Adapting a salutogenic critical appreciative inquiry approach to the co-production of culturally sensitive mental health service delivery for Black African and African Caribbean communities in Birmingham, UK.

by

Angela D. Kumah

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As for God, His way is perfect; The word of the LORD is proven; He is a shield to all who trust in Him.

-Psalm 18:30

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ABSTRACT

Adapting a salutogenic critical appreciative inquiry (AI) approach to the co-production of culturally sensitive mental health services for Black African and African Caribbean communities in Birmingham, UK

Background

A growing body of research has explored the prevalence of health inequalities in the delivery of mental health services for racialised communities in the UK, with an increased call for the use of equitable co-production methods to engage communities in the design and development of culturally sensitive services. There is, however, very little research on the use of asset-based frameworks to address the needs of specific ethnic groups, such as the Black African and African Caribbean community. This study, therefore, sought to explore the factors identified by the Black African/African-Caribbean community and service providers as important in the design and development of culturally sensitive mental health services, using a salutogenic, critical appreciative inquiry process.

Methodology

Implementing appreciative inquiry in 3 distinct phases, the qualitative research methods of online interviews and focus groups produced rich insights on the value of cultural norms and beliefs as protective factors for mental health, social and cultural capital in building resilience as well as the nuances surrounding resilience narratives and their impact on help-seeking behaviour, from both community members and service deliverers.

Findings

Recommendations made for service deliverers included improving diversity and representation in leadership, promoting holistic, community-tailored mental health services and access to alternative treatment options, and enhancing school and workplace based mental health support. Discussing the integration of recommendations, service deliverers focused on fostering sustainable interagency collaborations, confronting systemic and institutional racism and community ownership in culturally sensitive mental health service delivery. One of the novel contributions of this study is the development of a checklist that can potentially be tailored by service providers and community members to promote quality assessments and evaluations aimed at improving cultural sensitivity within services. This research further contributes to the literature by revealing that within Black African and African-Caribbean communities, resilience is seen as an integral part of identity, shaped by the profound impact of racism and discrimination, rather than a conscious choice.

Conclusion

Results from this study demonstrate the need for more research aimed at addressing the multiple factors that may be considered in the design and development of culturally sensitive mental health services for the specific racialised communities in the UK, beyond the BAME umbrella. Overall, this study evidences the value of a salutogenic, critical appreciative inquiry approach for engaging stakeholders as equal collaborators in addressing systemic issues and the nuances to be considered in the process of co-designing equitable culturally sensitive mental health services for diverse communities.

Keywords: Health inequalities; Salutogenesis; Critical appreciative inquiry; Cultural sensitivity; Black African and African Caribbean communities

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ABBREVIATIONS

AI – Appreciative inquiry

BAME- Black, Asian and Minority Ethnicities

CBPR- Community based Participatory Research

CDWs- Community Development Workers (CDWs)

DH- Department of Health

DHS- Department for Health and Social care

DRE- Delivery Race Equality

FISs- Focused Implementation Sites (FISs)

GRRs- Generalised resistance resources

MH- Mental health

PAR- Participatory action research

SOC- Sense of Coherence

CHAPTER ONE

INTRODUCTION

"Be brave enough to start a conversation that matters". -- Margaret Wheatley

1.1 INTRODUCTION

This chapter lays the foundation for this thesis, offering insights into its rationale, significance and relevance to the current research context around mental health and health inequalities, particularly among Black African and African Caribbean communities in Birmingham, UK. The comprehensive background and contextual evidence provided in this chapter present a roadmap for exploring the historical, social, cultural, and political factors that have been examined in broader scholarly discourse around health inequalities in mental health service delivery. Highlighting key debates and empirical evidence, the research aims and objectives presented here set the stage for further discussions in subsequent chapters on the philosophical underpinnings and the corresponding methodology applied in answering the research question. A general overview of the structure of this thesis is also briefly presented at the end of this chapter.

1.2 BACKGROUND AND CONTEXT

1.2.1 Mental health in the United Kingdom context

The apposite role of mental health in human functioning has become apparent in recent years. The World Health Organisation (WHO) (2004b) defines mental health as a person's ability to make a judgement of their capacity to effectively handle the stresses of everyday life, and function efficiently in their social and occupational settings, while making meaningful contributions to society. The WHO, however, suggests that this definition does not imply that the absence of mental illness equates to mental well-being, and advises that various socio-economic, political, and cultural factors must be taken into consideration in the evaluation of health and well-being.

The Diagnostic and Statistical Manual of Mental Disorders (DSM)-V (2018) goes on to define mental illness or a mental disorder as a condition that affects a person's psychological, developmental, and biological functioning, as a result of a disruption in the management of emotions, cognition and behaviour. A diagnosis of mental illness is given when symptoms displayed are at a clinically significant level and affect a person's social, interpersonal, and occupational functioning. At least, 90% of suicides, which the WHO (2019) listed as the 17th leading cause of death worldwide, may be attributed to mental illness. The 2017 Global Burden of Disease study, conducted by the Institute for Health Metrics and Evaluation, estimated that, averagely, one in ten people (10.7%), that is, about 792 million people worldwide, lived with a mental illness in 2017. More recent data, generated by the Global Health Data Exchange (GHDx), 2019, also showed that 1 in 8 people or 970 million people globally were living with, at least one mental illness, with approximately 280 million people living with depression, which was the most common diagnosis. In 2020, during the peak of the COVID pandemic, depression and anxiety levels rose by 26% and 28%, respectively, as recorded by WHO (2022).

In the UK, the Adult Psychiatric Morbidity Survey (APMS, 2014), found indications of depression and anxiety, which are the most common mental disorders, prevalent in 19.7% of persons, 16 and above, demonstrating that, averagely, one in six people in the UK may present with symptoms of depression or anxiety. Between 2021-2022 alone, data from the NHS England Mental health Dashboard (2022) reported that 3.25 million people accessed NHS mental health and learning disability support, with 18% of children being diagnosed with a mental health condition.

In dealing with the effects of mental illness, Davies (2013) estimated that the UK spent an estimated £74-£99 billion annually. A decade later, post-pandemic, a report by the Mental Health Foundation (2022) states that this figure has risen to £117.9 billion annually, and mental illness currently stands as the largest contributor to the national disease burden. According to the Mental Health Foundation (2016), dealing with the rates of increase in mental ill-health and its effects have proved to be one of the most arduous tasks in the field of public health in the last decade.

The need to improve access to mental health care and treatment, as well as create widespread awareness of the risk factors for mental illness have been a major global concern

over the last 20 years (WHO, 2013; SDG 3.4). As efforts are made to prevent the increase of mental health issues and improve individual and communal quality of life, the need for the promotion of mental health and improvement of mental health services in the UK has become more pertinent. Many barriers, however, still prevent the fair and equal distribution of care and support services for mental health in the UK.

1.2.2 Inequalities in mental health

The World Health Organisation (WHO, 2016) has defined health inequalities as the apparent disparity in the distribution of and contribution to health and well-being between various groups. The NHS (2020) further defines health inequalities as:

> "preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs".

