project. In light of this, opportunities to review the analysis and key findings will be discussed with my supervisor as outlined in section 4.3.2.5. Furthermore, I reflected on some of the processes that I experienced in the early stages of developing ideas for the research including having the desire to include Black men in the research but, receiving several messages that I should avoid it as it can be ‘hard to do’. This coupled with messages that processes with the university examination system were not clear on how to achieve inclusion whilst being appropriately assessed on my individual performance. These conflicting messages regarding the encouragement to include, yet the lack of processes set up to facilitate this perhaps influence my decisions. This made me consider how these messages often mirror several processes in platforms that advocate for more inclusion, such as commissioning structures which can then unfortunately result in exclusion.

4.4. Implications and Recommendations

In this section I will summarise implications of the findings and include ideas for ways that psychologists can support this as well as the implications the results have in relation to commissioning practices and more widely.

4.4.1. Implications

4.4.1.1. Further Research

As acknowledged in the analysis Black men’s needs and views are often excluded from various avenues, such as MHS, research, and commissioning structures where decision making regarding service provisions take place. The findings highlighted the relevance of understanding structural and social barriers to engaging with service provisions and the importance of working systemically and in partnership with community organisations in order to support engagement with MHS

and commissioning structures. Participants highlighted the importance of involving other systems, such as social care, housing, and education in order to address the needs of Black men and the relevance of working in partnership with community organisations who have better engagement with Black men to support this approach. Since the research was focused on obtaining the views of commissioners the perspectives of other stakeholders were not sought. Therefore, further research which explores the views and understandings, through interviews of 'stakeholders' could provide further insights into some of the issues discussed. The research could explore challenges to participation from service user's perspective, whilst investigating community organisations experiences of partnership working. This would enable a more comprehensive exploration of the issues highlighted in this research and shed light on the different perspectives of those implicated in the solutions to tackling those issues.

4.4.1.2 Reviewing Practices used within Commissioning Processes

The analysis revealed that barriers to involve Black men in commissioning structures that support decision making in service development were inextricably linked to the intersectionality between 'race', gender and socio-economic inequalities. The obstacles reflect wider oppressive practices that impact on Black men's ability to engage with services and provide them with adequate resources to manage their well-being. Failure to address this will prevent sustainable change and maintain hierarchical power structures that can serve to exclude minority groups, such as Black men (Atkins & Chatto, 2007). Policy recommendations have highlighted the need to involve BME communities within commissioning processes (Mind, 2013; Joint Commissioning Panel, 2015). Therefore, NHS mental health commissioners have a responsibility to review their practices, policies and develop mechanisms within the process to guard against disadvantaging any section of the community (MacPherson, 1999). Addressing some of the barriers would require commissioners to actively engage with community organisations who have relationships with Black men as a way of building trust. Building trusted relationships with community organisations might

allow for Black men to feel more able to get involved in user participation forums. Another key aspect of tackling the obstacles would be to provide Black men with material incentives such as payment for their time and expertise in providing their input. Changes in the processes to support engagement through building trust and actively considering the socio-economical context of Black men's experiences could enable co-production in developing service provisions. The implications of the findings mean that if the processes involved in commissioning are not examined this will lead to a maintenance of the inequalities for Black men in the MHS. This unfortunately contrasts with values embedded within the NHS constitution for England, which outlines that NHS services have a wider social duty to promote equality and be responsive to outcomes that are not in line with the rest of the population (DoH, 2015).

The analysis also revealed that overall hierarchical structural within NHS services and more widely in society would need to be challenged in order for processes and policy to be effectively implemented. This is because Black men are unlikely to occupy positions of power within systemic structures such as policy, politics and research perhaps leading to a lack of prioritisation towards their needs and issues. It is therefore important to ensure that more Black men are involved at the appropriate level of decision making. Providing equal opportunities for Black men to occupy such positions would require services to join up systemically to ensure that health and social care needs are appropriately addressed for an early age. Ensuring Black men have equal access to education, health and social care could provide them with opportunities to ensure needs across intersecting social context that can impact on well-being is met.

4.4.1.3. Conceptualisations of Mental Health and Identity for Black Men

Analysis revealed that participants conceptualised the challenges in providing appropriate services to support the mental health of Black men from an intersectionality framework (Crenshaw, 2012). This is in contrast to the majority of current mental health provisions available which are formed

on a basis that mind and body are two separate things (Mehta, 2011) and can be argued as being an institutionalised way of thinking transported from western countries that ignores the conceptualisation of mental health and identity amongst Black men (Mills & Fernando, 2014). This can both prevent engagement and help seeking as well as increase the risk of Black men being more likely to enter services through coercive settings and less likely to receive psychological support (Keating et al., 2002), resulting in a maintenance of the consistently demonstrated disparities in access to MHS (Jones & Berry, 1986; Health Development Agency, 2001; Fearon et al., 2006; Cabinet Office, 2018).

The analysis revealed that conceptualisations of mental health and identity should factor on several intersecting locations such as gender, 'race' social context and disadvantage. MHS within the NHS have a shared responsibility to review and provide adequate care provision for Black men that are more suited to supporting well-being which incorporates factors such as the influence of stressful life events (Watkins, Walker & Griffith., 2010), providing support that is inclusive of cultural, spiritual and religious needs (Williams, Turpin & Hardy, 2006) and constructions of masculinity that are situated in Black men's context (Myrie & Gannon, 2013). This requires a joined-up approach that is systemically coordinated (Fitzpatrick et al., 2014) involving the input of Black men. As the analysis highlighted that engagement with commissioning structures might be influenced by factors such as distrust with services, gender bias and socio-economic disadvantage it is imperative that commissioners actively engage with community organisations whom actively engage with Black men. Commissioners have a prime opportunity to support the implementation of co-production (DoH, 2015) through building partnerships with community organisations so they can contribute to decision making.

This will both enable the empowerment of Black men within hierarchies of power intrinsic within MHS (Rappaport, 1987) as well as support fractured relationships between service users and services. A failure to do this

effectively will maintain hierarchical structures that locate the problems in people (Boyle, 2006) embedded in MHS, which hold power to marginalise minority populations such as Black men (Connell, 2007).

4.4.1.4. Addressing Power Dynamics

The analysis revealed that power imbalances are still at play within commissioning processes and wider structures that shape decision making, such as research base, policy and politics, which leave Black men with very little influence over decisions regarding how services should be shaped to address conceptualisations of their wellbeing and identity. Since MHS are situated within broader structures (Smail, 2005) and commissioners have an imperative role to support the assessment of healthcare needs within a population, secure those services and monitor and evaluate the outcome (Woodlin, 2006) they have a responsibility to support the co-production of services that can help address some of these conceptual issues. In line with policy (NHS, 2015) and existing recommendations by Salwaymn et al., (2016) that calls for a system based approach which incorporates meaningful engagement with minority communities, a clear national direction with integration of commissioners working alongside providers, communities, service users and researchers could provide a platform for empowerment amongst Black men to take place. As identified in the analysis building trust with the help of community organisations is an important aspect of developing relationships with Black men, in order to bridge in diversity of voices amongst decision making forums. In addition to this evidence based practice that is inclusive of participants whom represent minority groups, such as Black men would provide helpful insights into decisions regarding service development. Such opportunities could recognise the diverse systems of knowledge to stimulate ‘knowledge-based practise’ (Glasby & Beresford, 2006). Allowing opportunities for Black men to participate through research and providing their knowledge of experiences and needs from services could provide a space of reflection to examine the current practices within MHS. Working together in this way could allow new knowledge to emerge in order to

address holistic needs more appropriately (Kirmayer, 2012). Failure to create space and opportunity to make a meaningful contribution to new knowledge can essentially lead to the maintenance of 'scientific and medical approaches' which are limited in their validity for addressing the holistic needs of Black men (Gupta, 2007) reinforcing individualistic notions of the person (Kirmayer, 2007). This will essentially lead to maintaining overt or covert practices within the NHS that reinforce individual prejudice and are being reinforced by them in turn (Sivanadan, 1999).

4.4.1.4. The Role of Clinical Psychologists

In considering the implications of this study I will now turn to how Clinical Psychologists might support the inclusion and involvement of Black men within the commissioning process within the NHS. Statutory requirements, health authority recommendations and discipline specific recommendations (e.g. BPS, 2010) require Clinical Psychologists to ensure that provisions of MHS are accessible, adequate and appropriate to all clients (Patel, et al., 2000). Since the analysis revealed that the conceptualisation of wellbeing was centered on intersecting locations within Black men's identity, it is imperative to facilitate discussions involving Black men into how services may be structured to address these issues. Psychologists have a responsibility to support aspects of commissioning through principles embedded in the term 'activist-practitioner' (Zlotowitz, 2013) and empowerment (Rappaport, 1987) to provide opportunities for Black men and VCSE's to be involved and critically reflect on their context, as well as contribute to co-producing solutions to providing more accessible resources to help shape mental health provisions. One of the key findings from the analysis is that commissioners could benefit from support to implement co-production within the commissioning process to help establish relationships and consider processes to support the active involvement of Black men and VCSE's. Clinical Psychologists are well positioned to utilise their skills in leadership, knowledge of research and theory to support ways that they can be involved in the commissioning process and beyond. Some specific suggestions are made below;

1. Clinical Psychologists position themselves within local CCGs to help support broader thinking of the issues related to Black men, and inequalities in the MHS and support relevant professionals to consider how they can shape service development to be more inclusive and appropriate. This could involve supporting commissioning in decision making by critically appraising evidence based practice, sharing their understanding of the psychological impact of social inequalities and discrimination in order to help support service development.
2. In line with recommendation number 1, Clinical Psychologists aligning themselves within CCG's to support the establishment of partnerships and relationships with local community organisations. Supporting key professionals within this context to invest time in building relationships with VCSE's that might have better in-reach to communities that have relationships with Black men.
3. In line with recommendation number 1 and 2, facilitating conversations in user participation forums between commissioners, Black men and community organisations in community settings around experiences of MHS and difficult topics that might emerge.
4. Supporting processes within commissioning to enable them to be more accessible, considering alternative locations that meetings can take place that are more embedded in the community and alongside trusted community figures.
5. Training and orientation of Clinical Psychologists to be aligned within broader macro system settings, for example NHS England and CCG's in order to support the principles of 'activist-practitioner' as a way of attempting to address societal issues that affect the overall mental health of Black men.
6. Clinical Psychologists to inform and align themselves appropriately in order to evaluate alternative methods of support within MHS that incorporate socio-economical context that can support practices that empower Black men.

