A systematic review of inequalities in the mental health experiences of Black African, Black Caribbean and Black-mixed UK populations: implications for action

A Systematic Review of Inequalities in the Mental Health Experiences of Black African, Black Caribbean and Black-mixed UK Populations: Implications for Action.

Devonport, T. J[1]*, Ward, G.[2], Morrissey, H.[3], Burt, C.[4], Harris, J.[4], Burt, S.[4], Patel., R.[4], Manning, R.[4], Paredes, R.[4], & Nicholls, W.[5]

*[1] Corresponding author T.Devonport@wlv.ac.uk, ORCID ID: 0000-0003-4808-244X, School of Sport, University of Wolverhampton, Walsall, UK.

[2] School of Sport, University of Wolverhampton, Walsall, UK.

[3] School of Pharmacy, University of Wolverhampton, Wolverhampton, UK.

[4] Birmingham Community Healthcare NHS Foundation Trust, Birmingham, UK.

[5] ORCID ID: 0000-0002-8623-7986, School of Psychology, University of Wolverhampton, Wolverhampton, UK.

Acknowledgements: We would like to acknowledge the Public Health Division in Birmingham City Council who commissioned and funded this systematic review.

Abstract

Background: Measurable differences in the experience and treatment of mental health conditions have been found to exist between different racial categories of community groups. The objective of this research was to review the reported mental health of Black African-Caribbean communities in the UK, determinants of mental health, and interventions to enhance their experiences of mental health services.

Method: The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement was applied. To be included, papers must be: published in a peer reviewed journal; report on adult populations (over 18) from any of Black African, Black Caribbean or Black mixed people in the UK; and assess (quantitative), or discuss (qualitative) mental health experiences, determinants of mental health, or interventions intended to enhance experiences of mental health services among the target population. The aims, inclusion criteria, data extraction, and data quality evaluation were specified in advance. Searches were conducted using EBSCO (PsychInfo; MEDLINE; CINAHL Plus; psychology and behavioural sciences collection). The search strategy included search terms relating to the aim (see Appendix 1). Risk of bias was assessed using a standard tool, records were organised using Endnote, and data were extracted and synthesised using Microsoft Excel.

Results: Thirty-six studies were included, of which 26 were quantitative and six reported exclusively on Black participants. Black populations were less likely to access mental health support via traditional pathways due to stigma and mistrust of mental health services. Black Africans especially, sought alternative help from community leaders, which increased the likelihood of accessing treatment at the point of crisis or breakdown, which in turn increased risk of being detained under the Mental Health Act and via the criminal justice system.

Discussion: Findings suggest a cycle of poor mental health, coercive treatment, stigma, and mistrust of services as experienced by Black communities. Evidence was limited by poorly defined ethnic categories, especially where Black populations were subsumed into one category. It is recommended that mental health services work collaboratively with cultural and faith communities in supporting Black people to cope with mental illness, navigate mental health pathways, and provide culturally appropriate advice.

Keywords: Healthcare, Inequalities, Interventions, Policy

Protocol Registration Number: PROSPERO CRD42021261510

Introduction

Measurable differences in the experience and treatment of mental health conditions have been found to exist between different racial categories of community groups [1,2]. For example, in the UK, Black African and Black Caribbean people are two to eight times more likely to be diagnosed with severe mental health conditions compared to white people [3,4]. Social determinants linked to the development of mental health conditions, such as employment, income, housing and exposure to criminality, are also more likely to be experienced by Black African and Black Caribbean communities [5,6]. Black populations are less likely to seek treatment for mental health conditions, and thus in research reporting the prevalence and treatment of mental health conditions, this racial group is often underrepresented [7,4]. Black populations have been reported to have less access to relevant support for their mental health [8] and experiences and outcomes for Black individuals are often less effective and, in some circumstances, cause harm [9,10].

Numerous studies have explored relationships between racial and ethnic groups, onset, diagnosis, treatment and outcomes of mental health conditions [10]. Research has also explored differences in the prevalence of mental health experiences by different racial groups' and their experiences of treatment services [11]. However, variations in the categorisation systems used to differentiate between groups has meant exploring causal relationships between the experience of mental health conditions by racial and ethnic groups is extremely challenging. Commissioned reports which aim to explore patterns in research related to racial and ethnic groups and mental health in the UK are available [4,7,8,12], however, these are based upon varying population and mental health parameters and have limited if any explanation of inclusion, exclusion and quality criteria related to the research from which they draw. Therefore, the purpose of this systematic review was to draw together peer reviewed research relating specifically to Black African, Black Caribbean and Black-mixed ethnicity UK populations and mental health. In doing so, the aim was to compare mental health by racial and ethnic groups,

to explore determinants of mental health, and interventions intended to enhance experiences of mental health services. From this, recommendations to enhance the provision of UK services involved in the diagnosis, treatment and rehabilitation of mental health conditions for this racial group will be presented.

Method

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement was applied. The protocol was registered (Prospero CRD42021261510) and aims, inclusion criteria, data extraction, and data quality evaluation were specified in advance.

Searches

Searches were conducted using EBSCO (PsychInfo; MEDLINE; CINAHL Plus; psychology and behavioural sciences collection). The search strategy included words relating to the aims as follows:

Search Terms

1. Black ethnic

   Search Terms; Black#African OR Black#Caribbean OR Black#mixed OR Black OR Afr* Caribbean OR Minority OR Ethnic* OR Race OR people colour

2. Mental health

   Search Terms; Mental health OR Well#being OR Psychological health OR mental ill#health OR Affective Disorder* OR Psychosis OR Bipolar Disorder OR Mood Disorder* OR Psychotic Disorder* OR Mental Disorder* OR depression OR anxiety OR Personality disorder* OR Mental Illness OR suicide OR Self Harm

3. Healthcare inequality

   Search Terms; Health#care access inequalit* OR Health#care access* OR Health#services access* OR Health Inequalit* OR Healthcare utilisation OR Health Disparit* OR Equit* OR Health Inequit* OR Health#care Bias OR Discrepan* OR Health Exclusion

Searches were delimited to peer reviewed articles, and English language. This article is examining publications in the past ten years (January 2011 - June 2021). The rationale for this is because the present review is focused on African and Caribbean populations, however prior to 2011 these subgroups were recognised under a global category of 'Black or Black British' in census data, and therefore the granularity in analysis that was required for the present review was less apparent in population health research. Following 2011, the subcategories of 'African' and 'Caribbean' were introduced in the census, denoting a better representation of subgroups which were of interest in the present review. We deemed using the word Black or mixed Black as poorly defined ethnicity during the quality assessment of publications. In addition, 2011 marked the final national census of the race and ethnicity of inpatients in the NHS in England and Wales [13]. No other restrictions were applied.

Inclusion Assessment

Reference management software was used to organise citations (Endnote). The search yielded 16612 records (see Figure 1). After deduplication and removing records published pre-2011, 9581 records remained and were independently screened by two reviewers based on the title of the article. Where there was disagreement, the full text manuscript was consulted by two reviewers to reach agreement using the exclusion criteria stated below. For research to be included, there had to be consensus that the following criteria were met:

(a) Empirical research;

(b) Published in a peer reviewed journal;

(c) Paper reports on any of Black African, Black Caribbean or Black mixed groups of people in the UK;

(d) Participants were aged 18-years and above;

(e) Paper must assess (quantitative), or discuss (qualitative) mental health experiences, determinants of mental health, or interventions intended to enhance experiences of mental health services among the target population.