Economic disparities, social status, race, ethnicity, and gender, among other factors, are major social determinants of the level of support different populations may receive in the area of health and social care (Hill, 2016). Recent developments have demonstrated that, even though the UK stands as a global leader in health inequalities research and policies, questions are still being raised regarding the ever-widening inequalities gap where the health of Black, Asian and Minority ethnic groups is concerned (Smith, Bambra and Hill, 2016; Wenham, 2020). The issue has grown in importance in light of the recent evidence the COVID-19 pandemic has uncovered, surrounding the systemic disparities that greatly affected many minority ethnic communities in the UK, as the deadly respiratory illness raged unabated for almost 2 years (Office for National statistics, 2020). Yet, still, researchers and healthcare professionals have barely skimmed the surface of the long-term impact of the pandemic on mental health within these populations (Katikireddi, 2021; Joshee et al., 2022).

Bhui and McKenzie (2008) have also stated that people of minority ethnic backgrounds are more susceptible to the risk of poor mental well-being. Further studies (Dowrick et al., 2009; McManus et al.,2016; Hui et al., 2020) have suggested that these communities have been

deprived of receiving the support and help suited to their mental health needs, resulting in lower rates of treatment and, subsequently, fewer recovery rates. Over the years, much evidence has been gathered on the prejudice, discrimination, and ill-treatment members of Black and minority ethnic groups face in the United Kingdom when accessing mental health services (National Institute for Mental Health in England, 2003; Friedli, 2009; Equality and Human Rights Commission, 2016). The services that are made available within these communities are ill-fitted to their socio-cultural needs and previous negative encounters have led to a common distrust of mental health services (Dein & Napier, 2008; Newbigging and Parsonage, 2017; Devonport et al., 2022).

The subject of health inequalities in the United Kingdom remains a dominant theme in discussions concerning people of minority ethnic backgrounds in the health and social care agenda, as well as on the political agenda. Many of these ethnic minority communities currently bear the brunt of the effects of the unequal and unfair distribution of healthcare resources and have been known to be in poorer health conditions and have lower life expectancy. Yet, still, these groups have experienced greater difficulties when it comes to accessing healthcare services (Tidyman, 2004; Suresh and Bhui, 2006; Bambra et al., 2010, Smith and Bambra, 2012). There is a substantial body of evidence on the high levels of inequalities that Black African and African Caribbean people living in the UK experience when accessing mental health services (Newbigging and McKeown., 2007; Bambra et al., 2010; Devonport et al., 2022). Given the multifactorial influences linked to these inequalities, researchers policy makers, and healthcare practitioners have constantly sought to find ways to alleviate these health disparities (Hussain et al., 2022). Yet, recent events, such as the COVID-19 pandemic, have brought to light the evidence of the widening disparities that still exists in the delivery of healthcare for people of Black ethnic background. Furthermore, a report produced by the Centre for Mental health (Allwood and Bell, 2020) on the impact of health inequalities on mental health during the pandemic led to calls for policymakers, healthcare commissioners and service providers to act with urgency on the matter of providing equitable care for people of minority ethnic background who faced the greatest risk during the pandemic. Especially with the current focus on cultural sensitivity and cultural competence training for healthcare professionals all over the UK, there is a greater need to address the foundational issues that mitigate these inequalities (Codjoe et al., 2021).

The influence of systemic/institutional racism and political structures that still impact healthcare policy and practice have been repeatedly addressed when the topic of health disparities comes up (Halvorsrud et al., 2018; Bansal et al., 2022). The BAME term (Black, Asian and Minority ethnicities) also plays a role in overlooking the individual realities of the various minority ethnic groups represented in the UK (Aspinall, 2020). Evidence of disparities, specific to the Black community, is, therefore, lost in statistics that lump all these groups together, losing sight of the specific cultural, socio-economic, and psychological needs of various populations.

Health inequalities among minority ethnic groups have been a major public health concern for decades and much research evidence exists on the detrimental effects of these inequalities on the quality of life of those of minority ethnic backgrounds living in the UK (Chouhan and Nazroo, 2020). Particularly in the delivery of mental health services, there is evidence of a lack of culturally sensitive care that is tailored to meet the needs of those receiving support. In the history of Black African and African Caribbean communities in the UK, systemic racism, discrimination, stigma, and other social determinants have been said to contribute to poorer outcomes for mental health within this population. There is already extensive literature that addresses the high statistics on detention rates of Black people in secure mental health facilities and the impact of maladaptive cultural narratives on mental health and the related stigma on help-seeking behaviour. Yet, there is a paucity of literature that effectively evaluates some of the protective factors within the culture and community of the Black African and African Caribbean population in the UK.

Concerns have also been raised regarding racial and ethnic discrimination from health service providers (Mclean et al., 2003; Weich et al., 2012; Sewell et al., 2021). In addition to this, having to deal with the stigma that is attached to mental illness in minority ethnic families and communities (Anglin et al., 2006; Memon et al., 2016; Kapadia, 2023) is a barrier that hinders the effectiveness of treatment and mental illness prevention, as well as mental health promotion. The National Institute for Mental Health in England (2003), acknowledged that one of the reasons why many issues existed in the delivery of mental healthcare to people of minority ethnic backgrounds, was that service evaluations and reforms did not consider cultural and ethnic factors in their service and organisational design. Two decades later, these very concerns are still at the forefront of discussions surrounding mental health inequalities

within these populations, and the current Mental Health Act White Paper (Department of Health and Social Care, 2021) highlights the most recent actions being taken to address this crucial issue.

Prior to this, the long-standing presence of health inequalities was outlined in The Black Report (Gray, 1982), published by the Department of Health and Social Security, which demonstrated evidence of unequal healthcare access and treatment and higher mortality rates among minority ethnicities in the UK. This report suggested that disparities in health and social care had not only existed since the formation of the National Health Service (NHS) in 1948 but had rather increased over time. However, in this report, health inequalities were generally attributed to social inequalities, such as, low income, lack of education, and lower employment levels prevalent among these minority populations, rather than the shortcomings of the delivery system of health and social care services (Gray, 1982). Forty years on, in the face of glaring evidence of the health inequalities clearly highlighted during the COVID-19 pandemic, the 2021 race report (Race Report, 2021: Commission on Race and Ethnic disparities) still purports that ethnicity/race is not the key player in the discrimination and unfair treatment Black, Asian and Minority ethnic groups have received from the health and social care system. Their report states:

> "The Commission rejects the common view that ethnic minorities have universally worse health outcomes compared with White people; the picture is much more variable. For many key health outcomes, including life expectancy, overall mortality, and many of the leading causes of mortality in the UK, ethnic minority groups have better outcomes than the White population. This evidence clearly suggests that ethnicity is not the major driver of health inequalities in the UK, but deprivation, geography, and differential exposure to key risk factors".