4.4.1.5. Dissemination

One of my aims was to stimulate conversation about addressing the inequalities Black men experience in the MHS with commissioners. In addition to this my intention is to prepare feedback and guidelines to disseminate to commissioners to help support implications and recommendations resulting from the research. In line with this I propose to draw on key issues resulting from the analysis, and recommendations to prepare some guidelines to initially use to share and consult with Black men who have accessed MHS within the NHS. These key issues include obstacles to engaging with MHS, and commissioning infrastructure's which serve to exclude Black men from accessing services and contributing to any change in service development. This is to ensure their voices and input gets incorporated into the recommendations and any implementations that may follow. I plan to use my relationships and contacts in my role as a community psychologist at MAC-UK to set up meetings with partnership organisations that might have better in-reach with Black men within the community.

In addition to this I note that it is important for this study to be accessible to a wide audience to highlight the challenges in commissioning services for Black men as well as the opportunities to address this more systematically opening up possibilities for change. In order for this to be achieved it is paramount that the results and recommendations alike are shared with other professionals and colleagues within the wider NHS context. My intentions are therefore, to publish the findings in a peer-reviewed journal.

4.5. Evaluation and Critical Review

4.4.1. Evaluating Qualitative Research

Notions of reliability, validity and replicability that are broadly applied to evaluate quantitative research are not fitting for a qualitative research paradigm (Smith et al., 2009). I draw on a number of authors who have

published guidelines on the evaluation of qualitative research (Marshall, 1996; Parker, 2004; Spencer & Ritchie, 2011; Yardley, 2000).

4.5.1.2. Contribution

For Spencer and Richie (2011) contribution broadly entails the value and relevance of the research, with regards to the development of theory, policy and practice. This research sought to recruit participants who had some responsibility in commissioning services within London NHS settings. This decision was taken in recognition that NHS services in London serve a diverse range of communities, a strength in this is that commissioners were recruited from a wide range of areas within London, which portrayed an array of views across different boroughs, enabling insights into the research question (Marshall, 1996). The small sample enabled a rich, nuanced and comprehensive analysis of the data (Smith, Flowers & Larkin, 2009) which could contribute to understanding some of the challenges of commissioning services for Black men offering some insights into how this can be addressed. By examining some of the processes involved in commissioning this study can provide some valuable perspectives on a previously unexplored area. Due to the specific population within this research (Black men) it is recognised that caution is required in extending this learning to other populations whose experiences of MHS and conceptualisations of well-being might be very different. As such, this study does not aim to make any generalisations beyond the population discussed, for example to other minority groups of men or Black women, owing to the subjectivity inherent in qualitative analysis, constructions and experiences of well-being.

I acknowledge that by focusing only on the perspective of commissioners, the wider picture of why the inequalities exist for Black men within the MHS is narrowed. This is because the nature of the inequalities is multifaceted, intersecting across various systems such as the criminal justice system, the education system and therefore limiting the sample does not reflect the complex nature of the struggles that are experienced by Black men within

various contexts. However future research could contribute towards understanding the nature of this by examining practices within other systems that might contribute to the inequalities. I also acknowledge that the NHS is a national service which spans the UK and therefore focusing on London based CCG's might not reflect the diverse range of views on the challenges of commissioning services for Black men. Further to this, using a snowballing method might have identified like-minded individuals whose ideas and experiences might have echoed similar issues. However, due to time restrictions I was unable to extend recruitment beyond London, future research might be helpful to provide supplementary insight into some of the challenges.

4.5.1.3. Credibility/ coherence, transparency and rigor

A significant element of qualitative research involves warranting the plausibility and credibility of its claims (Spencer & Richie, 2011). In an effort to ensure this I initially presented my rational and research topic to my supervisor who confirmed the applicability and suitability of the focus of my research. Other raters were not drawn upon to provide inter-rater reliability however the extracts and themes were discussed with my thesis supervisor as a credibility check.

Transparency can be thought about in describing the methods used and in detailing every stage of the research process and clarity of the final report and the presentation of verbatim quotes from the interviews. I have attempted to present a snapshot of a transcription with coding and themes as raw data (presented in appendix F) in keeping with this. Furthermore, appendices include the interview schedule, along with extracts of the interview in the analysis chapter.

4.5.1.4. Sensitivity to context

Sensitivity to context requires that relevant literature is utilised as part of being sensitive to the socio-cultural context of the research. This was attempted through the formulation of the idea for the study and the

introduction by consulting literature that has been conducted into the reasons for the inequalities for Black men within the MHS, as well as broad challenges to commissioning services for BME groups. However, the literature revealed an absence of research exploring the challenges of commissioning services for Black men, consequently the literature that was drawn upon to understand some of the challenges within commissioning processes might represent my perspective as a researcher on the challenges around this topic. Other attempts to maintain sensitivity included providing choice of the location and time to the participants for their interviews in allowing comfort and ease about the topic area whilst being sensitive to their context of working in a highly stressful time pressured environment.

4.5.1.4. Impact and importance

It is suggested that true validity involves the extent to which research is useful and determined by its ability to communicate to the reader something of importance. As discussed in the introduction, the rationale of this study was to explore how commissioners conceptualise the structural and social issues that are relevant when developing services for Black men and how these issues get drawn upon in commissioning MHS in the NHS. By utilising literature and theoretical understandings of such conceptual issues linked to the construction of identity using an intersectionality framework (Crenshaw, 2012) I was able to examine some of the challenges surrounding implementing structural and social issues in service development within commissioning. By exploring this I was able to situate some of the challenges of commissioning services for Black men in relation to this and how it has translated into the commissioning process. Examining this has provided some opportunities to address the challenges which could be utilised by Clinical Psychologists and commissioners to facilitate meaningful engagement of Black men in supporting service development.

4.6. Reflexivity

I aimed to maintain self-reflexivity throughout the research process. Considering and theorising the influences on the research process is important in ensuring research is ethical (Daralaston-Jones, 2007) and understanding the researchers' personal contribution in the knowledge produced. Therefore, reflexivity through epistemological, critical language awareness (Willig, 2008), personal and relational reflexivity is important in evaluating the processes and outcomes of this research.

4.6.1. Personal Reflexivity

My personal position as a researcher is rooted in the fact that I self-Identify as a Turkish woman, belonging to a Turkish and Cypriot culture from a working-class background. Growing up in a country experiencing feelings of being an 'other' has been perpetuated by social inequalities which has heightened my awareness of how my intersecting locations (Crenshaw, 2012) have provided challenges in my personal and professional life and development. I also recognise that my experiences of difference have pushed me to pursue a career in clinical psychology that is committed to my values of believing everyone has a right to equal access to services with a priority to develop opportunities for change. The process of developing and completing the research has enabled me to attend to ways in which my viewpoint and experiences outlined above might have influenced the analysis and direction of the research. In the introduction, I discussed the experiences of difference that I had growing up and how this had an effect on my understanding of what it meant to be different and my relationship to social disadvantage. I perhaps made some early assumptions that due to the difference I outlined above I perhaps would have some shared experiences of difference with Black men, although I acknowledge there might be shared sensitivity in some of the experiences of feeling different I cannot completely anticipate what it is like to be a Black man and doing so can create inaccurate assumptions being made. I perhaps made an assumption that I would be more familiar with the issues

related to Black men and overlooked the aspects of my identity rooted in my gender and ethnicity overlooking historical and contextual people with a 'visible' difference might experience. An example of this comes from my reflections upon conducting, transcribing and attempting to analyse my data where I realised I had overlooked the constructions embedded in the term Black and noticed that I had failed to recognise the multiple origins of people from Black communities. In addition to this I had not picked up on the constructions related to maleness in the analysis, such oversights might have reflected my personal positioning of being a Turkish female which may have influenced the way I had interpreted the data. It wasn't until I had spoken with my supervisor and taken a step back from the analysis to recognise my personal identity and the influence it may have in the analysis that allowed me to reproach the data. Keeping a reflective journal and engaging in this process of reflection then allowed me to return to the data and re-examine whilst paying attention to constructions of 'race' and gender and the influence it has on conceptualisations of the self and identity.

When I embarked on this project, despite feeling excited about the prospects of facilitating change I found myself feeling overwhelmed by the depth of the topic I chose to research. I felt myself being saddened by the multiple layers of oppression that I was reading about that overshadowed any opportunity to focus on what could be done to attempt any repairing of the damages that have impacted on Black men's experiences of MHS. In addition to this I felt the journey challenged ideas that I held regarding feelings that I somehow 'knew' more or could really understand being in a position of difference which perhaps put me in a naïve position of making assumptions. It highlighted how intersectionality (Crenshaw, 2012) can play a role in understanding how minority perspectives might get marginalised and the majority perspectives privileged in hierarchical structures which can serve to maintain the status quo. My hope it that using such a framework to understand how Black men's social locations might influence

how they might see themselves will support systems to understand how to better serve the community within MHS.

4.6.2. Epistemological Reflexivity

It is paramount for the researcher to acknowledge and consider the limitation of the knowledge they have produced (Willig, 2013). The critical realist epistemology I adopted meant that I interpreted the factors that may have influenced participants' accounts. This made me question the ethics of interpreting accounts about sensitive and personal conversations, not just about 'race' and racism but also about commissioning practices (Willig, 2013). I wondered if participants expected me to adopt a naïve realist position when analysing their data rather than use a deductive approach. In attempting to minimise my own influence, I endeavored to gather accounts by asking open questions, clarifying and using prompts to encourage participants to elaborate.