Fig. 1 PRISMA Flowchart Illustrating Selection and Identification of Included Studies

Following the title and abstract screening, the full text from 207 records was assessed for eligibility. A further 173 records were excluded at this stage. Reasons for exclusion were; sample outside of the UK (*n* = 81), no data specific to target population (*n* = 29), inappropriate format (e.g., Book chapters, editorials; *n* = 36), not reporting on relevant outcomes (*n* = 17), sample included children (*n* = 5), outside of the timeframe (*n* = 3), and duplicates (*n* = 2).

Following screening (see Figure 1), 34 relevant records were included**.** Two additional papers were identified from citations of included papers. These 36 records are identified with an asterisk in the reference list.

Data Extraction

Data extraction was handled in Microsoft Excel and headings captured pertinent information including participants, measures, reported outcomes, mental health interventions, research limitations, and implications for practice.

Data Quality

Quality of included papers was assessed by the first and last author using the standard quality assessment for evaluating primary research papers, QualSyst [14]. QualSyst was specifically designed for quality scoring within systematic reviews where a diverse range of study designs are identified for inclusion. Studies were evaluated against criteria covering design, sampling, methodology, analysis, results, and conclusions. QualSyst comprises two complementary tools, a qualitative tool with ten items and a quantitative tool with a maximum of 14 items.

Each item was scored on a scale from 0 to 2, with 2 presenting a higher quality score, using the published manualised benchmarking criteria [14]. On the quantitative tool, benchmarking criteria specify a score of 'Not Relevant' (NR) should be recorded where appropriate (e.g., item 5, "If random allocation to treatment group was possible, is it described?" is scored as NR for surveys). A mean quality score was calculated for each included paper to give a standardised overall rating of quality. The mean was calculated by summing the total relevant scores and dividing this by the number of total relevant items. The possible range of scores for each paper was therefore 0-2, with 2 indicating higher quality. The mean score across all papers for each criterion was calculated to indicate the relative strengths and limitations within included studies. Inter-rater agreement was assessed across a sub-sample and was within a satisfactory range (n = 10, κ = .615-1).

Results

Quality Assessment of Included Studies

The quality review performs two functions, firstly to help discriminate between papers within our review which are of a poor or particularly high standard. To address this, four papers scored more than one standard deviation below the mean quality score for all included papers (see Supplementary Table 1a and 1b), thus demonstrating comparably poorer quality within the pool of papers identified for this review. These papers should be interpreted with caution [15-18]. Five sources [19-23] were assessed as being of higher quality within the pool of included studies (scored more than one standard deviation above the mean).

The second function of the quality review is to comment broadly on the limitations and strengths within the body of work that is reviewed. Limitations are detailed later, whilst studies generally performed well on clearly describing objectives, analysis, and conclusions aligning with results. In addition, qualitative studies were strong on describing the context for their data gathering.

Table 1. Characteristics of the Population in Included Studies

	Authors	Year	Sample size	Black Participants* (*n*)						Ethnicity Coding method	Setting
				Black total *n* (%)		Black African (*n*)	Black Caribbean (*n*)	Black Mixed (*n*)	Other Black Background (*n*)		
24	Adams et al.	2015	320	160	(50)	0	160	0	0	Not specified	Clinical
25	Bansal et al.	2014	41997	60	(0.14)	60	0	0	0	Patient records	Clinical
21	Bhavsar et al.	2021	1455	303	(20.82)	187	116	0	NR	Self-described	Community
26	Brown et al.	2014	9197	NR**		NR	NR	NR	NR	IAPT patient records	Clinical
22	Calvert et al.	2012	5,354	1912	(35.71)	0	1912	0	0	Based on name and visual inspection	Community
27	Chakraborty et al.	2011	100	100	(100)	0	100	0	0	Self-described	Clinical
28	Cooper et al.	2013	23748	544	(2.29)	NR	NR	NR	NR	Self-described	Clinical.
29	Das-Munshi et al.	2018	10504	883	(8.41)	NR	NR	NR	NR	Patient records	Clinical
30	Edge et al.	2018	31	10	(32.26)	NR	NR	NR	NR	Self-described	Clinical
15	Eliacin	2013	62	62	(100)	NR	NR	NR	NR	Patient records	Community
31	Fernández de la Cruz et al.	2016	293	107	(36.52)	61	46	NR	NR	Self-described	Community
19	Gazard et al.	2018	1052	220	(20.91)	135	85	NR		Self-described	Community
20	Gazard et al.	2015	1698	377	(22.20)	234	143	NR		Self-described	Community
16	Gwaspari et al.	2011	79	79	(100)	31	17	0	31	Self-described	Clinical
32	Hackett et al.	2020	4883	1283	(26.27)	563	720	0	0	Self-described	Community
6	Hatch et al.	2011	1698	377	(22.20)	234	143	0	0	Self-described	Community
33	Hickson et al.	2016	5799	52	(0.89)	NR	NR	NR	52	Standardised questionnaire	Community
18	Hui et al.	2021	77	13	(18.05)	NR	NR	4	9	Not specified	Clinical & Community
34	Jankovic et al.	2020	615092	31,601	(5.14)	18,009	4,883	4,579	4,130	Patient records	Clinical
35	Jensen et al.	2021	34	29	(85.29)	NR	NR	7	22	Self-described	Clinical
36	Kapadia et al.	2018	2260	397	(17.57)	0	397	0	0	Self-described	Clinical
37	Karadzhov & White	2020	10	10	(100)	5	0	2	3	Self-described	Community
38	Kular et al.	2019	89	16	(17.98)	NR	NR	NR	16	Self-described	Clinical
39	Lawrence et al.	2021	35	17	(48.57)	0	17	0	0	Not specified	Clinical

	Authors	Year	Sample size	Black Participants* (*n*)					Ethnicity Coding method	Setting
40	Lawrence et al.	2021	35	17	(48.57)	0	17	0	0	Not specified	Clinical
23	Mann et al.	2014	674	357	(52.97)	188	78	36	55	Standardised questionnaire	Clinical
41	Mansour et al.	2020	5546	520	(9.38)	96	424	NR	NR	Patient records	Clinical
17	Mercer et al.	2019	32087	8471	(26.40)	NR	NR	NR	NR	Patient records	Clinical
42	Morgan et al.	2017	387	153	(39.53)	45	108	0	0	Not specified	Clinical
2	Qassem et al.	2015	26091	549	(2.10)	NR	NR	NR	549	Self-described	Community
10	Rabieea & Smith	2013	97	80	(82.47)	29	51	0	0	Not specified	Community
43	Sancho & Larkin	2020	17	17	(100)	12	1	4	0	Selection criteria	Community
11	Schofield et al.	2019	35	35	(100)	NR	NR	NR	35	Selection criteria	Community
44	Singh et al.	2014	4275	827	(19.35)	NR	NR	NR	827	Patient records	Clinical
45	Wallace et al.	2016	~40000	NR**		NR	NR	NR	NR	Self-described	Community
46	Weich et al.	2012	40	8	(20)	1	3	1	3	Not specified	Clinical

NR - Not Reported

*There was variance regarding the categories used to define race and therefore the total number of Black participants is calculated to allow for comparison between studies. Where studies identified specific Black populations, these numbers are reported under the appropriate heading. Where 'Not Reported' (NR) is noted, no data were reported using this category.