Indeed, ethnicity alone does not determine health outcomes, however, coupled with the higher rates of poverty and socioeconomic disadvantage, along with the deleterious effects of structural and institutional racism that greatly affect ethnic minority communities, these populations are more likely to experience poorer mental health outcomes (Bignall et al., 2019; Kapadia, 2023). Data generated by Public Health England (2020) and King's Fund (2021) revealed that Black Africans and African-Caribbeans, for instance, were more than four times and three times, respectively, likely to die of complications from COVID-19 when compared with other ethnic groups. The increased risk of death and complications from COVID-19 were

linked to low socio-economic status and occupational risks, as a result of many minority ethnic groups being on the frontlines, employed in key worker roles, such as health and social care (Ho et al., 2020; Millett et al., 2020; Vahidy et al., 2020; Platt, 2021). Notwithstanding, the controversy surrounding the truth in the statement released by the Race report against the statistics revealed is still being debated and demonstrates that multidimensional strategies need to be utilised in addressing the effects of structural and systemic inequalities on health outcomes for ethnic minority communities in the UK. Questions have also been raised regarding the use of the 'BAME' term and the resultant role it plays in perpetuating health inequalities among minority groups.

1.2.3 The 'BAME' term

The acronym 'BAME', which has been used by government agencies in the UK as a collective term to represent Black, Asian and Minority ethnic groups and communities, became popular in 2004. This lexicon, formally BME (Black and Minority ethnic groups), became common after it was used in parliamentary proceedings in the 1980s (House of Commons, 1987). In 2020, Public Health England (PHE) was reported to have used the term BAME 217 times in reference to health inequalities within these groups during COVID.

However, many issues have arisen because of the use of this term. Aspinall (2021) raised the argument against the use of the term 'BAME', because it is not an adequate reflection of the self-identity of the various ethnic groups and ignores the essential socio-cultural elements that differentiate many Africans and African Caribbeans, for instance, from each other by classifying different continents as one group of people.

The Commission on Race and Ethnic Disparities, in March 2021, requested that government organisations desist from using the term, submitting 24 recommendations for the purpose of increasing trust, promoting fairness, supporting inclusivity, and supporting greater control in the national decision-making process within minority ethnic groups. Further recommendations by the Commission were focused on tackling health disparities, especially within minority ethnic groups within the UK. In their opinion, by adapting a more detailed and ethnocentric approach across government organisations, right from the foundations of data

collection and analysis, there would be more scope for the development of quality plans and policies that cater better to the needs of the groups being served (Commission on Race and Ethnic Disparities, 2021).

An alternative term that the Black British Academics (2020) have referred to as preferable and a stance of resistance is 'people of colour', which is popularly used in the USA. In their opinion, it avoids the subservient position the term 'minority' places non-White people in, and the even further adaptation of the term 'racialised minorities' demonstrates a critique of White power.

However, for this research, the term 'Racialised communities' or 'Minority ethnic groups' or 'ethnic minorities' will be used interchangeably, where the term 'minority' refers to the statistical evidence on the representation of the population of Black African and African-Caribbean groups in the UK. Nonetheless, these petitions highlight the need for the recognition of distinctiveness in ethnic and cultural orientation when assessing issues surrounding health inequalities and drawing policies that cater to the needs of individual communities, such as Black African and African-Caribbeans living in the UK.

1.2.4 Black mental health outside 'BAME'

Black people (Black Africans and African-Caribbeans) in the UK constitute a population that have been subjected to significant discrimination and disproportionate treatment when it comes to accessing social, educational, economic, and healthcare needs. Since the influx of Black African-Caribbean and African immigrants into the UK in the 1940s and 1980s, respectively, the 2021 National census data showed that there are 2.4 million people (4.0%) from Black ethnic groups, 2.5% and 1.0% of whom identify as Black African and Black Caribbean, respectively. The percentage of Mixed or Multiple ethnic, White/Black African and Mixed White/Black African/Caribbean stands at 0.4% and 0.9%, respectively. The percentage of those identified as Other Black, stood at 0.5% (Office of National Statistics, 2021).

Even so, records exist of the presence of Black people in Great Britain as early as the 12th Century (Millard, 2016). According to Banton (1955) and Shyllon (1977), there were over fifteen thousand (15,000) Black people living in London and other parts of the UK at that time.

Nevertheless, the oversimplified categorisation of Black Africans and African-Caribbeans as culturally homogenous groups by many studies may be another issue at the heart of the lack of provision of culturally relevant support to these groups (Daley 1997; Lam and Smith 2009). The lack of consideration of the differences in culture and values, due to racial categorisations perpetuates narratives which downplay the individual experiences of each group's origin and history (Hall 1988; Modood 1994). Nonetheless, all categories of 'Black people', regardless of the variances in culture and values, share experiences of discrimination and oppression in various facets of their lives. Inequalities within these communities are rife across economic and social levels, putting many Black African and African-Caribbean people in disadvantaged positions. Across the UK, the highest rates of poverty and unemployment, exclusion in the education system (3 times more than the general student population) and over-representation in the prison system (18 per 1000 in contrast to 6 per 1000 for white groups) are common within the Black community (Catney and Sabater, 2015; Vernon, 2020; Strand and Lindoff, 2021).

The issue of mental illness and modes of treatment for people of minority ethnic descent, especially for people of Black African and African-Caribbean backgrounds, has also received considerable attention. In line with previous studies (Kiev, 1965; Hemsi, 1967), Sharpley, Hutchinson, Murray and McKenzie (2001) purport that, as early as the 1950s and 1960s, when large numbers of people from the Caribbeans migrated to England (Windrush), higher than normal diagnoses for schizophrenia were already being reported among these groups. Later studies by Pinto, Ashworth and Jones (2008) argued that even though migration is associated with an increased risk of schizophrenia, the higher records of diagnosis amongst second and third-generation Black African and Caribbean people could not solely be attributed to this factor.

Sharpley et al. (2001) attempted to categorise some proposed explanations, in line with those suggested by other researchers (Harvey et al., 1990; Marcellis et al., 1998), for these high rates of psychosis and schizophrenia among Black African and Caribbean people in the UK during this period. They explored the implications of misdiagnosis and cultural perceptions of the commonality of psychotic symptoms among this population and following some debates, they formally proposed a few theories about the controversial issue. Their biological theory suggested that genetic predisposition to mental illness, the effects of cannabis use, as well as

the effects of pre and postnatal complications could be associated with the high rates of diagnosis of schizophrenia and psychosis. Their exploration of the social hypotheses examined the outcomes of migration, socio-economic disadvantage and racism and maladaptive pathways to care. Their final examination of psychological hypotheses, linked to attributional styles and interpretation of life events, demonstrated that the paucity of consistent evidence surrounding these theories on 'ethnic vulnerability' (Fernando, 1991) drew questionable conclusions. Their inference was that more complex theories needed to be generated that considered the scope of political influences, cultural variation and other social disadvantages in the diagnosis and treatment of Black people (Sharpley et al., 2001; Morgan et al., 2005).

Further studies along the line (Cooper et al., 2008; Department of Health, 2003; Vernon, 2011) which compared rates of severe mental illness among various ethnic populations, found that Black African and Caribbean people were 2 to 8 times more likely to receive a diagnosis of psychosis as compared to White/Caucasian populations. Following this, Cooper *et al.* (2008) noted that data from carefully controlled research indicated a higher occurrence of psychotic symptoms among Black African and African Caribbean people, although prejudice and social context largely contributed to this. Vernon (2011), further corroborated these findings by attributing this frequent diagnosis to the discriminatory interpretation of psychotic symptoms, based more on culture and ethnicity than on psychological standards.