Critical language awareness involves the researcher reflecting on their use of language and how this might influence participants' responses. In using the construct of Black when asking questions, I might have contributed to homogenisation of Black people which I attempted to resist. Such a politicised use of language along with my power as a researcher may have influenced how the participants responded. Through my review of the literature and my epistemological stance I became aware of my own use of language throughout the write up of this research. This made me reflect at times of my naivety in using certain terms, (for example BME, race, culture) and how this can perpetuate homogenisation and othering, this allowed me to critically examine and review my writing and the terms I used throughout my write up.

4.7. Concluding Reflections

Throughout the journey of completing this project I experienced a range of emotions; from feeling excited and determined to open up possibilities for

change along with self-doubt, frustration and feeling paralysed at the depth of this area. The difficult journey enabled me to fully appreciate the critical stance embedded in the teaching within UEL. As well as questioning constructions, practices and assumptions that are held within the services that I have worked in over the course of my career as well as the society we live in. It has pushed me to question my own assumptions and use of language on a personal as well as professional level. It has also helped me to feel more confident and determined to work as a Clinical Psychologist where I can utilise my skills to support the empowerment of those who have otherwise been disadvantaged.

There is no doubt that the inequalities for Black men within MHS are built on several complex layers, as highlighted in the analysis and discussion. However, it has further emphasised to me that as Clinical Psychologists it is highly critical that we use our professional power to unlock these layers and work towards a change in a system that is clearly needed. This is not an easy task and nor is it one that will change overnight, however I hope this research can inspire and build on recommendations for action that can move towards opportunities to make some small steps towards much needed changes.

5. REFERENCES

Adetimole, F., Afuape, T., & Vara, R. (2005). The impact of racism on the experience of training on a clinical psychology course: Reflections from three Black trainees. *Clinical Psychology Forum, 48*, 11-15.

Afuape, T., & Hughes, G. (2015). *Liberation Practices: Towards Emotional Wellbeing Through Dialogue*. Oxon: Routledge.

Ahmed, S., (2007) You End up Doing the Document Rather Than Doing the Doing:Diversity, Race Equality and the Politics of Documentation. Ethnicity and Racial Studies, 30, 590-609.

Alexander, C. (2008). *(Re)thinking the gang*. London: Runnymede.

Allen, I. M. (1996). PTSD among African Americans. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfiel (Eds.), Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications. Washington: American Psychological Association.

Alleyne, A. (2005). The internal oppressor: the veiled companion of external racial oppression. The Psychotherapist, 26.

Anderson, B. R. (1991). Imagined communities: Reflections on the origin and spread of nationalism. London: Verso.

Anionwu, E., Atkin, K., (2001) The Politics of Sickle Cell and Thalassemia. OpenUniversity Press, Buckingham.

Atkin, K., Chattoo, S., (2007). The dilemmas of providing welfare in an ethnically diverse state: seeking reconciliation in the role of a reflexive practitioner. Policy Politics. 35 (3), 377-393

Attia, M., & Edge, J. (2017). Be(com)ing a reflexive researcher: A developmental approach to research methodology. *Open Review of Educational Research*, 4(1), 33-45.

Avdi, E. & Georgaca, E. (2007). Discourse analysis and psychotherapy: A critical review. *European Journal of Psychotherapy and Counselling*, 9(2), pp.157-176.

Ayalon, L., & Young, M.A. (2005). Racial group differences in help-seeking behaviour. *Journal of Social Psychology*, 145(4) 391-403.

Banton, M. (1987). *Racial theories*. Cambridge, New York, and Melbourne: Cambridge University Press.

Barnard, H., and Turner, C. (2011) Poverty and ethnicity: A review of evidence. York: Joseph Rowntree Foundation.

Bebbington, P.E., Feeney, S.T., Flanningan, C.B., Glover, G.R., Lewis, S.W., & Wing, J.K. (1994). Inner London Collaborative Audit of Admissions in Two Health Districts II: Ethnicity and the Use of the Mental Health Act. *British Journal of Psychiatry*, 165, pp.743-749.

Bennett, E., & Dennis, M. (2000). Adult Mental Health. In N. Patel, E. Bennett, M. Dennis, N. Dosanjh, A. Mahtani, A. Miller, & Z. Nadirshaw (Eds.), Clinical psychology, 'race' and culture: A training manual (pp. 89-109). Leicester: British Psychological Society.

Berman, G., & Dar, A. (2013) Prison population statistics. London: House of Commons. Retrieved: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN04334#fullreport

Bhat, S., Kaur, K. & Kauser, S. (2009), "Voices for change - involving BME groups in commissioning mental health services", A Life in the Day, 13 (3), 25-29. Retrieved: https://www.emerald.com/insight/content/doi/10.1108/13666282200900028/full/html

Bhugra, D., & Bhui, K., (2001). African-Caribbeans and schizophrenia: contributing factors. *Advances in Psychiatric Treatment*, *7*(4), 283-291.

Bhui, K., Ascoli, M., & Nuamh, O., (2012) The Place of Race and Racism in Cultural
Competence: What can we Learn From the English Experience About the Narratives
of Evidence and Argument? *Transcultural Psychiatry*, 49 (2), 185-205

Bhui, K., & Sashidharan ,S. (2003) Should there be separate psychiatric services for ethnic minority groups? *British Journal of Psychiatry*, 182,10-12.

Bhui, K. (2002). *Racism in mental health: Prejudice and suffering*. London: Jessica Kingsley Publishers.

Blackman, L., (2007) Psychiatric Culture and Bodies of Resistance. *Body & Society*, 13(2), 1-23.

Blakey, H. (2006) Participation. Why Both? The Views of Black and Minority Ethnic Mental Health Service Users on Participation in the NHS in Bradford. Report of a Community Research Process undertaken by the International Centre for Participation Studies. Mental Health Today. University of Bradford. Retrieved: https://core.ac.uk/download/pdf/136480.pdf

Boote, J., Wong, R., & Booth, A., (2009) 'Talking the talk or walking the walk?' A bibliometric review of the literature on public involvement in health research published between 1995 and 2009. *Health Expect*, 18, 44–57.

Boyle, D., Slay, J., Stephens, L., (2010) Public Services Inside Out. Nesta. United Kingdom. Retrieved: https://www.nesta.org.uk/report/public-services-inside-out/

Boyle, M. (2006). Developing real alternatives to Medical Models. *Ethical Human Psychology and Psychiatry*, 8, 191-200.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3 (2),* 77-101.

Brett, J., Staniszewska, S., Mockford, C, et al. (2012). Mapping the impact of patient and public involvement on health and social care research: a systematic review. *Health Expect,* 17, 637–50.

Briere, J. (2004). *Psychological assessment of adult posttraumatic states; Phenomenology, diagnosis, and measurement*, (2nd Edition). Washington DC: American Psychological Association.

British Psychological Society (2010). *Standards for Doctoral Programmes in Clinical Psychology*. Retrieved from www.bps.org.uk/sites/default/files/.../clinical_accred2010_web_0.pdf

British Psychological Society (2010). New Ways of Working for Applied Psychologists in Health and Social Care Working Psychologically in Teams. Retrieved from http://www.wiltshirepsychology.co.uk/Working%20Psychologically%20in%20Teams.pdf

Brown, P., & Zavestoski, S., (2004) Social movements in health: an introduction. *Sociology Health and Illness*, 26, 679–94.

Bryant-Davis, T., & Ocampo, C. (2005). Racist incident–based trauma. The *Counseling Psychologist*, 33(4), 479-500.

Bryman, A. (2008). "Of Methods and Methodology". Qualitative Research in Organizations and Management: *An International Journal*, *3(2),* 159-168.

Bulhan, H. A. (1985) *Frantz Fanon and the psychology of oppression*. New York & London: Plenum Press.

Burr, V. (2003). *Social constructionism*. (2nd ed.). London: Routledge.

Burton, M., & Kagan, C., (2004) Liberation Social Psychology: Learning from Latin America. *Journal of Community and Applied Social Psychology*, *15*(1), 63-78.

Byrne, A., Warren, A., Joof, B., Johnson, D., Casimir, C., Hinds, C., & Griffiths, S. (2011). 'A powerful piece of work': African and Caribbean men talking about the tree of life. (117), 40-45.

Cabinet Office. (2018). Race disparity audit: Summary findings from the ethnicity facts and figures website. London: Cabinet Office.

Cacari-Stone, L., Wallerstein, N., Garcia, A, P., & Minkler, M., (2014) The promise of
community-based participatory research for health equity*. American. Journal of Public Health*, 104 (9), 1615-1623.

Care Quality Commission (CQC). (2011). Count me in 2010. London: Care Quality Commission.

Cochrane, R. & Bal, S.S. (1989). Mental hospital admission rates of immigrants to England and Wales: an analysis of mental hospital admissions. Social Psychiatry, 24(1) 2-11

Collins, H, M., (2000) Four kinds of knowledge, two (or maybe three) kinds of embodiment, and the question of artificial intelligence. In: J. Malpas and M. Wrathall (eds), Heidegger, Coping, and Cognitive Science: Essays in Honor of Hubert L. Dreyfus, vol. 2, pp. 179 – 195. Cambridge, MA: MIT Press

Connell, R., (2007). Southern Theory: The Global Dynamics of Knowledge in Social Sciences. Allen and Unwin: Sydney; Polity Press, Cambridge.

Cooper, C., Morgan, C., Byrne, M., & Dazzan, P., (2008) Perceptions of disadvantage, ethnicity and psychosis. British Journal of Psychiatry, 192, 185-190.

Crenshaw, K. (2012). On Intersectionality: the essential writings of Kimberley Crenshaw. New York: New Press.

Darwin, C. (1959). On the origin of species by means of natural selection. London: J. Murray.

Darlaston-Jones (2007). Making connections: The relationship between epistemology and research methods. *The Australian Community Psychologist, 19 (1),* 19-27.

Davidson, S., & Patel, N. (2009). Power & Identity: Considerations for Personal & Professional Development In J. Hughes & S. Youngson (Eds.), *Personal Development and Clinical Psychology* (pp. 75-88). Chichester: BPS Blackwell.

Dayson, C. & Bennett E. (2016) Evaluation of the Rotterdam Mental Health social prescribing Pilot. Centre for Regional Economic and Social Research. Sheffield Hallam University. Retrieved: https://www.healthylondon.org/wp-content/uploads/2017/10/Social-prescribing-Steps-towards-implementing-self-care-January-2017.pdf

De Maynard, V. (2012). Developing the racialised body image disturbance scale. *International Journal of Culture and Mental Health*, 6, 108-129.