** Being large scale surveys, these studies did not report exact number of participants who were Black, but it was clear that the target group participated in the study.

Comparison of Mental Health among Black and White Populations

In presenting findings, the term patients refers to research undertaken in a clinical setting (see Table 1), service users refers to participants accessed from community healthcare settings, and participants, people, or populations reflect studies undertaken with community populations, or a synthesis of findings from both community and clinical settings.

Four studies reported better or equivalent outcomes for Black populations compared to White [41,45,44,42]; including a lower prevalence of depression in a population of older adults [41, mean age 76.8, SD = 8], and less likelihood of reporting self-harm [41,42]. In addition, racial grouping was not a significant predictor of being detained under the Mental Health Act once assessment sites (London, Birmingham or Oxford) were controlled for [40].

Thirteen included studies indicated that there *are* disadvantageous differences in prevalence of mental health disorders associated with Black race and ethnicity. When compared to White patients, Black Caribbean and Black African patients experience double the risk of being diagnosed with psychotic symptoms [41], more frequent, longer hospital admissions, more often involving police [10,26,42], and have worse rates of recovery from psychosis at ten-year review [42]. They are also more likely to be prescribed with psychotics when compared to White British service users [29]. Despite this, they make significantly less use of health services [19] for problems with emotions, nerves, alcohol or drugs. Black African (and White) patients were more likely to present with self-injury than were Black Caribbean patients [41]. Black African patients were twice as likely to receive short-term detention [25], four times as likely to have a compulsory treatment order [25], more likely to be hospitalised [23,44], and had significantly higher rates of involuntary admission [44] than White British individuals. Black Caribbean participants were shown to have a greater risk of meeting criteria for CMD (typically defined as depression, generalised anxiety disorder,

phobias, obsessive compulsive disorder, and panic disorder) than Black Africans, and White British [6,20]. Black Caribbean patients presented a higher incidence of suicide *attempt* than Black African [42]. Where prevalence statistics combined all Black ethnic groups into one category, Black participants were more likely to have anxiety [40], depression [40], attempt suicide [40], and be more likely to be diagnosed with psychosis before the age of 45 [2] than participants from a White background.

Determinants of Mental Health

Within the included studies, Black participants considered their mental health problems to be a consequence of exposure over time to negative life experiences and adversities, ranging from poor housing and inadequate income, to discrimination, loss of culture, and trauma [11,15,26]. Support for this contention comes from the work of Wallace et al. [45] who, when controlling for economic disadvantages and racism, found a mental health advantage for Black African participants as compared with a White British group. Common determinants of mental health identified across included sources, as detailed below, included employment, racism, stigma, and pathways to mental healthcare.

Employment

Evidence of social disadvantage among Black patients, as compared to White patients, was identified at the point of admission for mental healthcare services [42] and at follow-up [40]. For example, unemployment rates were the highest for people from a Black background (26%) in comparison with their White counterparts (11%) [6], and Black Caribbean women were more likely (32.9%) than White women (18.9%) to be in the lowest household income quartile [36]. At ten-year follow up from onset of psychosis, only 6% of Black Caribbean patients and 5% of Black African patients unemployed at baseline were employed and were respectively five and three times more likely than White British patients to be employed for less than 75% of the ten-year study period [40,42].

Racism

Included studies highlight that societal racism contributes to poor mental health outcomes, such as psychosis, psychological distress, and poorer mental functioning [32]. Chronic exposure to racial discrimination was reported to have an incremental negative long-term effect upon mental health including longer psychiatric hospital admission [30,45]. Furthermore, racism was reported by Black communities' when accessing mental health services, creating a mistrust of mental health services/professionals that associated with disillusionment, a sense of hopelessness, a lack of agency, a feeling of resignation, lower perceptions of effectiveness and poor adherence [10,11,19,20,24,26-28,40]. Negative and persistent media portrayals of a 'suffering' or fragmented community contribute to stressors (e.g., a sense of apathy, defeat, fragmentation in the community and hopelessness) which impact mental health [15]. In a specific example, Black Caribbean patients experienced less success in challenging psychiatric decisions and negotiating their treatment than White British patients [26].

A sense that Black service users feel trapped by the system was conveyed in qualitative research [11]. For example, in a theme identified by Lawrence et al. [40] entitled "losing self within the system", the struggle of being unable to break the cycle of service use was evident in the narratives of 64.7% of Black Caribbean patients as compared to 20% of White British patients' narratives. Conversely, the theme "steadying self through the system", presents a belief that recovery from mental illness is possible, this is evident in the narratives of 93.3% of White British patients and in none of the narratives of the Black Caribbean patients [40].

Cultural Beliefs and Associated Stigma

Several sources [10,11,30,31,37,38-40,43,45] examined the influence of cultural beliefs and attitudes on the understanding and management of mental illness within Black communities. For example, the stereotype of Black African and African Caribbean women as being 'strong' can stop them seeking help, as illustrated in the following quote: 'Oh yeah, women of Colour,

African Caribbean, African, whoever they are, there is a stigma attached. They are not supposed to have breakdowns. We are supposed to be strong Black women. Put up an appearance and take care of the house and so on.' [43, p. 36].

Religious/spiritual practises and their associated stigma were identified as presenting a barrier; first in recognising mental illness, and second with help-seeking behaviours, such as accessing mental health services [11,43]. Black patients used self-stigmatising language to describe their mental illness and hospitals (e.g., "mad house"; 40, p. 4). This was linked to spiritual beliefs (including obeah, juju, possession, spirits, magic and curses), which existed within families and the wider community, and functioned to compound the consequences of being diagnosed with mental illness [10].

Stigma towards individuals labelled with a mental illness can act as a substantial obstacle to the recovery and provision of care for many people experiencing mental health problems. This was evidenced by Kular et al. [38] who found that stigma was a significant predictor of longer duration of untreated psychosis in patients. Indeed, in one study [37], Black clergy respondents explicitly distinguished themselves from the 'typical African pastor' and cautioned that the dominant cultural and religious beliefs about mental health in Africa were oftentimes counterproductive to recovery.

Alternative conceptualisations of mental health and illness (including beliefs about the role of spirituality; 26,30) resulted in a lower uptake of treatment among Black ethnic groups. Evidence suggests that Black African and Black Caribbean individuals would be less inclined to seek help for mental health difficulties, or should they do so, were conflicted between approaching the church or professional services [31]. For example, if their child were presenting with symptoms of obsessive-compulsive disorder (OCD) described in a vignette, Black African parents were significantly more likely to agree with seeking help from their religious community (59.3 %) than White British parents (11.8 %). Black African parents

were also less likely to attribute OCD to biopsychosocial factors than White British parents and less likely to seek help [31].