Some studies have also shared evidence on the relationship between the extroverted nature displayed by Africans and African Caribbeans in social interactions and the rate of misinterpretation of these behaviours as signs of schizophrenia (Littlewood, 1986; Mclean et al, 2003; Schwartz et al, 2019). In their opinion, the use of hand gestures, loud voices and raised tones that are common to the nature of Africans and Caribbeans may be perceived as aggressive and threatening behaviour, and the likelihood of these behaviours being amplified in the case of a schizophrenic patient is high. The treatment the individual may then receive may be more severe than that of a patient of different ethnic background whose symptoms manifest differently. This may lead to higher rates of involuntary admission into mental health facilities, greater use of force and restraint and higher doses of medication (Campbell et al*.,* 2004; York et al., 2016).

Several studies have reported that Black Africans and African Caribbeans make less use of mental health services than other populations (Thornicroft et al., 2007; Bhui et al., 2007; Grey

et al., 2013; Nazroo et al., 2020). Fear, in various forms, has been said to be a major contributing factor to the poor access to support for people living with mental health problems within the Black community. The negative experiences of discrimination of members of the Black community by mental health services have been a long-standing issue, with the interactions between both groups hardly improving in the last few decades (Bhui et al., 1995; Bowl, 2007; Rabiee and Smith, 2014; Nwokoroku, 2022). The combination of a fear of people with mental illness, mostly due to the stigma of violence attached to mental illness and the fear of services feeds into the deleterious cycle of poor mental health within the Black community (Link & Phelan ,1999; Morgan et al., 2005; Sweeney et al., 2015). Based on service user experiences of methods of diagnosis, hospital care, lack of cultural sensitivity in support services and concerns of racism and discrimination (HM Government, 2007; 2018), reports of these concerns spread within the community. This, consequently, reduces the likelihood of Black people accessing mental health support until critical care is needed. Unfortunately, they also commonly encounter discrimination in other aspects of life, such as education, employment, in the criminal justice system and in mainstream health settings (Moffat et al., 2009; Forrester and Hopkin, 2019). An amalgamation of all these distresses further perpetuates the delay in help-seeking and reinforces the culture of silence and stigma that exists around mental illness (Morgan et al., 2005; Keating, 2007; Jensen et al., 2021). NICE (2017) further highlighted that language and cultural barriers contributed to the decreased utilization of mental health services within Black African and Caribbean communities.

The repeated cycle of maladaptive pathways to mental health services, either through prisons, mandatory, involuntary psychiatric detention, police involvement in sectioning and through the courts and social services have been the same points discussed in literature from over 30 years ago (Littlewood, 1986; Bhui et al., 2003; Keating and Robertson, 2004; Butt et al., 2015; Synergi, 2018). When compared with other White or Caucasian groups, ethnic minorities, spanning all age ranges are 2 to 6 times more likely to be referred to mental health services through social services or the criminal justice system rather than through the GP. Among Black African and Caribbean youth, between the ages of 16-17, the disparity is especially wide, with an increased likelihood of them being referred to inpatient rather than outpatient services (Morgan et al., 2005; Chui et al., 2021). Hospitalization, which 19-39% of the time is more likely to be involuntary, is markedly more common among individuals of

Black African, African-Caribbean, or mixed heritage background, standing at 3 times more than the average person from a White, Chinese or Indian background. This same population have also been found to have records of the longest hospital stay, especially among African-Caribbean people (Count me in: HealthCare Commission, 2006; Mckenzie and Bhui, 2007; NHS Digital, 2022). A 2022 summary of detention statistics presented by NHS Digital (2022) shows that, spanning across the five broad ethnic categories in the UK, Black or Black British persons were four times more likely to be detained under the Mental Health Act (341.7 detentions per 100,000 population) than their white counterparts (72.4 per 100,000 population). Another major obstacle to receiving support for mental health within the Black community is the lack of alternative options for treatment, such as psychological therapies to alleviate symptoms of mental illness (Glover & Evison, 2009; Bansal et al., 2022).

Concerns surrounding the treatment of Black men in the mental health system have also received considerable attention from researchers. One area of concern is engagement with services among Black African and African Caribbean men, where Men's Health Forum (2006) have addressed the prevailing issue of a lack of access to mental health support services as a result of scarcity of information surrounding the availability of said support. In the cases where access to information is available, there still exists a reluctance to approach such services, an issue addressed by Keating in the Sainsbury report on Circles of Fear in mental health treatment (Keating & Robertson, 2004; Edge & Rogers, 2005).

Some commonly identified factors that contribute to the fear found among Black men in seeking support stem from the notion that autonomy and independence will be lost if they admit the weakness of dealing with mental illness (White, 2006). Also, given the nature of treatment other Black men have reportedly received in the past (Orville Blackwood, 1991; David Bennett, 1993; Mikey Powell, 2003), a compelling sense of fear keeps them from accessing or engaging with mental health services (Keating and Robertson, 2004). In what Robinson et al. (2011) referred to as 'a stalled cycle of recovery', they found in their study among Black men, that the lack of access to mental health care was linked to a high incidence of multiple experiences of stereotyping as Big, Black, Mad and Dangerous (Keating, 2007; Walker, 2020), as well as a lack of access to alternative therapies outside of psychotropic medication. Ultimately, it is evident that numerous factors contribute to the mental ill health and limited access to mental health care experienced by the Black population.

1.2.5 The Myth of "Maladaptive and Hard-to-Reach Communities"

Within the context of mental health research in the UK, Black African and African Caribbean communities have been known to fall in the category of 'hard-to-reach' communities, based on their lack of engagement in discussing and associating with sensitive topics, such as mental health and even physical health issues, such as cancer and sickle cell disease (Haywood et al., 2009; Bulgin et al., 2018; de-Graft Aikins et al., 2023). There is also a general distrust in engaging these communities in health-based research, as a result of past studies, such as the Tuskegee experiments (Green et al., 1997; Smirnoff et al., 2018; Bajaj and Stanford, 2021).

The phrase 'hard-to-reach' has been debated and challenged for the last three decades, leading to suggestions for the use of the term 'hardly reached' instead. Previous literature has referred to 'hard-to-reach' groups as 'obstinate' (Bauer, 1964), 'information poor' (Childers and Post, 1975) and 'chronically uninformed' (Freimuth, 1989). Doherty, Hall and Kinder (2003) propose another categorisation of hard-to-reach groups, where they referred to them to 'service resistant'. The service resistant, are those who may have had various adverse experiences with service providers, making them reluctant to engage further with them. The issue with the classification of groups as service resistant is that it attaches negative stereotypes to the service users and blames them for their unwillingness to engage with these services. In addition to having deep distrust for statutory and government institutions, these groups have been viewed as having poor access to mainstream communication channels leading service providers to think they have decreased information processing skills and assume a resigned, almost fatalistic attitude to seeking help in various areas (Freimuth and Mettger, 1990). Freimuth and Mettger, (1990) and, subsequently, Sokol and Fisher (2016), have also suggested that the term 'hard-to-reach' pointed blame to the affected groups, signifying that they were responsible for being out of the reach of services, even though service providers and their interventions may rather have been unsuitable for the targeted population. Brackertz (2005), Coe et al. (2008) and Sokol and Fisher (2016), on the other hand, proposed favouring the term 'hardly reached' over 'hard-to-reach', to further displace blame targeted at the fundamental values and qualities of the members of the groups, whom these services have an interest in reaching.