Department of Education. (2012). A profile of pupil exclusion in England. London. Retrieved: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/183498/DFE-RR190.pdf

Department of Health (2005). *Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside services*. London: Department of Health.

Department of Health (2014). Mental Health Crisis Care Concordat Improving Outcomes for People Experiencing Mental Health Crisis. London: Department of Health.

Department of Health (2015). Modernising the Mental Health Act-Final Report from the Independent Review. London: Department of Health.

Dillon, J. (2011). The Personal is The Political. In: Rapley, M., Moncrieff, J., & Dillon, J. (Eds.), *De-Medicalizing Misery* (pp.141-148). London: Palgrave McMillan.

Donaldson, L., (2008) The Challenge of Quality and Patient Safety. *Journal of Royal Society of Medicine*, 101, 338–41.

Dreachslin, J, L., (2007). Diversity Management and Cultural Competence: Research Practice, and the Business Case. *Journal Healthcare Management*, 52 (2), 79-96.

Elder-Vass, D. (2006). A Method for Social Ontology. Paper presented at IACR Conference. Tromso, Norway.

Faugier, J., & Sargeant, M. (1997). Sampling hard to reach populations. Journal of Advanced Nursing. 26, pp.790-797.

Feagin, J. (1984). Racial and ethnic relations (2nd Edition). Englewood Cliffs: Prentice-Hall.

Fearon, P., Kirkbride, J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., & Murray, R. M. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. *Psychological Medicine*, 36 (11), 1541-50.

Fernando, S. (2017). *Institutional racism in psychiatry and clinical psychology*: Race matters in mental health. London: Palgrave Macmillan.

Fernando, S. (1991). *Mental health, race and culture.* London; Macmillan Education, in conjunction with MIND.

Fernando, S., Ndegwa, D., & Wilson, M. (1998). *Forensic psychiatry, race and culture.* London: Routledge.

Ferns, T. (2005). Violence in the accident and emergency department – an international perspective. Accident and Emergency Nursing, 13(3), 180–185.

Fitzpatrick, R., Kumar, S., Nkansa-Dwamena, O., & Thorne, L. (2014). Ethnic inequalities in mental health: Promoting lasting positive change. London: Confleunce Partnerships.

Fogg-Rogers, L. (2017) Society vs the individual: How can we work together to enable behaviour change? In Community Psychology Festival 2017, Bristol, UK, 15-16 September 2017. Retrieved from: http://eprints.uwe.ac.uk/33503

Francis, E. (1989). Black people, dangerousness and psychiatric compulsion'. In A. Brackx, & C. Grimshaw (Eds.), Mental health care in crisis. London: Pluto.

Freidson E. (1970) Professional dominance: the social structure of medical care. Chicago: Aldine Publishing Company.

Frosh, S. & Young, L. (2008). Psychoanalytic Approaches to Qualitative Psychology. In Willig, C. and Stainton-Rogers, W. (Eds.). *The Sage Handbook of Qualitative Research in Psychology*. London: Sage.

Frueh, B, C., Ford, J, D., Jon, D., Elhai, & Anouk, L, G., (2012) Handbook of Evidence-Based Practice in Adult Mental Health. In Sturney. P. & Hersen. M. (Ed). Handbook of Evidence-Based Practice in Clinical Psychology. John Wiley & Son.

Fryer, D. (2008). Some Questions about "The History of Community Psychology". Journal of Community Psychology, 36, 572-586.

Glasby, J., & Beresford, P. (2005) Who knows best? Evidence-based practice and the service user contribution. *Critical Social Policy*, 26 (1) 268-284.

Glesne, C. (1992). *Becoming Qualitative Researchers: An Introduction*. Ontario: Longman.

Glover, G., & Evison, F. (2009) Use of new mental health services by ethnic minorities in England. Durham, England: North Eat Public Health Observatory. Retrieved from http://www.nepho.org.uk/publications /782/

Graham, L. (2005). Discourse analysis and the critical use of Foucault. Conference paper presented at Australian Association for Research in Education, Sydney. Retrieved: http://eprints.qut.edu.au/2689/1/2689.pdf

Graham, M., & Robinson, G. (2004). “The Silent Catastrophe”: Institutional Racism in the British Educational System and the Underachievement of Black Boys. *Journal of Black Studies*. 34(5), 653-671.

Gray, P. (1999). Voluntary organisations' perspective on mental health needs. In D. Bhugra & V. Bahl (Eds.), *Ethnicity: An Agenda for Mental Health*. pp. 202-210). London: Gaskell.

Grey, T., Sewell, H., Shapiro, G., Ashraf, F. (2013). Mental Health Inequalities Facing U.K. Minority Ethnic Populations Causal Factors and Solutions. *Journal of Psychological Issues in Organisational Culture*, 3, s1.

Gunter, A. (2017). Race, gangs and youth violence: Policy, prevention and policing. London: Policy Press.

Gupta, M., (2007) Does Evidence-Based Medicine Apply to Psychiatry. *Theoretical and Bioethics*, 28(2), 103-120.

Hankivsky, O. (2014) Intersectionality 101. Institute of Intersectionality Research & Policy. SFU

Harrison, G., Holton, A., Neilson, D., Owens, D., Boot, D., & Cooper, J. (1989). Severe mental disorder in Afro-Caribbean patients: some social, demographic and service factors. *Psychological Medicine*, 19, 683-696.

Harper, D, J. (2005) The Critical Professional and Social Policy: Negotiating dilemmas in the UK Mental Health Act Campaign. *International Journal of Critical Psychology,* 13, 55-75.

Harper, D. J. (2011). Choosing a Qualitative Research Method. In D. Harper &
R. Thompson. (eds.). Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners (pp. 83-97). Chichester: Wiley-Blackwell.

Hartmann, P., & Husband, C. (1974). Racism and the mass media. London: Davis-Poynter.

Helms, J. E., Jernigan, M., & Mascher, J. (2005). The meaning of race in psychology and how to change it: a methodological perspective. *American Journal of Psychology*, 60(1), 23-67.

Hodgson, E., Stuart, R, J., Train, C., & Lloyd., (2018) A Qualitative Study of an Employment Scheme for Mentors with Lived Experience of Offending within a Multi-Agency Mental Health Project for Excluded Young People. *Journal of Behavioural Health Services & Research*, 46(1),140-150.

Hook, D. (2007). *Foucault, Psychology and the Analytics of Power*. Basingstoke: Palgrave Macmillan.

Howitt, D., & Owusu-Bempah, J. (1994). *The racism of psychology: Time for change*. New York: Harvester Wheatshea.

Joffe, H. (2012). Thematic Analysis. In D. Harper & A.R. Thompson (Ed.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (83-98). West Sussex: John Wiley & Sons.

Johnson, M., (2009). End of life care in ethnic minorities; providers need to overcome their fear of dealing with people from different backgrounds. *BMJ* 338, 489-490.

Jones, G. & Berry, M. (1986). Regional secure units: the emerging picture. In: Edwards. G (Ed.) Current Issues in Clinical Psychology IV. London: Plenum Press.

Kai, J., Beavan, J., Faull, C., Dodson, L., et al., (2007). Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study. *PLoS Med*. 4 (11), 323

Kalathil, J (2009) Dancing to Our Own Tune: Reassessing Black and Minority Mental Health Service User Involvement. London:

Kalathil, J., (2009) Towards Cohesive Voice of Black and Minority Ethnic Mental Health Service Users: A Position Paper Based on the Work of The Afiya Network. The Afiya Trust: Retrieved: https://www.academia.edu/3297509/Dancing_to_our_own_tunes_Reassessing_black_and_minority_ethnic_mental_health_service_user_involvement

Kalathil, J (2011) Recovery and Resilience: African, African-Caribbean and South Asian's Women's Narratives of Recovering from Mental Distress. London: Mental Health Foundation and Survivor Research. Retrieved: http://www.survivor-research.com/images/documents/black%20women%20recovery%20and%20resilience%20final%20report.pdf

Kagan, C., Burton, M., Duckett, P., Lawthom, R., & Siddiquee, A. (2019) Critical Community Psychology: Critical Action and Social Change. London: Routledge

Karlsen, S. (2013) Evaluation of the Strengthening Families, Strengthening Communities Program. Race Equality Foundation. London Retrieved http://www.raceequalityfoundation.org.uk/sfsc/evidence-and-evaluation

Keating, F. (2009). African and Caribbean men and mental health. Ethnicity and Inequalities in Health and Social Care, 2(2), 41-53.

Keating, F., Robertson, D., Francis, E., McCulloch, A. (2002). Breaking the Circles of Fear: A Review of the Relationship between Mental Health Services and African and Caribbean Communities. London: Sainsbury Centre for Mental Health.

Khan, L., Saini, G., Augustine, A., Kyle, P., Johnson, M., & Donald, R., (2017) Evaluation of the Mind Birmingham up My Street Program. Centre for Better Mental Health. Retrieved: https://www.centreformentalhealth.org.uk/sites/default/files/2018-10/Against%20the%20odds%20-%20Up%20My%20Street%20evaluation.pdf

The King's Fund (2020). 'How is the NHS structured?'. The King's Fund website. Available at: www.kingsfund.org.uk/audio-video/how-is-nhs-structured-funding-flow (accessed on 7 September 2020).

Kirmayer, L, J., (2007) Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry*, 44(2), 232-257.

Kitzinger, C., & Wilkinson, S. (1996). *Representing the other: A Feminism & psychology reader*. London: Sage

Kitzinger, J (2005). Focus Group Research. In. I. Holloway (Ed.). *Qualitative Research in Health Care* (pp. 56-68). Maidenhead: Open University Press.