Pathways to Mental Healthcare

Pathways to mental healthcare more often involved the police and criminal justice referral for Black individuals when compared to White individuals [10,23,26,42]. This experience was echoed in a qualitative study; "Black people, you know, it's either hospital or prison" [10, p. 171]. There was fear of being put in a 'white jacket with the laces up' among Black Caribbean patients and their families [26, p. 3]. Such mistrust of healthcare services evidenced here may be influenced by the higher risk of Black people being detained for compulsory treatment under the Mental Health Act. For example, Black Africans had a twofold excess risk of short-term detention and over fourfold excess risk of compulsory treatment order compared to White Scottish people [25], Black African women had a higher proportion of involuntary admissions under the Mental Health Act compared to White British women [44], and hospital admissions were more frequent, longer and two times more likely to involve police and compulsory admission in Black Caribbean and Black African patients compared with White British [42].

Some studies argue that distrust of the system contributes toward low rates of early uptake of mental health services evidenced among individuals of Black African and Black Caribbean heritage [26], meaning that mental health crisis and breakdown feature as significant entry points into mental health services. However, included sources indicate that mistrust is not the only consideration. Additional explanations as to why Black ethnic groups might consult less with health care professionals for mental health problems include: perceived racism, disillusionment with doctors, perceived exclusion from services, a sense of stigma, a lack of knowledge about mental illness and services, different illness models, a feeling that care is a family responsibility, fears of confidentiality, language barriers for

service users, carers and service providers alike, and doubts about the cultural competence of services [10,24,26].

Rather than *engagement* with services, some studies found *access* to community mental health services to be the problem among Black African and African Caribbean populations [10,21,29,34]. This was attributed to language barriers, failure to refer to secondary care because of not recognising the severity of mental health problems at primary care, and lack of out-of-hours support [10]. It is of note that Black African service users and carers from both Somalia and Congo were less aware of mental health services offered and were accessing support from faith-based communities [10]. Black ethnic service users mentioned bypassing traditional GP filters and accessing psychiatric services via accident and emergency departments, either because they did not know any other way, or because GPs did not pick up on the severity of their problems [10]. Indeed, whilst police were described as heavy handed at times, there was also appreciation that they turned up and tried to assist, with General Practitioners (GP's) described as offering minimal support; a source of repeat prescriptions [46]. A similar pattern was observed in a sample of post-partum Black African women, who were referred to secondary services less often when seen in primary care, had more complex pathways to specialist care, and were more likely to be involuntarily admitted to psychiatric inpatient care [34]. A lack of continuity in care for talking therapies was identified as an issue for service users [10].

Interventions Intended to Enhance Experiences of Mental Health Services for Black Populations

Cultural competency is a term used to describe interventions that aim to improve accessibility and effectiveness of health care services for people from ethnic minorities [47]. Across included studies, few interventions alluded to cultural competence. Where evident, addressing the communication skills of mental health care practitioners, as well as those working in relevant partner organisations (e.g., police forces, immigration removal centres, social care

etc) was a common focus. Specifically, using a high patient centred communication style was advocated [24], allowing Black patients a voice in conveying their experiences [18]. This was to facilitate discussions about racialised identity, as well as engage in conversations about religious, spiritual and cultural beliefs that influence help-seeking behaviours and outcomes pertaining to mental health [10,11,37]. Hui et al. [18] cautioned mental healthcare professionals to be mindful not to discredit lived experiences, voices, perspectives, and personal identities of Black patients as doing so can lead to their disengagement from mental health services. Conversely, where experiences were attended to, Black people selected more patient-centred treatments (e.g., talking therapy), as opposed to taking medication or waiting to see how their symptoms develop [24].

Edge et al. [30,35] delivered a Culturally adapted Family Intervention (CaFI) for African-Caribbean individuals diagnosed with Schizophrenia. The CaFI included a collaborative psycho-educational approach whereby therapists, relatives and service users would share each other's experiences and acquire knowledge. This led to more beneficial ways of managing difficulties related to schizophrenia and psychosis in the family. This was considered an important aspect of cultural adaptation, particularly in terms of addressing beliefs around mental illness, offering explanatory models, and laying the groundwork for behaviour change. Using a patient centred communication style helped to lessen power imbalances typically inherent in relationships between mental health practitioner and patient, and often magnified when White practitioners work with Black service users [30]. Developing strategies to address this was deemed to be crucial for trust-building [30], with aspects of the therapeutic approach described as important including the therapists' patience, ability to listen to service users, tailoring information to suit the abilities of service users, and involving family members collaboratively in therapy sessions [35].

Included papers offer that culturally adapted interventions should be co-designed [30], delivered, and evaluated with larger and representative samples of service users and family

members in diverse settings and at different stages of the therapeutic process [35]. Black patients and service users stated that Black doctors would be more likely to understand their perspective and concerns [10,30,43]. Indeed, wariness of mental health treatments amongst Black people has been associated with living in predominantly White societies [24], with race-based discrimination, including institutional racism often forming part of their experience of mental illness and mental health services [27,30]. Increasing the number, and visibility of Afro-Caribbean mental health professionals presents one strategy to demonstrate an increased awareness, embedded in the workforce, of the context in which mental health problems of Afro-Caribbean service-users exists [40]. This should be complemented by training to develop a high patient centred communication style, as previously described, across the entire workforce.

Discussion

Interpretation of the results

Collectively, findings illustrate a cycle whereby disempowerment, felt stigma, and mistrust lead to resistance to, passive acceptance of, or under use of mental health services [26,28,45]. In turn, this, along with seeking help from alternative sources, increases the likelihood of Black African and Black Caribbean populations accessing mental health treatment at the point of crisis or breakdown. This also increases the risk of being involuntarily detained under the Mental Health Act and via the criminal justice system. It has been argued elsewhere that this leads to and reinforces stereotypes of Black people with mental health concerns as being more dangerous and thus requiring more severe interventions [48-51]. The Independent Review of the Mental Health Act [48] found that this cycle creates and perpetuates ethnic inequalities in the diagnosis and management of mental illness, resulting in disproportionately high rates of hospital inpatient admission, compulsory admission, admission to intensive care and secure services, and use of seclusion and restraint in all types of hospital [48].

Exploring processes that affect help-seeking behaviours or impact on quality of care has important implications for engagement and overall quality of mental health services for Black people and reducing disparities in their access [21,28,40]. The review highlights that racism, stigma, cultural beliefs, and socioeconomic disadvantage are key processes. The association between adverse mental health and unemployment, persistent poverty and lower paid work has been reported as a consideration in explaining inequalities in mental health [6, 36]. Social and economic disadvantage tends to persist and differences between ethnic groups widen and become more entrenched over time [40,42]. It is argued that this produces increased risk for ill mental health in individuals with Black African or Caribbean heritage [52]. Chronic exposure to racial discrimination has an incremental negative long-term effect upon mental health and probability of seeking help for mental health related issues [45,53]. Furthermore, experiencing actual and perceived racism from healthcare staff contributes to longer hospital stays, and feelings of disempowerment and mistrust.