In the case of individuals in Black African and African- Caribbean communities in the UK, the label 'service resistant' has also been applied to justify the hard-to-reach categorisation, further perpetuating the stigma service providers attach to these groups. Subsequently, this could maintain the low expectations service providers have towards this group without fully considering the social and systemic issues that affect access to mental health services (RAWOrg, 2010). Haywood and Darko (2021) and Krobath and Taylor (2021) highlight that the implications of the continuous use of the term 'hard-to-reach' culminates in a shift in focus from the health inequalities and barriers faced in accessing healthcare among minority ethnicities to an argument on semantics. This further homogenises various groups of people constituting different ethnicities with distinct cultures and values, blurring individual ethnic identities, and undermining the diversity present. Cortis, Katz and Patulny, (2009) were of the view that the debate around the term hard-to-reach was an issue of relational communication between the service users and service deliverers.

Nevertheless, there is no shortage of research that sheds light on the reality that minority ethnic groups and so-called 'hard-to-reach' individuals have limited access to services, owing to their perceptions and past experiences of these services. Katz, La Place & Hunter (2007) and Sawrikar & Katz (2008) further drew attention to the fact that these 'unreachable groups' rather perceived the services as 'hard-to-reach' based on their experiences of treatment received in relation to their needs, rendering some of these services irrelevant and inappropriate for receiving support. Sewell (2012) was of the view that the 'hard-to-reach' or 'maladaptive communities' argument failed to take into consideration the effects of racism on service provision and access, and how this affected the attitude of service providers towards service users of minority ethnic background. A critical re-evaluation of terms, such as 'hard-to-reach', is imperative if there are to be any changes to the current narrative around access to services among minority ethnic groups.

1.2.6 Structural and Institutional Racism and Mental Health

The issue of structural (systemic) and institutional racism is also a continuing concern in research focused on Black mental health and inequalities in service delivery. Structural racism encompasses the normalisation of racism and discriminatory actions across broader cultural and institutional systems which interact at a macro level to perpetuate racial inequalities. Structural racism reinforces notions of white supremacy and privilege, leading to adverse outcomes for racialised communities (Lawrence and Keleher, 2004; Gee and Ford, 2011). Macpherson et al. (1999) defined institutional racism as the discriminatory actions and attitudes directed towards people of specific cultures, ethnicity, or race by specific organisations or groups, resulting in poor provision of professional services. This action of withholding a level or quality of care and support in the delivery of services from specific groups of people is underpinned by ignorance and racial stereotypes, that place minority ethnic populations in a disadvantaged position. Over the years, a significant number of studies (Patel and Fatimilehin, 1999; Karlsen, 2007; Chakraborty et al., 2010; Nazroo et al., 2020) have demonstrated the adverse, deleterious effect racism has on mental health, especially within the UK healthcare context. Following a recent review of the Dalhgren-Whitehead rainbow model of health determinants (1991), Dahlgren and Whitehead (2021) have highlighted the extensive influence of racism as the basis for the majority of health inequalities and have emphasised the collective impact of racial discrimination, as well as institutional and structural racism on the health and well-being of many racialised communities.

Came & Griffith (2018) and Halvorsrud et al. (2018) elucidate the need for policymakers and practitioners in the field of mental health practice to actively consider the role racism and racial bias play in reflecting the shortfalls of other aspects of social, economic, and interpersonal disadvantage in pathways to care for minority ethnicities. The covert nature of institutional racism may provide further breeding grounds for health inequalities to be perpetuated, as it is less apparent when compared to physical, racial violence and other acts of discrimination (Shiner, 2010).

Nonetheless, despite the influence of systemic and institutional racism, it is noteworthy to highlight the efforts of practitioners and policymakers who are still determined to offer their best service in both statutory and voluntary sector-based mental health care, where race and

ethnicity are at the forefront of many conversations. It is also worth noting that discrimination, a culture of silence and stigma around mental health and mental illness are still common within Black African and African-Caribbean communities and still act as barriers to receiving efficient mental health care. Ferdman and Sagiv (2012) highlight the controversy and dilemma many Caucasian professionals in the mental health field may face when it comes to addressing the difficulties, they experience in supporting clients from minority ethnic groups. For, as much as there is evidence of unequal distribution of healthcare resources to people from minority ethnic background, there are still many cultural barriers that prevent well-meaning professionals from offering mental health support to these groups. For fear of being labelled racists, many professionals fail to contribute their views on how the stigma and myths affect the quality-of-care people are willing to receive, because of their deeply entrenched cultural beliefs surrounding mental health. The volatility of the situation makes it increasingly difficult to contribute effectively to organisational change which focuses on addressing these barriers in a culturally sensitive manner. Notwithstanding, critical attention must be paid to appraising the socio-political structure and systems built around healthcare provision in the UK, that perpetuate racial injustices in an implicit manner (Bonilla-Silva, 2017; Younis, 2021).