Kimberlee, R. (2013) Developing a Social Prescribing Approach for Bristol, A report for Bristol Clinical Commissioning Group. Retrieved: http://webcache.googleusercontent.com/search?q=cache:http://eprints.uwe.ac.uk/28452/7/Value%2520of%2520social%2520prescribing2.pdf

Laurence, J. (2015). Community disadvantage and race-specific rates of violent crime: an investigation into the “racial invariance” hypothesis in the United Kingdom *Deviant Behavior*, 36(12), 974-995

Lindow, V. (1999). Power, lies and injustice: the exclusion of service users' voices. In M. Parker (Ed.), *Ethics and Community in the Health Care Professions* (pp. 154 - 172). Routledge.

Littlewood, R., & Lipsedge, M. (1981). Some social and phenomenological characteristics of psychotic immigrants. *Psychological Medicine,* 11(2), 289-302.

Lloyd, P. & Moodley, P. (1992). Psychotropic medication and ethnicity: An inpatient survey. *Social Psychiatry and Psychiatric Epidemiology*, 27(2), 95-101.

MacPherson, W. (1999). The Stephen Lawrence inquiry. London: The Stationary Office.

Mangalore, R., & Knapp, M. (2011). Income-related inequalities in common mental disorders among ethnic minorities in England. *Social Psychiatry and Psychiatric Epidemiology*, 47(3), 351-359.

Martín-Baró, I. (1994). Writing for a Liberation Psychology. Cambridge:Harvard University Press.

Martin, M.J., McCarthy, B., Conger, R.D., Gibbons, F.X., Simons, R.L., Cutrona, C.E., & Brody, G.H. (2011). The enduring significance of racism:

Discrimination and delinquency among Black American youth. *Journal of Research on Adolescence, 21*(3), 662-676.

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice,* 13, 522-525.

Mason, J. (2003). 'Qualitative Interviewing'. In T. May (Ed.), *Qualitative Research in Action* (pp. 225-241). London: Sage.

Mayer, C., & McKenzie, K. (2017). "...it shows that there's no limits': the psychological impact of co-production for experts by experience working in youth mental health. *Health & Social Care in the Community*, 25, 1181-1189.

McKenzie K., Samele C., Van Horn E., Tattan T., Van Os J., & Murray R. (2001). Comparison of the outcome and treatment of psychosis in people of Caribbean origin living in the UK and British Whites: Report from the UK700 trial. *British Journal of Psychiatry*, 178, pp.160-165.

McKenzie-Mavinga, I. (2005). Understanding black issues in postgraduate counsellor training. *Counselling and Psychotherapy Research, 5*, 295-300

Mclean, C., Campbell, C & Cornish, F. (2003). African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. *Social Science & Medicine*, 56, 657–669.

McLean, A., (1995). Empowerment and the psychiatric consumer/ex-patient movement in the United States: contradictions, crisis and change. *Social Science Medicine*, 40, 1053–1071.

Mehta, N. (2011). Mind-body Dualism: A critique from a Health Perspective. *Mens Sana Monographs*, 9 (1), 202-209.

Mental Health Act. (1983). Retrieved from https://www.legislation.gov.uk/ukpga/1983/20/contents

Mills, C. and Fernando, S. (2014). Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health. *Disability and the Global South*,1, (2), 188-202.,

Mistry, M & Latoo, J., (2009). *Uncovering the face of racism in the workplace. British Journal of Medical Practitioners*, 2 (2), 20-24.

Mind. (2013). Mental health crisis care: physical restraint in crisis. Stratford: Mind.

Morgan, C., Kirkbride, J., Hutchinson, G., Craig, T., Morgan, K., Dazzan, P., & Fearon, P. (2008). Cumulative social disadvantage, ethnicity and first episode psychosis: a case-control study. *Psychological Medicine*, 1701-1715.

Nadirshaw, Z. (1993). The implications for equal opportunities training in clinical psychology: A realist's view. Clinical Psychology Forum, 5, 3-6.

National Institute for Mental Health in England (NIMHE). (2003). *Inside outside: Improving mental health services for black and ethnic minority ethnic communities in England*. London: NIMHE.

Ocloo, J., & Matthews., (2016). From tokenism to Empowerment: Progressing Patient and Public Involvement in Healthcare Improvement. *BMJ Quality & Safety*, 25, 626-632.

Odusanya, S. O. (2016). The Experience of Qualified BME Clinical Psychologists: An Interpretative Phenomenological and Repertory Grid Analysis. Submitted to the University of Hertfordshire in partial fulfilment of the requirements of the degree of *Doctor of Clinical Psychology*, 7- 123.

Owen, S., & Khalil, E. (2007). Addressing diversity in mental health care: A review of guidance documents. *International Journal of Nursing Studies*, 44, pp.467-478.

Parker, I. (2005). Qualitative Psychology: Introducing Radical Research. Maidenhead: Open University Press

Parker, I. (2004). Criteria for qualitative research in psychology. *Qualitative Research in Psychology*, *1*, 95–106.

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, 135(4), 531-554.

Patel, N. (1999). Getting the Evidence: Guidelines for Ethical Mental Health Research Involving Issues of „Race", Ethnicity and Culture. London: Mind Publications.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nadirshaw, Z. (Eds.). (2000). Clinical psychology, 'race' and culture: A training manual: A resource pack for trainers. Leicester: British Psychological Society.

Patel, N., & Fatimilehin, I. A. (1999). Racism and Mental Health. In C. NEwnes, G. Holmes, & C. Dunn (Eds.), This is madness: A critical look at psychiatry and the future of mental health services (pp. 51-70). Hertfordshire, UK: PCCS BOOKS.

Patel, N. (2012). Difference and power in supervision: The case of culture and racism. In I Fleming & L. Screen (Eds), Supervision and clinical psychology (pp.239-255). London: Taylor & Francis.

Paulraj, P. S. (2016). How do Black Trainees Make Sense of Their 'Identities' in the Context of Clinical Psychology Training? Professional doctorate thesis, University of East London., 1-91.

Pollock, A. (2017). Open letter to Jeremy Hunt on the 69th anniversary of the NHS. Retrieved from: https://www.huffingtonpost.co.uk/allysonpollock/jeremy-hunt_b_17390584.html

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology*, 2,38-55.

Sidanius, J., & Pratto, F. (1999). Social dominance: An intergroup theory of social hierarchy and oppression. Cambridge, UK: Cambridge University Press.

Rogers, A., & Pilgrim, D. (2003). *Mental health and Inequalities*. Basingstoke: Palgrave Macmillan.

Rogers, E. S., Chamberlin, J., Ellison, M. L., *et al* (1997) A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services*, 48, 1042–1047

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology*. American journal of community psychology*, 15, 121-148.

Rutter, D., Manley, C., Weaver, T., et al. (2004) Patients or partners? Case studies of user involvement in the planning and delivery of adult mental health services in London. *Social Science Medicine*, 58, 1973–84.

Salway, S., Mir, G., Turner, D., Ellison, G. T., Carter, L., & Gerrish, K. (2016). Obstacles to “race equality” in the English national health service: Insights from the healthcare commissioning arena. *Social Science Medicine*, 152, 102–110.

Sanders-Thompson, V.L.S. (2002). Racism: Perceptions of Distress Among African Americans. *Community Mental Health Journal,* 38 (2), 111-118.

Sandamas, G. & Hogman, G. (2000). No Change: A report by the National Schizophrenia Fellowship comparing experiences of people from different ethnic groups who use mental health services. London: National Schizophrenia Fellowship.

Sashidharan, S. (2003). From outside to inside: Improving mental health services for Black and minority ethnic communities in England. *Mental Health Review Journal*, 8(3), 22-25.

Sashidharan, S. (1993). Afro-Caribbeans and schizophrenia: the ethnic vulnerability hypothesis re-examined. *International Review of Psychiatry*, 5, 129-144.

Sashidharan, S.P. (1986). Ideology and politics in transcultural psychiatry. In J.L. Cox (Ed.), *Transcultural psychiatry.* Sydney: Croom Helm.

Shweder, R. A., & Haidt, J. (2000). The cultural psychology of the emotions: Ancient and new. In M. Lewis & J. Haviland (Ed.), *Handbook of emotions, 2nd ed*ition, (pp. 397-414). New York: Guilford

Smail, D. (2005). *Power, Interest, and Psychology: Elements of a Social Materialist*
Understanding of Distress. Ross-on-Wye: PCCS Books.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE Pubications.

Smith, K. D., Türk Smith, S., & Christopher, J. C. (2007). What defines the good person? Cross-cultural comparisons of experts' models with lay prototypes. *Journal of Cross-Cultural Psychology*, *38*, 333–360.

Speer, S. A. (2007). On recruiting conversation analysis for critical realist purposes. *Theory and Psychology*, *17*, 125–135.

Spencer, L., & Ritchie, J. (2011). In Pursuit of Quality. In D. Harper & A. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (pp. 227–242). West Sussex: John Wiley & Sons Ltd.

Sue, D. W. & Sue, D. (2003). *Counselling the culturally diverse: Theory and practice* (4th ed.). New York, NY: John Wiley & Sons, Inc.

Tarbuk, P., Topping-Morris, B., & Burnard, P. (1999) Forensic mental health nursing: Policy, strategy and implementation. London, England: Whurr Publications.

The Equality Act. (2010).

The Public Health England (2020) Disparities in the Risk and Outcomes of COVID-19. The Public Health England, Retrieved: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/890258/disparities_review.pdf

The Health Foundation (2012) Leading the Way to Shared Decision Making. London: The Health Foundation. Retrieved: https://www.health.org.uk/sites/default/files/LeadingTheWayToSharedDecisionMaking.pdf

The Kings Fund (2017). How is the NHS structured. Retrieved: https://www.kingsfund.org.uk/audio-video/how-new-nhs-structured

Townsend P, Davidson N, Whitehead M. (1988) Inequalities in health: the black report and the health divide. London: Penguin.

Tritter, J. Q., (2009) Revolution or Evolution: The challenges of Conceptualizing Patient and Public Involvement in a Consumerist World. *Health Expect*, 12, 275–87

Tritter, J, Q., & McCallum, A., (2006) The Snakes and Ladders of User Involvement: Moving Beyond Arnstein. *Health Policy,* 76, 156–68.

Trivedi, P. (2002) cited in Bhui, K. (2002) Racism & Mental Health Prejudice and suffering Kingsley London

Triandis, H. C. (1996). The psychological measurement of cultural syndromes. *American Psychologist*. 51(4), 407-415.