Limitations of evidence

It is fundamentally accepted that research only represents those who have opportunity and/or are comfortable enough to participate [39]. Participants with the greatest need may not be represented, including; those declining participation [26], those not having the opportunity to participate, such as individuals who have less severe mental health conditions [41] and people who do not engage in mental health services [35]. When seeking to understand variables that may present barriers to the use of mental health services, recruiting service users who chose to discontinue therapy may provide better insight into the factors which make mental health services and therapy challenging or unacceptable to some users [35]. Such research offering insight into experiences of different ethnic groups may inform development of a culturally adaptable model of therapy that meets the needs of individuals/families from diverse ethnic and socio-cultural backgrounds [26]. This will support the development of more detailed

hypothesis-driven research to better understand mental health, and healthcare disparities as a basis for improving services and promoting equality of care [23].

Studies did not generally perform well on study design (see supplementary Table 3 for a summary of design, objectives, measures and outcomes). A poor description of participants' ethnic groups across many of the included studies must be acknowledged (e.g., 28). Consequently, caution must be exercised in seeking to compare and contrast the mental health experiences (along with protective and risk factors) of different ethnic categories or in making inferences for each category. Contributing to this limitation, the means used to determine ethnic status varied between studies. Seventeen studies asked participants to self-identify their ethnicity during interview, or focus groups [2,6,16,19-21,27-32,35-38,45], seven used patient hospital or electronic records [15,17,25,29,34,41,44], two asked participants to select ethnicity as part of the enrolment criteria [11,43], two used standardised questionnaires [23,33], one used the IAPT patient records [26], and one study used GP familiarisation with cultural name and visual inspection [22]. Seven studies did not specify their method [10,18,24,39,40,42,46].

There were missing or under-represented ethnic groups in several studies (e.g., 18,36,38,41,46), which could be a result of some minority groups being less likely to access the services being investigated [34,41]. Several studies recognised that their sample sizes were small [2,11,17,19,23,31,37,39,41,45] or highly specific [33,41], which limited generalisability of findings. It is of note that the number of Black participants in seven studies was below 10% of the total sample (see Table 1); and these findings should be interpreted with caution [2,25,28,29,33,34,41]. For example, in a study exploring ethnic mental health inequalities [25] there were only 60 Black participants among a sample of 41997 (0.14%). The dominant use of urban populations [6,19-21,23,26,43], also limits generalisability of conclusions to rural Black UK populations.

Qualitative studies performed poorly on reflexivity of their approach, with most studies failing to recognise how the interrelationship of the researcher's race and ethnicity

may have influenced the research process; a consideration that has recognised implications and importance [39,40]. White-European researchers recruiting participants may have resulted in problems in accessing ethnic minority groups [31] and a limited understanding of experiences of individuals in minority ethnic groups, with a need for Black researchers to be involved in processes for future research [40].

Data gathered by the South-East London Community Health Study (SELCoH) survey of psychiatric and physical morbidity [6] were used in four subsequent papers, each co-authored by Hatch [19-21,26]. Similarly, data from the AESOP-10 study [42] were used by two subsequent studies [45,46], whilst data from the UK Household Longitudinal Study (UKHLS) were used in two studies [32,45]. Whilst the practice of producing more than one paper from large data sets is not uncommon, it is important to acknowledge where this takes place because of possible idiosyncrasies of the population sampled and represented, and considerations in drawing generalisations from studies utilising the same data set.

Limitations of the review process

With regards to limitations of the systematic review process, the EBSCO database was chosen as the data source because of its wide coverage of relevant literature and return of the most unique sources relevant to the aims of this review [54]. Whilst Dimensions has wide coverage [55], its document classification seems less reliable, which would allow some non-articles to be included in the results. Google Scholar also has wide coverage [56] but does not split articles by document type, which was helpful here. However, we must consider the omission of such databases to be a limitation of the review process followed. As a funded systematic review, the broad scope was determined by the funder in order to inform an overall regional mental health strategy. We acknowledge that further and more focused reviews on specific mental health diagnoses could better disentangle differences by ethnic groups to inform policy and practice relating to specific mental health issues.

Implications for practice, policy, and future research

A recommendation for both research and practice is to gather and analyse data by specific ethnic categories rather than merging ethnic groups, as was the case in some included studies [28-30]. Mann et al. [23] is an example of best practice providing a very clear description of ethnic groups. Merging Black ethnic groups, or using 'BAME' (Black, Asian and Minority Ethnic), masks unique protective and risk factors relative to mental health. Gathering and analysing data by specific racial and ethnic groups will enable better understanding of the complex relationship between race, ethnicity and mental health in relation to protective and risk factors [21]. This includes social disadvantage [11,20], discrimination [19,32], social support structures in family and community [15,34], spirituality [30,37], specific mental health awareness and/or stigma associated with mental health [11,38], migration experiences and cultural assimilation [20-21].

Better understanding the cultural and faith beliefs of Black communities would complement services and promote recovery. Elsewhere, it has been suggested that matching the cultural, linguistic, religious and/or racial identity between service users and practitioners is an important means to improve treatment duration [49]. A trend in the included studies is for Black Africans to seek help from community leaders, especially those associated with religion [31,37,40], and for friends and family to encourage this [46]. Church leaders could play an important role in recognising signs and symptoms of mental health problems [37] and facilitate early signposting to mental health services. Karadzhov et al. [37] illustrated how Christian clergy were willing to collaborate with health professionals, believing they have capacity to ameliorate the symptoms of poor mental health, whilst the spiritual and pastoral interventions they offered could address the primary cause of the condition [37]. This illustrates how voluntary, community and social enterprise organisations may play an important role in supporting Black people to cope with mental illness, navigate mental health pathways, and provide culturally appropriate advice [10,42]. Indeed, the Independent Review of the Mental Health Act, 1983 [8] stated that culturally appropriate advocacy may improve

the mental healthcare experiences and recovery rates of individuals of African and Caribbean heritage. However, a reported barrier to a collaborative approach between church and mental health services, is a lack of understanding noted from both parties. Church leaders [37] and patients [10] note the scepticism of health professionals regarding the role of spirituality and faith in a person's mental and physical wellbeing. Equally, religion could become a barrier to accessing services where mental illness was not recognised as a medical condition, and it is believed that prayer alone can provide a cure [10,40].

Involving voluntary, community and social enterprise organisations in mental healthcare marks a step towards a holistic approach, a practice advocated by service users [43]. Furthermore, there was also benefit found in involving carers, families, and friends in a person-centred way [30,35]. To help preserve the support of informal carers on discharge from hospital, there is a need to involve them in care plans [10]. Improving knowledge about mental health within family and close circles, could help prevent stigmatised views towards mental health and encourage help-seeking and self-referral [40,46].

Conclusions

This review found evidence of inequalities in experiences of mental health and treatment for Black communities in the UK. Societal determinants (such as employment, housing, and institutional racism) not only influenced mental wellbeing, but also access to and experiences with mental healthcare services. Black communities were more likely to seek help from voluntary, community and social enterprise organisations as opposed to professional healthcare services, notably those offered by the faith community. Targeting collaborative mental healthcare initiatives between professional healthcare services and voluntary, community and social enterprise organisations may enhance understanding of, and dispel myths with mental health. It may also increase access to culturally competent professional mental health services, enhancing satisfaction with the mental healthcare received among Black populations. When undertaking research examining mental health by race and ethnicity,

capturing mental health prevalence, and treatment outcomes using precise ethnic groups will greatly assist in efforts to monitor trends in this area, and help ensure that progress is made towards a more equitable experience for all.