1.2.7 The picture of mental health in Birmingham

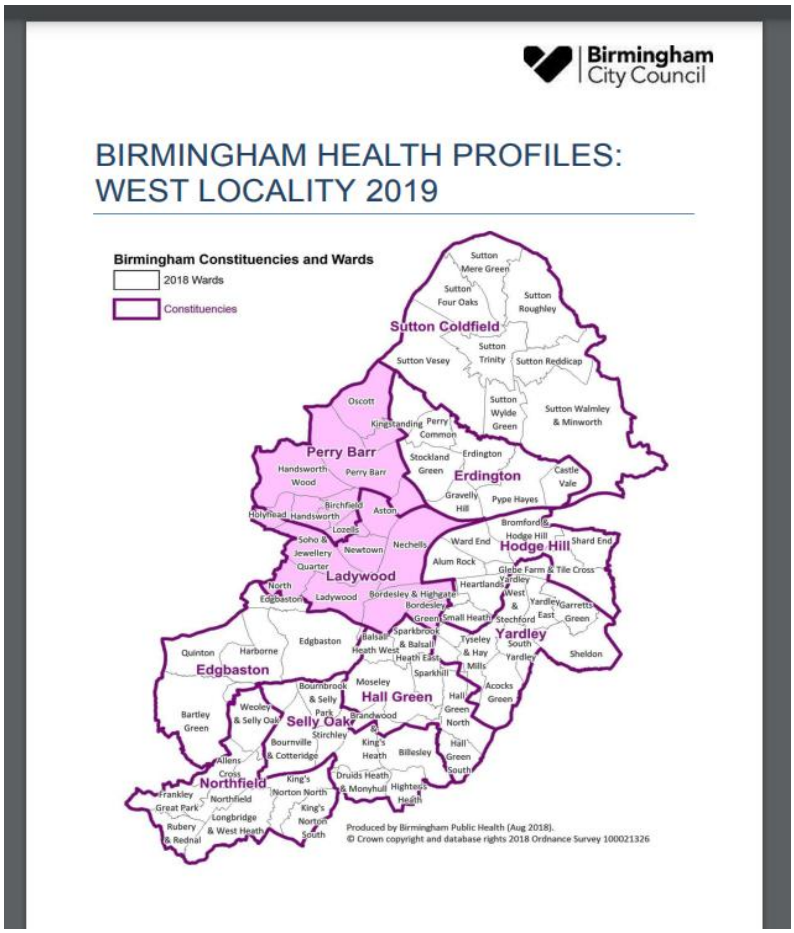

Figure 1: Birmingham Health Profiles- West Locality

Birmingham, the 2nd largest city in the West Midlands region of England, is one of the most diverse cities in the UK. The 2021 Population Census put the population of Birmingham at 1,144,900, showing a 6.7% increase in residents since the 2011 census (Office of National Statistics, 2021). These statistics go on to show that the representation of minority ethnic groups in the city is 51.4%, while those of predominantly white backgrounds make up 48.6%, with over 100 languages spoken in Birmingham and people of South Asian background making up 31% of this population. The next largest racialised community are those of *Black African and African Caribbean* heritage, making 125,760 or 11% of the Birmingham population. Accounting for 8% of the total population of *African Caribbean* people in the UK, the demographic breakdown of the 2021 census showed that 5.8% of this population identified as *Black African or Black British*, 3.9% as *Black Caribbean or Black British* and 1.2% as *Other Black*. The population of *Mixed or multiple ethnic groups, White and Black Caribbean* also

stood at 2.2%, with another 0.4% identifying as *Mixed or multiple ethnic groups, White and Black African.*

This data demonstrates that there is a considerable representation of residents of Black African or African Caribbean or Mixed heritage background in Birmingham, who are likely to be facing the same kind of health inequalities highlighted earlier. The economic and social demographics of the city also paint a vivid picture of the level of deprivation that exists within the city, with 46% of the population living in the 10% of England's most deprived areas (Birmingham City Council, 2021). With homelessness and unemployment rates 3 times and 2.5 times higher than the England average, respectively, Birmingham is the 7th most deprived local authority in England (Birmingham and Solihull Mental Health Trust Foundation, {BSMHFT} 2023).

Given the context of deprivation that has been presented, it is no surprise that data from studies conducted in the city by Public Health England (2022) showed that the reports on the levels of depression and anxiety between 2021/2022 were at 14.6%, which is relatively higher than the national average (13.7%). At 10.4% and 11.6%, respectively, low satisfaction and low happiness scores were also significantly higher than the regional average. Even though the effects of the pandemic and lockdown may have influenced the outcomes of this data, it is still an indication of the stark differences in the mental health and well-being of people living in Birmingham. Also, being the youngest core city in Europe with almost half of the city's population being under 30 years, the mental health of children and young people is high on the city's agenda, especially given the high rates of crime and gang violence that exist (BSMHFT, 2023).

The reality of health inequalities as a result of the depravation is quite evident in the differences in life expectancy, where though the average life expectancy is 77.7 years, 7 years could be shaved off between a male living in Sutton Coldfield (less deprived) and Nechells (more deprived), even though there are about nine bus stops between both suburbs (Birmingham Health Profile, 2019). The story is no different for Black communities living in the city, where compared to white populations, maternal mortality rates were significantly higher in women of Black ethnic background. In addition to this, elders of Black ethnic origin had higher rates of diagnosis and prevalence of early onset dementia (Birmingham City Council, 2022). Even though very little evidence is presented for the factors influencing these

disparities, the data still indicates that more efforts must be made to address these health concerns. Also, with a growing population of refugees (42% being of Somali origin) in the city, the pressure to meet the complex needs of the various communities represented in the city is heightening.

Over the last decade, several policies and initiatives have been implemented to bridge the health inequality gap and promote equitable access to health care delivery. Following a re-assessment of the mental health needs of the population within the West Midlands Combined Authority (Newbigging and Parsonage, 2017), their review emphasised the need for policymakers and service providers to prioritise co-production and community engagement when considering service transformation in the region. In Birmingham, innovative projects like 300 Voices (2014), Up My Street (2016), Against the Odds (2017) and Shifting the Dial (2018) saw the Birmingham and Solihull Mental Health NHS Foundation Trust, West Midlands Police, Birmingham City Council and Time to Change partnering to address the needs of young, Black African, and Caribbean young men, between the ages of 11 to 30. In a bid to engage this population to share their experiences of in and outpatient mental health services, researchers made use of appreciative inquiry, as well as storytelling, dialogue methods, and restorative practices. The success of these projects has led to the development of toolkits that have aided mental health professionals to help address the stigma around mental health among young Black men and build mental health resilience, using a culturally sensitive and empowering approach (Khan et al, 2017; Mind: Time to change campaign, 2021; Centre for Mental Health, 2022). These partnerships between statutory and voluntary sector services prove that efforts are being made to address these disparities in mental health service delivery. Furthermore, reports like the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) (Birmingham City Council, 2022), highlight some of the current policies and models, driven by evidence, being put in place to listen to, prioritise and co-produce solutions to meet the needs of the Black African and African Caribbean communities in Birmingham. While all these efforts are commendable, there is still a substantial way ahead to adequately address the structural racism and discrimination that perpetuates health inequalities within this population.

1.3 STATEMENT OF THE PROBLEM

Current academic discourses regarding the need to tackle health inequalities and promote cultural sensitivity in service delivery have led to a proliferation of studies that seek to offer a critical, evidence-based perspective on this topic. Renewed interest in the influence of socio-economic and political structures in the delivery of mental health services has led to a rise in studies examining the varied roles of both service deliverers and service users in facilitating change. However, in the many efforts to ensure equality and inclusivity in mental health service delivery for minority ethnicities in the UK, the conversations still focus mostly on deficits and problems. There is, indeed, a great appreciation for the need to create awareness, bring to light conversations that have been had in the shadows around mental health and provide further evidence for the need to tackle health inequalities in higher income countries like the UK. However, much of the existing literature fails to offer a solution-focused, salutogenic response to the subject of mental health in the Black community in the UK, which for many centuries, has been centred on concerns around stigma, discrimination, and poor access to mental health care. Perhaps, while the problems are still being highlighted, it is a good time to offer a perspective on protective factors, such as resilience and social and cultural capital, and their role in facilitating the co-production of mental health service delivery that meets the needs of Black African and African-Caribbean communities in the UK.

Morgan and Ziglio (2007) have challenged the *"pathogenesis-inspired and risk factor-oriented"* approach of current mental health service delivery and promotion models that fail to consider the influence of health and structural inequalities and their impact on overall well-being. They have suggested the promotion of methods aimed at empowering stakeholders to support the re-evaluation of public health models and policies that lend themselves to the alleviation of ill health and health inequalities. They also encouraged the use of more asset-based models of health promotion aimed at fostering communal ownership of interventions, and public health initiatives tailored to the needs of the target population.