Vernon, P. (2011) Put race equality in mental health back on the agenda. Retrieved http://www .guardian.co.uk/society/joepublic/2011/mar/01/race - equality-mental-health

Wait, S., & Nolte., (2006) Public Involvement Policies in Health: Exploring Their Conceptual Basis. *Health Economy Policy Law*, 1, 149–62.

Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative effect of racial discrimination on the mental health of ethnic minorities in the United Kingdom. American Journal of Public Health., 106(7), 1294-300.

Watkins, D. C., Walker, R.L. & Griffith, D.M. (2009). A meta-study of Black male mental health and well-being. *Journal of Black Psychology*, 1-29.

Williams, J. (1999). Social Inequalities and Mental Health. In C. NEwnes, G. Holmes, & C. Dunn (Eds.), This is madness: A critical look at psychiatry

and the future of mental health services (pp. 51-70). Hertfordshire, UK: PCCS BOOKS.

Williams, D.R., Neighbors, H.W., & Jackson, S.J., (2003) Racial/Ethnic Discrimination and Health: Findings from Community Studies. *Journal of Public Health*. 93(2), 200-208.

Williams, D., & Garner, J., (2002) The case against 'the evidence': A different perspective on evidence-based medicine. The British Journal of Psychiatry. 180 (1), 8-12

Williams, P. E., Turpin, G., & Hardy, G. (2006). Clinical psychology service provision and ethnic diversity within the UK: A review of the literature. *Clinical Psychology and Psychotherapy*, 324–338.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionist work. In D. J. Nightingale & J. Cromby (Eds.), *Social Constructionist Psychology: A Critical Analysis of Theory and Practice* (pp. 37-51). Guildford: OU Press.

Willig, C., & Stainton-Rogers, W. (Eds.). (2007). *Sage Handbook of Qualitative Research in Psychology*. London: Sage Publications

Willig, C. (2013). Introducing qualitative research in psychology (3rd edn.). Maidenhead: Open University Press.

Wilkinson, S. (1998). Focus Group Methodology: A Review. *Social Research Methodology, 1 (3),* 181-203.

Wilson, M., 2009. Delivering Race Equality in Mental Health Care: A Review. Department of Health, London.

Wood, N., & Patel, N. (2017). On addressing "whiteness" during clinical psychology training. *South African Journal of Psychology*, 1-12.

Woodin, J., 2006. Healthcare commissioning and contracting. In: Walshe, K.,Smith, J. (Eds.), Healthcare Management. Chapter 12. Open University Press, Maidenhead

Woolgar, S. & Pawluch, D. (1985). Ontological Gerrymandering: The anatomy of social problems explanations. *Social Problems, 32,* 214-227.

Wye, L., Brangan, E., Cameron, A., Gabbay, J., Johnathan, H, K., & Pope, C., (2015) Evidence Based Policy Making and The 'Art' of Commissioning-How English Healthcare Commissioners Access and use Information and Academic Research in 'real life' Decision-making: an Empirical Qualitative Study. *BMC Health Services Research*, 15, 430,

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*, 215–228.

Zimmerman, M. (2000). Empowerment theory: Psychological, organizational
and community levels of analysis. In J. Rappaport and E. Seidman (Eds.), Handbook of Community Psychology (pp. 43-63). New York: Plenum Press.

Zimmerman, M. A. (1990). Toward a theory of learned hopefulness: A structural model analysis of participation and empowerment. Journal of research in personality, 24, 71-86.

Zimmerman, M. A. (1995). Psychological empowerment: Issues and illustrations. American Journal of Community Psychology, 23, 581-599.

6. APPENDICES

6.1. Appendices A- Written Confirmation of Permission to use Diagram

Megan Price
Mon 9/7/2020 2:42 PM

To:

Cc:

Kathy Johnson

Hi Aynur,

I hope you're well. I'm just following up on your request to reproduce our commissioning diagram. We have recently updated that particular diagram, with the new version available here. We would be happy for you to reproduce that version, and any accompanying text necessary, with an appropriate reference. Something like the following would work:

The King's Fund (2020). 'How is the NHS structured?'. The King's Fund website. Available at: www.kingsfund.org.uk/audio-video/how-is-nhs-structured-funding-flow (accessed on 7 September 2020).

Thanks,
Megan

6.2. Appendix B- Copy of Email Invitation

Dear ----------,

I am writing to you to request some information. As part of my Doctorate in Clinical Psychology I am hoping to conduct some research with mental health service commissioners. The aim is to explore the challenges of providing services for black men.

I was wondering if you could provide me with the contact details for your mental health services commissioner/commissioner's? This would enable me to run the idea past them and gauge whether this is something they would be interested/participate in.

I look forward to hearing from you,

kind regards

Aynur Yalcin

Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology
University of East London

Dear ----------,

I understand that you and your team are responsible for commissioning mental health services for -------London. I am currently in the process of conducting some research as part of my Clinical Psychology Doctorate. I am looking at exploring the challenges of commissioning mental health services for Black men.

By speaking with you I would hope to explore this and gain an understanding of some of the challenges surrounding this. Understanding these challenges may provide a unique opportunity to help shape the development of guidelines that could be utalised within your organisation.

I would really appreciate the opportunity to talk with you. I am willing and able to travel to a room/space that is convenient for you.

Please find enclosed my information leaflet and contact me if you require any additional information.

I look forward to hearing from you,

kind regards

Aynur Yalcin

Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology
University of East London

6.3. Appendix C- Copy of Information Sheet

PARTICIPANT INFORMATION SHEET

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator
Aynur Yalcin

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

Project Title
Exploring the challenges of commissioning mental health services for Black men

Project Description
Much research has highlighted consistent inequalities for Black men within the mental health care system. Government guidelines consistently emphasise the importance of addressing these inequalities. This research therefore aims to explore the challenges of this from a commissioner's perspective, with a view to using this information to help support the development of appropriate services for Black men in the mental health care system.

Why are you being asked to take part in the study?
I believe you could help me to explore some of the challenges of commissioning services for Black men in order to help provide some insight into with an aim to develop some guidelines that might support service provisions within this area.

What will you be asked to do?

I am interested in meeting with you to carry out an interview where I ask questions about your experiences as a commissioner and make a digital recording of the discussion.

What are the benefits of taking part in the study?

By participating in an interview, you will have the chance to give your perspective on what the challenges may be for providing appropriate services for Black men in the mental health care system.

Location

I am able to book rooms at the University of East London for the interviews to take place. However, I am also able to travel to a location that is more convenient for you, including your work base if a room is available.

Keeping your information safe

In order to meet with you, I might need to have some basic contact details, like your name, role and phone number. To protect this information, I will need to record it on an excel file and password protect it on my computer. I will destroy this file and any paper copies when the study is completed.

Before the interview starts, I will ask you your name and what your role involves. This will help me to understand the recording when I listen to it at a later stage.

When the interview is finished, I will copy the recording onto a disc, this will be password protected so only I can access the information from the interviews. The interviews will be transcribed on completion and I will assign different names to your interview to protect your identity. The audio recordings will be destroyed following completion and submission of the project. The transcription will be kept for a few years following the completion of the project as I may wish to publish the findings and/or use information from them to help support service development for Black men in the NHS. All identifiable information will be anonymised in any transcripts, write up of the thesis and any publications resulting from it.

As this research is part of my university course, I have two supervisors who will be supervising and supporting me with the study. Information gathered from the interviews will be discussed with them.

Are there any risks in taking part?

I aim to carry out research which is fulfilling and useful activity for those involved. I would like to consider some of the difficulties that may occur with the research, so that they are clear to you at this stage.

Although the topic we will be discussing will be non-personal in nature it is important that if you experience any distress as a result of it you let me know. This is so I can direct you to information on receiving appropriate support.

It is important that you feel comfortable to be open about the challenges of your role but may have some hesitation regarding the consequences of this. As discussed above it is important that you are aware that any identifiable information will be anonymised in order to keep your identity protected.

Deciding not to continue with the interview

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. You do not have to answer a question you are not comfortable with and you may withdraw from the interview at any point.

If you wish to withdraw from the study it is important that you inform me by September 2019 otherwise I reserve the right to use your anonymised data in the write up of the study and any further analysis.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [XXXXXX, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone XXX Email address XXXX]

or

Chair of the School of Psychology Research Ethics Sub-committee: XXXXXXX , School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: XXXXX . Email: XXX@uel.ac.uk)

Thank you in anticipation.
Yours sincerely,
XXXX XXXXXX

6.4. Appendix D- Consent Form

PARTICIPANT CONSENT FORM

UNIVERSITY OF EAST LONDON
Consent to participate in a research study

Exploring the challenges of commissioning mental health services for Black men

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.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

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

Having given this consent, I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

…….
.

Researcher's Name (BLOCK CAPITALS)

……
.

Researcher’s Signature

……
…

Date: ……..…….

6.5. Appendix E- Interview Schedule

INTERVIEW SCHEDULE

The following provides a guide to the areas that will be covered in the interview as the interviews are semi-structured. The exact way in which the interview unfolds will be shaped by the participant's responses.

Introduction and engagement
Re-iterate consent, confidentiality and information about being able to withdraw at any time. Agree approximate length of interview (maximum 50 mins to an hour). Acknowledging that time can be precious working in the NHS and appreciating the time they have provided to participate.

Introduction of topic area:
Explain rationale for exploring the topic area. Provide bullet points of findings:

- Much research has highlighted the inequalities for BME communities in particularly Black men within the mental health system.
- Government guidelines have consistently emphasised the importance of focusing on addressing these inequalities.
- However, despite this the problem still remains in the inequalities amongst these groups within mental health services in the NHS.
- From a commissioning perspective wanted to explore the challenges in providing this. Can acknowledge this is a difficult task to address considering the variety of agendas required to consider. Especially in such financially challenging times.

Research Questions

1. How do commissioners conceptualise the structural and social issues that are relevant when developing services for Black men?
2. How do these issues get drawn upon in commissioning NHS services?