Statements and Declarations

Funding

This work was supported by the Public Health Division in Birmingham City Council who commissioned and funded this systematic review.

Competing Interests

On behalf of all authors, the corresponding author states that there is no conflict of interest.

Availability of Data and Material

As a systematic review, all original data sources are highlighted by an asterisk in the references section and can be located using the following details author(s), title, publisher (repository name), and DOI identifier (expressed as full URL's). Raw scores for data quality assessment are available as supplementary materials, as is the summary extraction table.

Code Availability

There is no code created and that directly relates to the results described in this systematic review article.

Author Contributions

All authors contributed to the study conception and design. Material preparation and data collection were performed by Tracey Devonport, Wendy Nicholls, Gavin Ward, and Hana Morrissey. Data synthesis was completed by Tracey Devonport and Wendy Nicholls. The first

draft of the manuscript was written by Tracey Devonport and Wendy Nicholls and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Ethics Approval

This is a systematic review. The University of Wolverhampton Research Ethics Committee has confirmed that no ethical approval is required.

Consent to Participate

As a systematic review, informed consent to participate was obtained from individual participants included in each respective included study.

Consent for Publication

As a systematic review, it is not possible to state with certainty that consent to publish was sought from participants as part of informed consent.

References

**** Sources identified as evidence in the systematic review***

1. Davis T, Moore WL, Bell JM. Teaching in Black and White: Reflections of Teaching the Social Construction of Race. In Challenging the Status Quo (pp. 117-132). Brill. 2018.

2. *Qassem T, Bebbington P, Spiers N, McManus S, Jenkins R, Dein S. Prevalence of psychosis in black ethnic minorities in Britain: analysis based on three national surveys. Soc Psychiatry Psychiatr Epidemiol. 2015; https://doi.org/10.1007/s00127-014-0960-7

3. Grey T, Sewell H, Shapiro G, Ashraf F. Mental health inequalities facing UK minority ethnic populations: Causal factors and solutions. J Psychol Issues in Organ Cult. 2013; https://doi.org/10.1002/jpoc.21080

4. Bignall T, Jeraj S, Helsby E, Butt J. Racial disparities in Mental Health: Literature and evidence review. Race Equality Foundation. 2019 Available at: https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf Accessed 31 March 2022

5. Mental Health Foundation. Black, Asian and Minority Ethnic (BAME) communities. 2021 Available at: https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities Accessed 31 March 2022

6. *Hatch SL, Frissa S, Verdecchia M, Stewart R, Fear NT, Reichenberg A, Morgan C, Kankulu B, Clark J, Gazard B, Medcalf R, Hotopf M. Identifying socio-demographic and socioeconomic determinants of health inequalities in a diverse London community: the South East London Community Health (SELCoH) study. BMC Public Health. 2011; https://doi.org/10.1186/1471-2458-11-861

7. Dyer J, Gilbert S. Independent review of the Mental Health Act 1983: Supporting documents. Mental Health Act Review African and Caribbean Group - final report to the review chair. 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778898/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf Accessed 31 Jan 2022.

8. Wessley S. Modernising the mental health act: Increasing choice, reducing compulsion. Final report of the independent review of the Mental Health Act 1983. 2018. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review Accessed 31 Jan 2022.

9. Sewell T, Aderin-Pocock M, Chughtai A, Fraser K, Khalid N, Moyo D, Muroki M, Oliver M, Shah S, Olulode K, Cluff B. Commission on race and ethnic disparities: The

report. 2021
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf Accessed 31 Jan 2022.

10. *Rabiee F, Smith P. Being understood, being respected: An evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK. Int J Ment Health Promot. 2013; https://doi.org/10.1080/14623730.2013.824163

11. *Schofield P, Kordowicz M, Pennycooke E, Armstrong D. Ethnic differences in psychosis-Lay epidemiology explanations. Health Expect. 2019; https://doi.org/10.1111/hex.12901

12. Mind. Inequalities for Black Asian and Minority Ethnic Communities in the NHS mental health services in England. 2020 Available at: https://www.mind.org.uk/media/6484/race-equality-briefing-final-oct-2020.pdf Accessed 31 March 2022.

13. Care Quality Commission. Count Me In. Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales. 2011. https://www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf Accessed 31 Jan 2022.

14. Kmet LM, Lee RC, Cook LS. Standard quality assessment criteria for evaluating primary research papers from a variety of fields. Edmonton, AB, Canada: Alberta Heritage Foundation for Medical Research. 2004. https://doi.org/10.7939/R37M04F16

15. *Eliacin J. Social capital, narratives of fragmentation, and schizophrenia: An ethnographic exploration of factors shaping African-Caribbeans' social capital and mental health in a North London community. Cult Med Psychiatry. 2013; https://doi.org/10.1007/s11013-013-9322-2

16. *Gwaspari M, Hochhauser S, Bruce M. Unmet needs and antisocial personality disorder among Black African and Caribbean service users with severe mental illness. Ethnicity and Inequalities in Health and Social Care. 2011; https://doi.org/10.1108/17570981111189579

17. *Mercer L, Evans LJ, Turton R, Beck A. Psychological therapy in secondary mental health care: Access and outcomes by ethnic group. J Racial Ethn Health Disparities. 2019; https://doi.org/10.1007/s40615-018-00539-8

18. *Hui A, Rennick-Egglestone S, Franklin D, Walcott R, Llewellyn-Beardsley J, Ng F, Roe J, Yeo C, Deakin E, Brydges S, Penas Moran P, McGranahan R, Pollock K, Thornicroft G, Slade M. Institutional injustice: Implications for system transformation emerging from the mental health recovery narratives of people experiencing marginalisation. PloS One. 2021:

https://doi.org/10.1371/journal.pone.0250367

19. *Gazard B, Chui Z, Harber-Aschan L, MacCrimmon S, Bakolis I, Rimes K, Hotopf M, Hatch SL. Barrier or stressor? The role of discrimination experiences in health service use. BMC Public Health. 2018; https://doi.org/10.1186/s12889-018-6267-y

20. *Gazard B, Frissa S, Nellums L, Hotopf M, Hatch SL. Challenges in researching migration status, health and health service use: an intersectional analysis of a South London community. Ethn Health. 2015; https://doi.org/10.1080/13557858.2014.961410

21. *Bhavsar V, Jannesari S, McGuire P, MacCabe JH, Das-Munshi J, Bhugra D, Dorrington S, Brown JSL, Hotopf MH, Hatch SL. The association of migration and ethnicity with use of the improving access to psychological treatment (IAPT) programme: A general population cohort study. Soc Psychiatry Psychiatr Epidemiol. 2021; https://doi.org/10.1007/s00127-021-02035-7

22. *Calvert M, Duffy H, Freemantle N, Davis R, Lip GYH, Gill P. Population health status of South Asian and African-Caribbean communities in the United Kingdom. BMC Health Serv Res. 2012; https://doi.org/10.1186/1472-6963-12-101