Interventions aimed at promoting good mental health and advancing culturally competent service delivery, therefore, should emphasise the need for collaborative community efforts that foster a mutual goal of bridging health inequality gaps. They must also facilitate the

building of confidence, by actively involving the members of the community in the design and implementation process (Jane-Llopis et al., 2005; Friedli, 2009; Kobau et al, 2011). Research aimed at promoting mental health and culturally sensitive service delivery should also seek to find protective factors that help build resilience by engaging communities -- in this case, Black African and African-Caribbeans in the UK -- to evaluate how their cultural and social systems foster mental health and well-being, and identifying how these structures can be integrated into service delivery.

Prilleltensky and Prilleltensky (2003) have emphasised that critical research, aimed at health promotion and improved service delivery, should endeavour to transcend the status quo, and strive to discover knowledge that drives action and vice-versa. The relationship between knowledge and action births experiences, which later develops to become beliefs, based on the meanings associated with these experiences in a particular social context (Denzin, 2012). The process of making inquiries regarding these experiences requires deep reflection, positive introspection, and an awareness of self-consciousness (Morgan, 2007). As evidence of the effectiveness of mental health promotion in the general population increases, there is also the need to focus on catering to the needs of specific groups, such as Black African and African-Caribbeans and other migrant populations (Bhugra et al., 2011), specifically around the delivery of culturally sensitive healthcare services. Mclean et al. (2003) in their study on the experiences and expectations of African-Caribbeans in their interactions with mental health services highlighted the lack of consideration of the rich culture of African and African-Caribbean communities, one that provides a supportive environment for its own, including those with mental health issues. In their view, there was still a lack of studies that adopted a qualitative lens to understanding contextually embedded perspectives on mental health issues within specific minority ethnic communities, and those that had been conducted were local case studies that often went unpublished and were difficult to access. Hence, they proposed the need for more studies that utilised explanatory frameworks in ethnically specific contexts to gather the perspectives of local communities on their interactions with mental health services, with the goal of addressing the lack of, and promoting active inclusion of community members in the design and delivery of services (Mclean et al., 2003).

Bernal and Santiago (2006), Rathod et al., (2010; 2019) and Degnan et al. (2018) explored the impact culture had on enhancing coping mechanisms among people from minority ethnic

backgrounds, suggesting that when cultural values are effectively integrated in care, people with mental health needs are more willing to receive support and engage with treatment. For instance, Rathod et al.'s (2010) qualitative study with 114 service users, mental health professionals and lay community members across 2 locations in London, aimed at producing a culturally sensitive model of an existing Cognitive Behavioural Therapy (CBT) manual, was later tested in a randomised control trial (Rathod et al., 2013) and produced positive results for the effectiveness of culturally adapted treatments. A subsequent systematic review and meta-analysis of forty-six studies by Degnan et al. (2018) on the relevance and efficacy of culturally adapted psychosocial interventions for mental illness demonstrated that culturally adapted interventions were more effective for the treatment of psychosis among ethnic minority service users than regular treatment. Several other studies corroborate these findings, emphasising the need to involve service users, particularly those of minority ethnic backgrounds, in the co-production of culturally sensitive mental health services (Lwembe et al, 2017; Burgess and Choudary, 2021).

The current issue concerning modern regimes of mental health in developed, multicultural countries, such as the UK, is that many concepts, theories, and models are still based on Western culture and lack insight into the significance of the unique cultural and social perspectives that need to be integrated in the provision of mental healthcare. This lack of recognition of the distinct needs of the diverse populations, thus, creates a disparity that perpetuates health inequalities, especially among racialised communities (Gopalkrishnan, 2018). There is still a substantial amount of knowledge to be generated on processes and approaches that may be more efficient for the co-design and delivery of interventions and services to be tailored to meet the needs of these groups (Friedli, 2009). The need for more value-driven approaches that promote co-production and mutual, reciprocal relationships between service users and service deliverers cannot be over-emphasised (Filipe, Renedo and Marston, 2017).

A more effective approach would be one that adopts an asset-based framework that values the diversity in perspectives presented by those engaged in the co-production process and provides further opportunities for them to take part in co-implementation and subsequent evaluations of services (Dunston et al., 2009; Batalden et al., 2016). Such strategies may hold much potential for engaging key stakeholders, in this case, minority ethnicities like Black

African and African Caribbean communities in research and initiatives aimed at alleviating health inequalities and improving mental health service delivery.

1.4 RESEARCH JUSTIFICATION

A few negative narratives and perceptions still exist, which speculate that Black African and African Caribbean communities are the cause of their ill fortune when it comes to addressing their mental health (Brown, 2003; Brown and Scheid, 2010). Indeed, as stated earlier, self, and social stigma, discrimination and late access to mental health services may contribute to the high incidence of mental health issues within Black African and Caribbean communities. Nonetheless, there are greater complexities to the issue than meets the eye, and careful considerations need to be made to understand the factors at play. Particularly on the issue of the effectiveness of the policy on tackling inequalities within this population, concerned coalitions dedicated to ending racial inequality in mental health, such as the Rights and Wellbeing Advocacy Groups (RAWOrg, 2010), came out to address concerns following a review of the Delivering Race Equality policy (2005). They argued that the amplification of the failures of these communities to confront mental health issues, such as stigma, only reinforced already engrained deficit narratives and produced low expectations of these communities. In their opinion, there still exists a wealth of resilience, social capital and cultural assets within these communities that have fostered mental health and well-being over time; yet they are overlooked and remain untapped and under-utilised in efforts to promote mental health and improve service delivery. Vernon (2011) emphasised that the assessment of data trends apropos to access to mental healthcare should be evaluated alongside the resources and assets that already exist, to fill some of the gaps identified along the way. Barry (2009) further advocated for extensive research into social determinants of resilient communities.

Renowned scholar Antonovsky (1979) who has made significant contributions to the field of health promotion and health psychology, was of the view that in a bid to improve health and well-being and delivery of related services, much emphasis was to be placed on the factors and resources that promoted health and wellbeing more than on those that caused illness and increased health risks. His theory on salutogenesis, therefore, focused on the assessment

of a problem by an individual or a group of people (in this case, health inequalities), their approach to solving it and the appraisal of the resources at their disposal (Lindstrom and Eriksson, 2005) which could be suitable for addressing the concern. Billings and Hashem (2010) were of the view that the appraisal and identification of values and strengths within an individual or their surroundings affected their perspective on health and well-being.

Following on from Antonovsky's (1996) insights, having a salutogenic, positive approach to research on the promotion of health and in the case of this study, culturally sensitive service delivery, requires the inclusion of all individuals in a cultural or social setting, as the identification of what works best is dependent on their appraisal of their available internal and environmental resources. Kobau et al. (2011), consequently, advocated for an increase in asset-based approaches to mental health research that reinforce psychological resilience, promote mental health, and improve service delivery. The strength-based, salutogenic framework of Appreciative Inquiry (AI) offers the opportunity to explore these assets within the Black African and African-Caribbean community in Birmingham, UK.

1.5 APPRECIATIVE INQUIRY

Appreciative inquiry (AI), having its roots in organisational development, is a bottom-up approach that seeks to gather the contributions of individuals in a group, by emphasising the strengths and skills that these individuals contribute to ensure the growth of the group (Cooperrider & Srivastva, 1987). The recognition of the collective efforts and capabilities of individuals in a setting, who are best placed to provide effective solutions to challenges around them, is what drives the generative approach of AI (Cooperider et al., 2008). Addressing these successes from the point of view of the contributors helps to highlight the strong suits of the organisation and seek ideas from them on how to foster improvement and further growth, from a positive, solution-focused perspective (Johnson, 2015).