Interview questions

The aim will be to start broad and ask about the experiences of commissioning. The focus will then move towards asking questions around their conceptualisation of Black men with mental health difficulties. Ending with questions broadly around challenges and the direction of service development for Black men.

1. Tell me about what its like to be a commissioner?
2. What is your understanding of the needs of black men with mental health difficulties?
3. Why do you think black men have poorer mental health?
4. What ideas do you have about why they are less likely to receive help?
5. Do you think they are significantly more at risk of experiencing inequalities in mental health care? And if so why?
6. How do services get designed to meet the needs of Black men?
7. How are decisions made with regards to this?
8. What do you think Black men need to help them to access appropriate care for their needs?
9. What is being done in your trust to address these inequalities?
10. What do you think may enable or help you as a commissioner to tackle these problems?
11. What are the future directions or plans if any for this group in mental health?

Prompts If commissioner is unsure of the literature around Black men's inequalities provide some more literature around how they are more likely to receive treatment at the harsher end of services (i.e. criminal justice system or mental health act) and less likely to receive psychological therapy.

Tell me more about this? Have you got any examples? Can you elaborate? How would you describe that?

Debrief

Thank you for your participation, it is very much appreciated. How did it feel to be asked such questions? How are you feeling after the interview? Do you have any questions for me?

6.6. Appendix F- UEL Ethical Approval Form

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates

REVIEWER: Dr Neil Rees

SUPERVISOR: Dr Chanelle Myrie

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Aynur Yalcin

TITLE OF PROPOSED STUDY: Exploring the challenges of commissioning mental health service for Black men.

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)

APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*

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
	MEDIUM
X	LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer: *Neil Rees*

Date: 07.04.17

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

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):*
Student number:

Date:

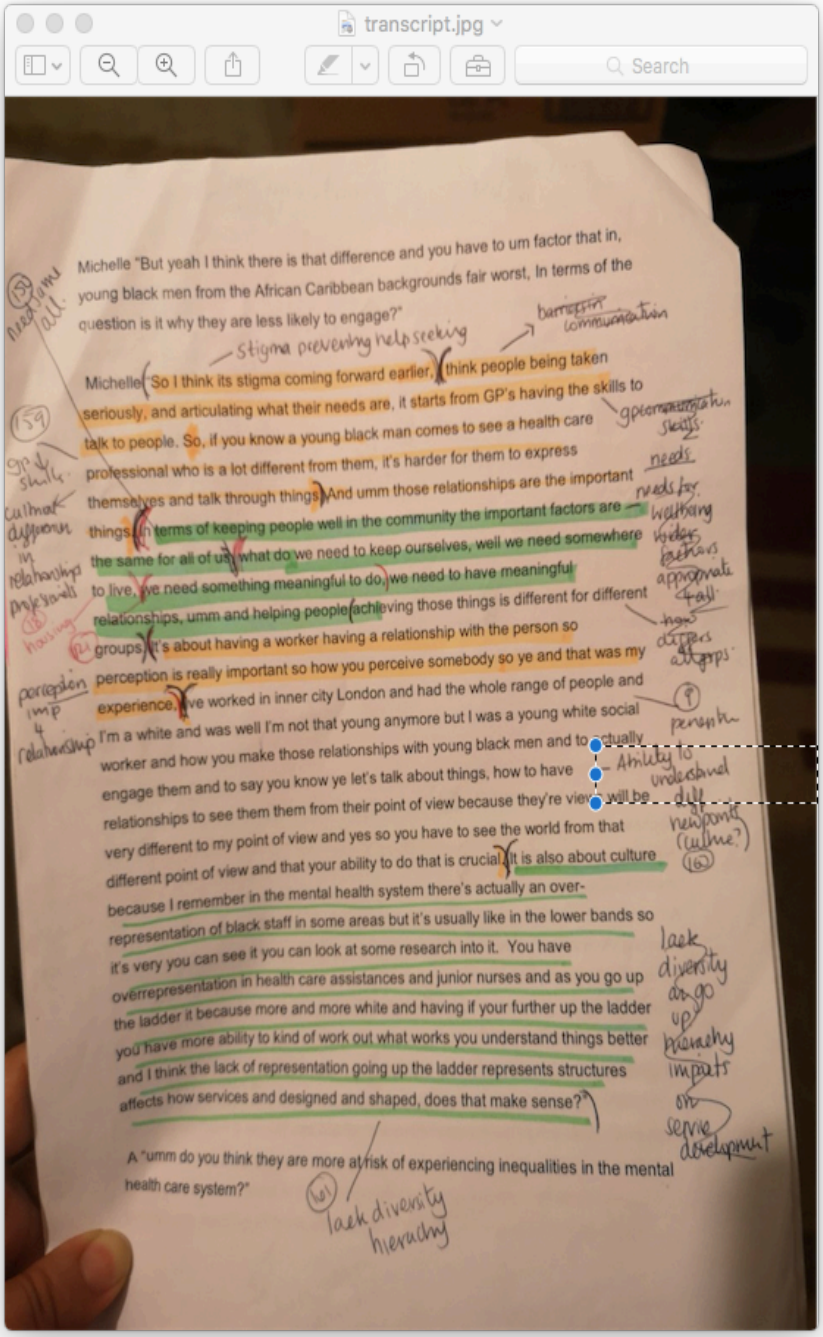
(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, 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 the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

6.7. Appendix G- Except of Transcription



6.8. Appendix H- Initial Coding and Theme's Development

	Partnership working	Participant 5: "Some of it so we put more resources in third sector in ……. to get bring together some voluntary services under one umbrella by mind in ……. to work behind primary care but also to do our user involvement to do community work to try and bring those different voices and perspectives together to then plug into the NHS [partnership working can help bridge gap]."

2:

Question 2: What's understanding of the needs of BM? And their difficulties (what do they need)	Awareness of inequalities	Participant 1 "but actually there are parts of the population that have who experience some more coercive parts of the mental health system, which are black men." Participant 6 "Um I mean I think you know what's the needs specifically for black men I mean my response to that is more that in …….. we recognise that were got the highest prevalence rates for psychosis in western Europe higher

		Schizophrenia and bipolar [awareness of high severe and enduring diagnosis]"
	Intersectionality (causes cut across several areas) – caution not to homogenise (need joined up approach- systemically)	Participant 1: "who experience some more coercive parts of the mental health system, which are black men. [awareness of increased coercive care with Black men] And I think there are a number of reasons why that happens, I think there's culture, [cultural different] there's racism, [racism] there's how they come into the system [entering the system]. And there's issues about how young black men are perceived by society" [societal perceptions]. Participant 2 "there is the social factors the environmental factors and their cultural factors [biopsychosocial factors]so I think their needs are good mental health care interventions good social care interventions and also for inclusion or flexibility of services so if the fundamentals could be describes for

		people from any background ermm you need [services being flexible in delivery to fit needs]nuance and flexibility in ways of delivering or have them well received so I think there are on the whole more barriers to engagement for people from BME groups, was it black men specifically."[barriers to engagement for BME populations] Participant 4. "Um I think poverty and that's for BME groups, it's a key factor so young black men are more likely to be out of work not educated involved in drugs and gangs, as working people are too but definitely for young black men [increased social issues for BME and Black men]. I think I can't say this is true for black men its true for all people who have lack of

		educationally attainment, teenage pregnancy all of those things that impact on people's lives." Participant 6. "we're recognising that also you can't pin any of the causes there isn't a causal link with [need systemic change] just one intervention its multiple interventions so therefore it's important that all organisations are aliened in their endeavors and we join up we integrate or what-ever term you want to use." Participant 6. "living well network where you put all of our funding into a single pot 66 million a year all our spend on beds acute services."[culture change in system]

		Participant.6. “regardless of race and I mean poverty and discrimination and many of the people who access our services are second third generation errm and you know so experience of migration e.t.c for many communities and particularly for some of the newer communities that have arrived is equally traumatic, [multiple societal factors influencing MH]community services third sector placements and umm all of providers are working towards a single suit of outcomes rather than multiple and I suppose the [culture change in terms of systemically working towards same outcomes] culture that we put in place is that my problem is your problem so it’s not the case that so a few years ago a problem in the

		inpatient part of the system.” Participant 6. “people with mental health issues and substance misuse and who are clearly acutely unwell they’re not equipped to manage those individuals and often that can end up in quite disastrous outcomes with people end up getting jailed and they’re an litany of incidents where people have died in police custody e.t.c and I think those examples highlight why we need to work as a system and alien and rather than beating the crap out of each other we need to come together to resolve I think.” Participant 6. “well poverty [poverty influencing] its errr you know for many people you know you know you

		sort of say men generally don't seek out support e.t.c part of that is societal [constructs maleness] not something we do maybe cultural." Participant 5. "Umm I mean in this borough if you overlay maps of ethnicity and poverty, poor housing, work-lessness or low income work um they all sit on top of each other pretty neatly but not uniformly but there is a high correlation with [high social problems with Black people]um with that so the east of the borough particularly the north east there's a higher concentration of black male population there are high levels of social housing and um low income so Participant 4. I think people who live in poverty in general and

		not specifically to young black men are always there's not on the same equal footing, so they are more likely to develop mental health problems because of all the other factors in their life, so I think there's that massive inequality there. [poverty impacting on MH] A" And how do you think that has an impact?" Participant 8 "It has a massive impact on all walks of life, your ability to go into a job, retain a job, to look after your family, your ability to keep social services from your door, you know there's loads of relationships, whether you become that vulnerable that you become." [poverty and social issues impacting on all areas of life]