23. * Mann F, Fisher HL, Major B, Lawrence J, Tapfumaneyi A, Joyce J, Hinton MF, Johnson S. Ethnic variations in compulsory detention and hospital admission for psychosis across four UK Early Intervention Services. BMC Psychiatry. 2014; https://doi.org/10.1186/s12888-014-0256-1

24. *Adams A, Realpe A, Vail L, Buckingham CD, Erby LH, Roter D. How doctors' communication style and race concordance influence African–Caribbean patients when disclosing depression. Patient Educ Couns. 2015; https://doi.org/10.1016/j.pec.2015.08.019

25. *Bansal N, Bhopal R, Netto G, Lyons D, Steiner MFC, Sashidharan SP. Disparate patterns of hospitalisation reflect unmet needs and persistent ethnic inequalities in mental health care: the Scottish health and ethnicity linkage study. Ethn Health. 2014; https://doi.org/10.1080/13557858.2013.814764

26. *Brown J, Ferner H, Wingrove J, Aschan L, Hatch S, Hotopf M. How equitable are psychological therapy services in South East London now? A comparison of referrals to a new psychological therapy service with participants in a psychiatric morbidity survey in the same London borough. Soc Psychiatry Psychiatr Epidemiol. 2014; https://doi.org/10.1007/s00127-014-0900-6

27. *Chakraborty A, King M, Leavey G, McKenzie K. Perceived racism, medication adherence, and hospital admission in African-Caribbean patients with psychosis in the United Kingdom. Soc Psychiatry Psychiatr Epidemiol. 2011; https://doi.org/10.1007/s00127-010-0261-8

28. *Cooper C, Spiers N, Livingston G, Jenkins R, Meltzer H, Brugha T, McManus S,

Weich S, Bebbington P. Ethnic inequalities in the use of health services for common mental disorders in England. Soc Psychiatry Psychiatr Epidemiol. 2013; https://doi.org/10.1007/s00127-012-0565-y

29. * Das-Munshi J, Bhugra D, Crawford MJ. Ethnic minority inequalities in access to treatments for schizophrenia and schizoaffective disorders: findings from a nationally representative cross-sectional study. BMC Med. 2018; https://doi.org/10.1186/s12916-018-1035-5

30. *Edge D, Grey P. An assets-based approach to co-producing a Culturally Adapted Family Intervention (CaFI) with African Caribbeans diagnosed with schizophrenia and their families. Ethn Dis. 2018; https://doi.org/10.18865/ed.28.S2.485

31. *Fernández de la Cruz L, Kolvenbach S, Vidal-Ribas P, Jassi A, Llorens M, Patel N, Weinman J, Hatch SL, Bhugra D, Mataix-Cols D. Illness perception, help-seeking attitudes, and knowledge related to obsessive–compulsive disorder across different ethnic groups: A community survey. Soc Psychiatry Psychiatr Epidemiol. 2016; https://doi.org/10.1007/s00127-015-1144-9

32. *Hackett RA, Ronaldson A, Bhui K, Steptoe A, Jackson SE. Racial discrimination and health: a prospective study of ethnic minorities in the United Kingdom. BMC Public Health. 2020; https://doi.org/10.1186/s12889-020-09792-1

33. *Hickson F, Davey C, Reid D, Weatherburn P, Bourne A. Mental health inequalities among gay and bisexual men in England, Scotland and Wales: a large community-based cross-sectional survey. J Public Health. 2017; https://doi.org/10.1093/pubmed/fdw021

34. *Jankovic J, Parsons J, Jovanović N, Berrisford G, Copello A, Fazil Q, Priebe S. Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities-a population-based study. BMC Med. 2020; https://doi.org/10.1186/s12916-020-01711-w

35. *Jensen E, Carr R, Degnan A, Berry K, Edge D. Exploring service user and family perspectives of a Culturally adapted Family Intervention (CaFI) for African-Caribbean people with psychosis: A qualitative study. Br J Clin Psychol. 2021; https://doi.org/10.1111/bjc.12273

36. *Kapadia D, Nazroo J, Tranmer M. Ethnic differences in women's use of mental health services: Do social networks play a role? Findings from a national survey. Ethn Health. 2018; https://doi.org/10.1080/13557858.2016.1263283

37. *Karadzhov D, White R. Between the "whispers of the Devil" and "the revelation of the Word": Christian clergy's mental health literacy and pastoral support for BME congregants. J Spiritual Ment Health. 2020; https://doi.org/10.1080/19349637.2018.1537755

38. *Kular A, Perry BI, Brown L, Gajwani R, Jasini R, Islam Z, Birchwood M, Singh SP.

Stigma and access to care in first-episode psychosis. Early Interv Psychiatry. 2019; https://doi.org/10.1111/eip.12756

39. *Lawrence V, McCombie C, Nikolakopoulos G, Morgan C. Ethnicity and power in the mental health system: experiences of White British and Black Caribbean people with psychosis. Epidemiol Psychiatr Sci. 2021; https://doi.org/10.1017/S2045796020001043

40. *Lawrence V, McCombie C, Nikolakopoulos G, Morgan C. Navigating the mental health system: Narratives of identity and recovery among people with psychosis across ethnic groups. Soc Sci Med. 2021; https://doi.org/10.1016/j.socscimed.2021.113981

41. *Mansour R, Tsamakis K, Rizos E, Perera G, Das-Munshi J, Stewart R, Mueller C. Late-life depression in people from ethnic minority backgrounds: Differences in presentation and management. J Affect Disord. 2020; https://doi.org/10.1016/j.jad.2019.12.031

42. *Morgan C, Fearon P, Lappin J, Heslin M, Donoghue K, Lomas B, Reininghaus U, Onyejiaka A, Croudace T, Jones PB, Murray RM, Doody GA, Dazzan P. Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: The ÆSOP-10 study. Br J Psychiatry. 2017; https://doi.org/10.1192/bjp.bp.116.193342

43. *Sancho TN, Larkin M. "We need to slowly break down this barrier": understanding the barriers and facilitators that Afro-Caribbean undergraduates perceive towards accessing mental health services in the UK. J Public Ment Health. 2020; https://doi.org/10.1108/JPMH-12-2019-0099

44. * Singh SP, Burns T, Tyrer P, Islam Z, Parsons H, Crawford MJ. Ethnicity as a predictor of detention under the Mental Health Act. Psychol Med. 2014; https://doi.org/10.1017/S003329171300086X

45. *Wallace S, Nazroo J, Bécares L. Cumulative effect of racial discrimination on the mental health of ethnic minorities in the United Kingdom. Am J Public Health. 2016; https://doi.org/10.2105/AJPH.2016.303121

46. *Weich S, Griffith L, Commander M, Bradby H, Sashidharan S, Pemberton S, Jasani R, Bhui K. Experiences of acute mental health care in an ethnically diverse inner city: qualitative interview study. Soc Psychiatry Psychiatr Epidemiol. 2012; https://doi.org/10.1007/s00127-010-0314-z

47. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Serv Res. 2014; https://doi.org/10.1186/1472-6963-14-99

48. Dyer J, Gilbert S. Independent review of the mental health act 1983: Supporting documents. Mental Health Act Review African and Caribbean Group - final report to the review chair. 2019; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data

/file/778898/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf Accessed 13 Jun 2022.

49. Bignall T, Jeraj S, Helsby E, Butt J. Racial disparities in Mental Health: Literature and evidence review. Race Equality Foundation. 2019. https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf Accessed 13 Jun 2022.

50. Sewell T, Aderin-Pocock M, Chughtai A, Fraser K, Khalid N, Moyo D, Muroki M, Oliver M, Shah S, Olulode K, Cluff B. Commission on Race and Ethnic Disparities: The Report. 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf Accessed 13 Jun 2022.

51. The Sainsbury Centre for Mental Health. The Costs of Race Inequality. 2006. https://www.centreformentalhealth.org.uk/sites/default/files/costs_of_race_inequality_policy_paper_6.pdf Accessed 13 Jun 2022.

52. Mental Health Foundation. Black, Asian and Minority Ethnic (BAME) communities. 2021. https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities Accessed 13 Jun 2022.

53. Sewell H. Toxic interaction theory: One reason why African Caribbean people are over-represented in psychiatric services and potential solutions. Ethnicity and Inequalities in Health and Social Care, 2012; https://doi.org/10.1108/17570981211286741

54. Bramer WM, Rethlefsen ML, Kleijnen J, Franco OH. Optimal database combinations for literature searches in systematic reviews: a prospective exploratory study. Syst. rev. 2017; https://doi.org/10.1186/s13643-017-0644-y

55. Thelwall M. Dimensions: A competitor to Scopus and the Web of Science? J Informetr. 2018; https://doi.org/10.1016/j.joi.2018.03.006

56. Martín-Martín A, Thelwall M, Orduna-Malea E, López-Cózar ED. Google Scholar, Microsoft Academic, Scopus, Dimensions, Web of Science, and OpenCitations' COCI: a multidisciplinary comparison of coverage via citations. Scientometr. 2021; https://doi.org/10.1007/s11192-020-03690-4

57. Brooks R, EuroQol Group. EuroQol: the current state of play. *Health policy*. 1996; https://doi.org/10.1016/0168-8510(96)00822-6

58. Chakraborty A, McKenzie K, Leavey G, King M. Perceived racism in African-Caribbean patients in the United Kingdom: the modified perceived racism scale. Clin Pract Epidemiol Ment Health. 2009; https://doi.org/10.1007/s00127-010-0261-8

59. Hogan T, Awad A, Eastwood R. A self-report scale predictive of drug compliance in

schizophrenics: reliability and discriminative validity. Psychol Med. 1983; https://doi.org/10.1017/S0033291700050182

60. Kemp R, Hayward P, Applewhaite G, Everitt B, David A. Compliance therapy in psychotic patients: randomised controlled trial. BMJ. 1996; https://doi.org/10.1136/bmj.312.7027.345

61. World Health Organization. WHO schedules for assessment in neuropsychiatry. WHO. 1992.

62. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophr Bull. 1987; https://doi.org/10.1093/schbul/13.2.261

63. McGuffin P, Farmer A, Harvey I. A polydiagnostic application of operational criteria in studies of psychotic illness. Arch Gen Psychiatry. 1991; https://doi.org/10.1001/archpsyc.1991.01810320088015

64. Lewis G, Pelosi AJ, Araya R, Dunn G. Measuring psychiatric-disorder in the community—a standardized assessment for use by lay interviewers. Psychol Med. 1992; https://doi.org/10.1017/S0033291700030415

65. Broadbent E, Petrie KJ, Main J, Weinman J. The brief illness perception questionnaire. J Psychosom Res. 2006; https://doi.org/10.1016/j.jpsychores.2005.10.020

66. Kroenke K, Spitzer RL, Williams JB. The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. Psychosom Med. 2002; https://doi.org/10.1097/00006842-200203000-00008

67. Babor TF, De La Fuente JR, Saunders J, Grant M. The alcohol use disorders identification test: guidelines for use in primary health care. World Health Organization. 1992.

68. Ware Jr. JE, Kosinski M, Keller SD. A 12-item short-form health survey: construction of scales and preliminary tests of reliability and validity. Med. Care. 1996; https://doi:10.1097/00005650-199603000-00003.

69. First MB, Gibbon M, Spitzer RL. The structured clinical interview for DSM-IV axis II personality disorders (SCID-II), American Psychiatric Press. 1997.

70. Phelan M, Slade M, Thornicroft G, Dunn G, Holloway F, Wykes T, Strathdee G, Loftus L, McCrone P, Hayward P. The Camberwell assessment of need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. Br. J Psychiatry. 1995: https://doi:10.1192/bjp.167.5.589

71. Berman AH, Palmstierna, T, Källmén H, Bergman H. (2007). The self-report Drug Use Disorders Identification Test: Extended (DUDIT-E): reliability, validity, and motivational

index. *J. Subst. Abuse Treat.* 32, 357–369. https://doi: 10.1016/j.jsat.2006.10.001

72. Goldberg D, Williams P. A user's guide to the general health questionnaire. Basingstoke: NFER-Nelson; 1988.

73. Kroenke K, Spitzer R, Williams J. The PHQ-9: the validity of a brief depression severity measure. J Gen Intern Med. 2001; https://doi.org/10.1046/j.1525-1497.2001.016009606.x

74. Spitzer RL, Kroenke K, Williams JB. A brief measure for assessing generalised anxiety disorder: the GAD-7. Arch Intern Med 2006; https://doi:10.1001/archinte.166.10.1092

75. King M, Dinos S, Shaw J, Watson R, Stevens S, Passetti F, Weich S, Serfaty M. The stigma scale: Development of a standardised measure of the stigma of mental illness. Br. J Psychiatry. 2007; https://doi.org/10.1192/bjp.bp.106.024638

76. Singh SP, Cooper JE, Fisher HL, Tarrant CJ, Lloyd T, Banjo J, Corfe S, Jones P. Determining the chronology and components of psychosis onset: The Nottingham onset schedule (NOS). Schizophr. Res. 2005; https://doi.org/10.1016/j.schres.2005.04.018

77. World Health Organization. ICD-10: international statistical classification of diseases and related health problems: tenth revision. World Health Organization. 2004.

78. Evans C, Connell J, Barkham M, Margison F, McGrath G, Mellor-Clark J, Audin K. Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE–OM. Br. J Psychiatry. 2002; https://doi.org/10.1192/bjp.180.1.51

79. Endicott J, Spitzer RL, Fleiss JL, Cohen J. The global assessment scale: A procedure for measuring overall severity of psychiatric disturbance. Arch. Gen. Psychiatry. 1976; https://doi:10.1001/archpsyc.1976.01770060086012

80. Bebbington PE, Nayani T. The psychosis screening questionnaire. Int J Methods Psychiatr Res. 1995.

81. Ware J, Kosinski M, Turner-Bowker D, Gandek B. User's manual for the SF-12v2 health survey with a supplement documenting SF-12 health survey. Lincoln, RI: QualityMetric Inc; 2009.