6.9. Appendix I- Preliminary Themes and Sub-Themes

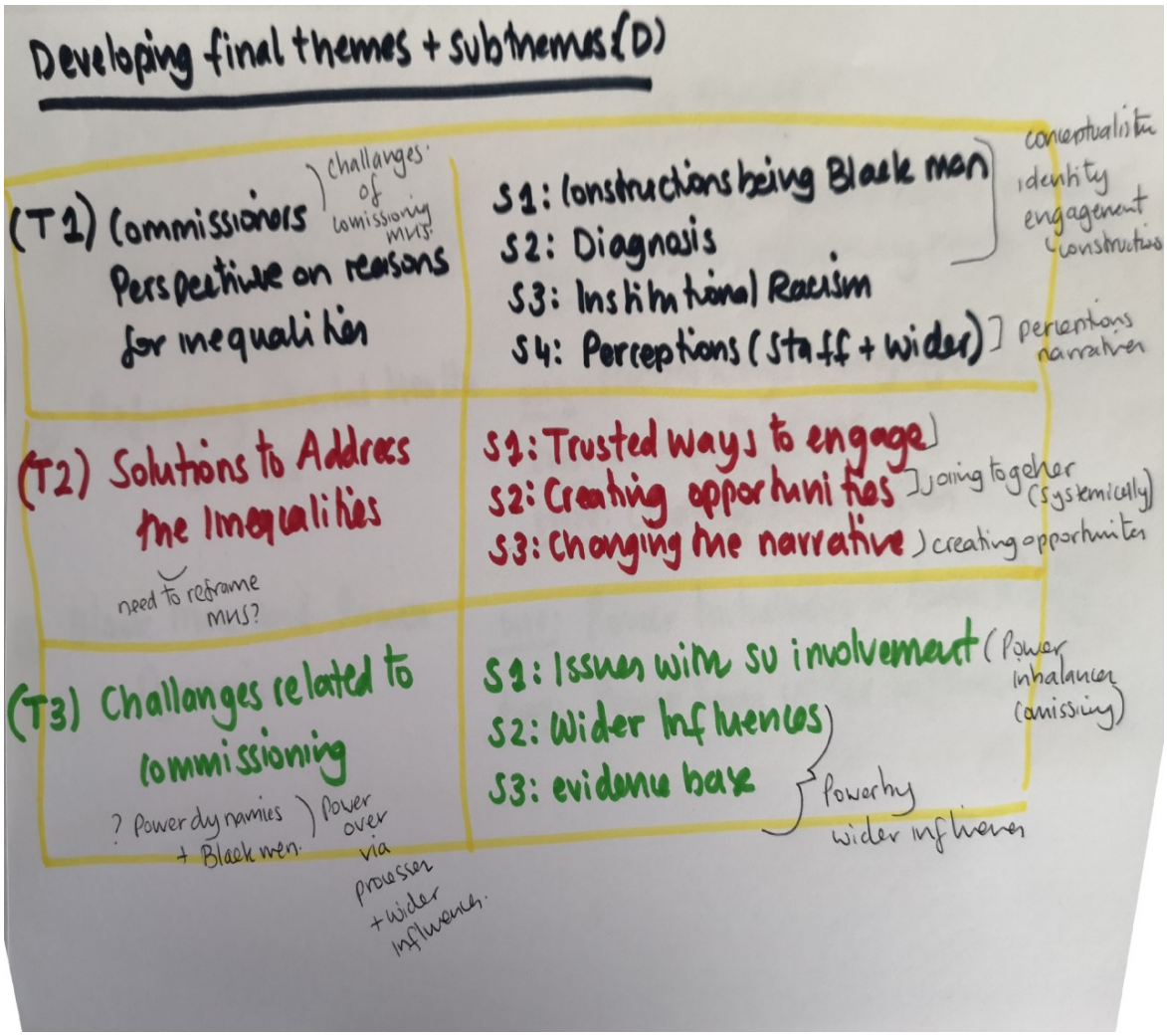
Theme one	Commissioner's perspective on reasons for Inequalities for Black Men OR Factors Influencing Inequalities for Black men in MHS	**Sub-Theme one:** Constructions of being a Black Male *-Constructions impacting on engagement & help-seeking* *-intersect of being Black and male and what this means* *-caution to not homogonise* *Participant 7*. "I cannot answer that definitively but as the research shows that black men don't normally access you know health provisions and this is my personal point as a black man is that often err you know when you go for help it's been a part of our tradition culture [black masculinity impacting on engagement] whatever um don't seek help we have to stand up on our own we have to be mature and also we have to be shown outwardly that were handling things going into sort of like health care provision is can be seen as a form of weakness" Participant 7. "Er yes and I don't need help I can manage on my own and I think that's something that has

		been part of our culture part of our you know heritage you know the whole thing around you know moving from a lot of use I wouldn't say displaced immigrated to a number of different countries [black masculinity influencing construction of Black men & help seeking] around the world and we you know it shows that we have not achieved and can be seen as a failure and we can't fail it's not appropriate for us to" *Participant 8*. "There a number of things that are interconnected so it's not just the issue of ethnicity and Blackness African heritage it's the fact of maleness and also youth as well those [black masculinity] two things are also factors in the engagement process so it's important to also think to some extent the problems facing black men there are no doubt problems facing men in terms of engagement in therapy and men tend to engage less in therapy problems in the early stage and end up in the acute end young people *Participant 8* "The issue is for African heritage is not one community where

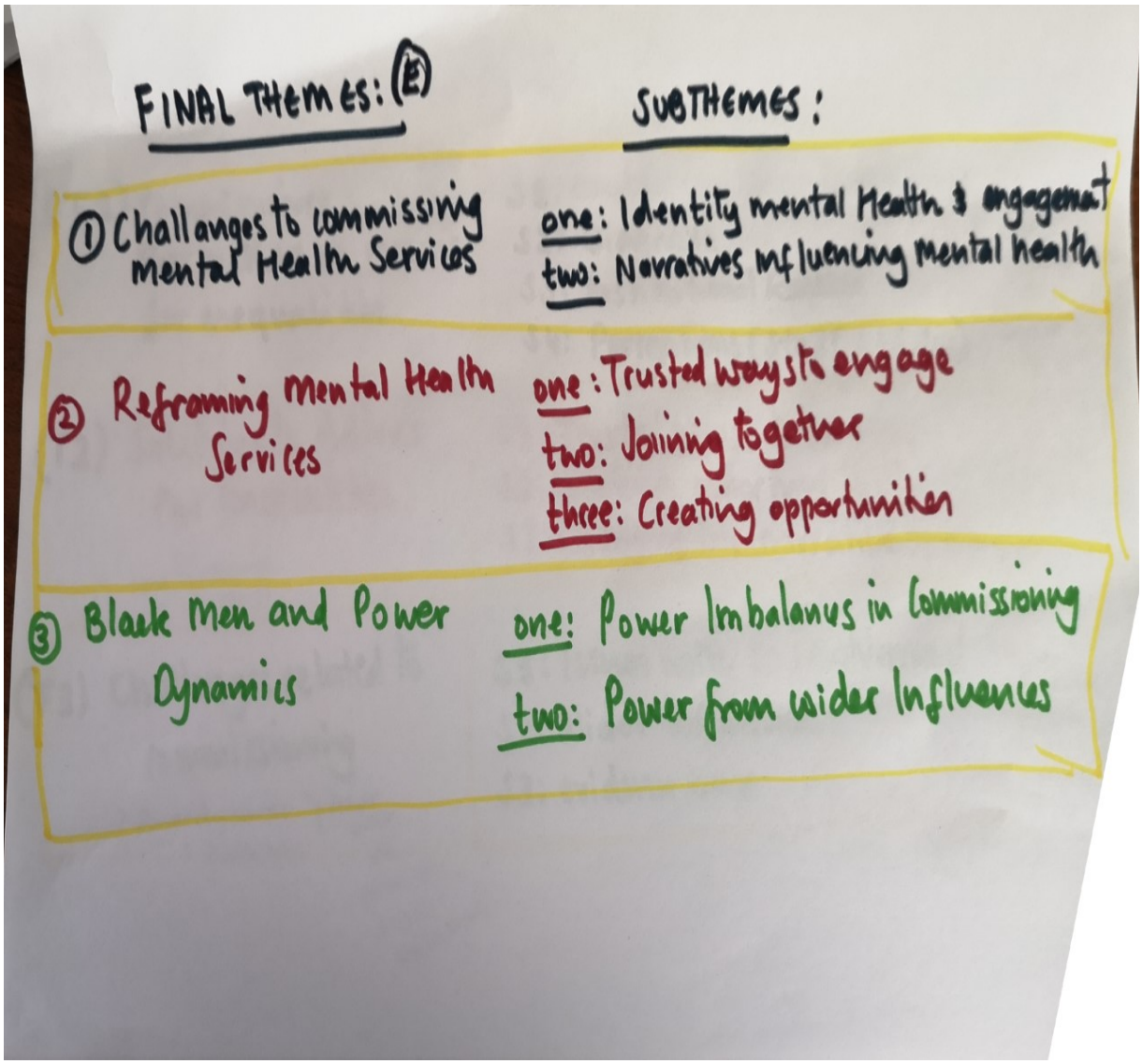
		as those communities are homogenised [black men not a homogeneous groups if we talk about African heritage we talk about Afro Caribbean black African so many different cultures and um but having said that the best to talk about African heritage there is enough sense of homogeneity to to um you know create a community to think about a community approach in that community and kind of approaches we take out with people so." Participant 1. "umm because they don't engage early I think there is stigma to do with having a mental health problem, I think there's an issue about saying young black men because there are quite a lot of cultural differences [caution to not homogonise And so umm you know African Caribbean men are a distinct population who fair worst." *Participant 2*. "last but not least you've got all the issues of maleness so you've got men don't like to seen as weak and won't go to therapy [constructions masculinity impacting on engagement] early etc. etc. and young

		men are not bothered with this stuff and then and finally we've got the double stigma issue so if you think maleness if there's a fragile ego who feel they have to be strong um and therefore can't be seen as weak then we might say black men identity is increasing that cause they already feel perhaps [double discrimination of being black and with a mental health label stigmatised for being black if they're perceived as also won't confess to having a mental health so that's double stigma and then extra weakness in terms of being a man." *Participant 6.* "But yeah some would argue that about you know masculinity men we don't like fessing up to problems we don't seek help etc that's one argument, I think you know many of my fathers, you know." [construction of masculinity] *Participant.6*. "you sort of say men generally don't seek out support etc part of that is societal [constructs maleness] not something we do maybe cultural."

6.10. Appendix J- Developing Final Themes and Sub-themes



6.11. Appendix K- Final Themes and Sub-themes



6.12. Appendix L- Guidelines for Good Thematic Analysis

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.