AI can contribute to the narrative on the promotion of mental health and culturally sensitive service delivery, by facilitating the exploration of the cultural competencies and skills that enhance mental well-being and resilience among Black African and African-Caribbeans. AI employs techniques in evaluating experiences, strengths, and capabilities, which are then

translated into actions. Appreciative inquiry performs a salutogenic role as it facilitates the exploration of what Antonovsky (1979) refers to as generalised resistance resources (GRRs), which are psychosocial assets an individual or group possesses that allow them to cope and adapt to stressful situations. Some of these assets or protective factors include resilience (Werner, 1995), empowerment (Rappaport, 1987), and cultural and social capital (Bourdieu, 1986) within a group.

Merging these ideas and principles, the AI framework is well-suited for focussing on identifying what works best for a group of people, through collaborative partnerships and evaluating how best to achieve sustainable, best-practice reforms for an organisation or community (Jane-Llopis et al., 2005). The field of research on mental health promotion and improved service delivery emphasises the aspects of life and culture that ensure protective factors against the stressors of everyday life. This solution-focused approach, therefore, offers a viable framework to motivate efforts towards identifying and developing coping abilities and resilience against mental illnesses.

Understanding the processes employed in the implementation of salutogenic health service delivery and its outcome will expand the knowledge base on what has already been studied in this area on the promotion of mental health and culturally sensitive service delivery. In this regard, the premise of the methodology applied in this study is grounded in discovering and understanding the facilitators that can support the effective design and development of culturally sensitive mental health promotion and service delivery for Black African and Caribbean communities in Birmingham, using a salutogenic approach. As will be discussed in later chapters, AI has been proven to be efficient for promoting sustainable change within organisations and groups by focusing on the strengths and capabilities present, towards fostering positive collaboration and encouraging creativity and innovation.

While AI holds much potential for promoting change, some of the limitations include the biased focus on positive perspectives that overlooks critical issues that need to be addressed to foster sustainable change. For instance, the systematic approach that AI adapts may also be time-consuming and may not be efficient for situations that require immediate action to resolve issues, as the process of dialogue and collaborative engagement demands substantial investments of time and efforts (Uys and Cloete, 2020). Grant and Humphries (2006), also highlight the potential to unconsciously apply this social constructionist method of inquiry in

a fanciful, positive manner, without critically contextualising and considering the social, economic, and political influences at play. They call for a critical appreciative inquiry approach that explicates an in-depth understanding and appreciation of the interactions between socio-cultural, emotional, political, and interpersonal aspects of the lives of the population being studied. Their idea is that by inquiring about 'what is' and 'what might have been', before asking 'what works best', the researcher offers an integrated approach to facilitating positive change, without downplaying the effects of external influences. Fostering community-based, culturally sensitive mental health promotion and service delivery cannot be accomplished without establishing effectively integrated partnerships with the community where the effects of these interventions will be implemented and disseminated (WHO, 2004a; Barry and McQueen, 2005). A more in-depth discussion of the Appreciative Inquiry framework will be explored in Chapter 2, particularly concerning its relevance to the current study.

This thesis contributes important evidence towards the application of salutogenic models towards improving mental health and service delivery, particularly for minority ethnic communities in a multicultural setting, like Birmingham. With 11% of the population in Birmingham identifying as Black or Black British (Census, 2021), it is necessary to constantly reassess the mental health needs of this population and collaborate with them in the development and design of services that will cater to their mental health needs (Mind, 2009; Rabiee & Smith, 2014; BLACHIR, 2021).

The critical appreciative inquiry approach used in this study may be suitable for addressing the mental health needs of Black African and African Caribbean communities by integrating a strength-based approach that acknowledges the value of culture in service delivery while critically examining and challenging the systems that perpetuate health inequalities. It also offers the opportunity for the collaborative co-production of culturally sensitive mental health service, engaging both community members and healthcare providers in the process of designing and developing these services.

1.6 RESEARCH QUESTIONS

This study into the holistic delivery of mental health services broadens the scope of the conversation around cultural sensitivity beyond the treatment of mental illnesses, by exploring areas of prevention and promotion as well. Other studies that seek to evaluate access and provision of mental health services within Black African and African-Caribbean communities usually tend to focus solely on service user experiences, which usually generates negative responses. This thesis offers an innovative and rigorous qualitative study design, using the organisational development-based critical appreciative inquiry approach and thus, sought to address the aims and objectives discussed below.:

RESEARCH QUESTION

In a bid to transform the narrative around Black mental health and offer a salutogenic-inspired and protective factor-oriented approach to the current literature, the research question guiding this study, therefore, is as follows:

How can a critical appreciative inquiry approach facilitate the engagement of community members and service providers as equal collaborators in the co-design of culturally sensitive mental health services for Black African and African-Caribbean communities in the UK, towards addressing health inequities?

The research question for this study was explored through the following objectives, using the 4D Cycle of Appreciative Inquiry (Discovery, Dream, Design, Deliver), that encourages reflection and appreciation of the past and present, while articulating plans, in the evaluation of mental health and service delivery in the study population. This 4D cycle of AI was explored in three distinct phases, in order to evaluate the significance of the critical appreciative inquiry approach for engaging mental health services providers in the co-production of sustainable solutions to facilitate the delivery of equitable culturally sensitive services for Black African and African Caribbean communities. The corresponding sub-questions that guided each Phase of this study, therefore, are:

Phase 1: What are the cultural values that indicate resilience, strength, and coping abilities that foster mental health and well-being among Black African and African-Caribbean communities in Birmingham?

Phase 2: How can community members be effectively engaged in the co-design of culturally sensitive mental health services that build upon the identified strengths and assets of Black African and African-Caribbean communities?

Phase 3: How can sustainable solutions be collaboratively designed and implemented with mental health service providers to promote equitable, culturally sensitive mental health service delivery for Black African and African-Caribbean communities in Birmingham?

In this study, appreciative inquiry is used to explore the role of culture and resilience in the mental health and well-being of members of Black African, African Caribbean as well as, mixed heritage communities in Birmingham, by asking the questions, '*What has been, what is, what will be and what can be?'*. This study will seek to engage the views of members of the community on issues surrounding stigma and mental illness, while balancing conversations around the areas of black culture worth celebrating, and promoting towards the improvement of mental health promotion and service delivery within these communities.

1.7 TERMS OF REFERENCE

BLACK*:* According to McKenzie and Crowcroft (1996), the term 'Black' is a broad classification of a range of people of African ancestry, used as a political term to refer to people of mid to dark brown skin complexion (Bhopal, 2004). African, Caribbean or any other people of Black background may be classified under this term, for which reason some scholars argue, makes the term potentially offensive and unhelpful, as it homogenises and erases the diversity of culture and identity among a broad group of people, further perpetuating racial inequality (LaVeist, 1994). However, the term is used in epidemiological and public health settings to signify aggregated ethnic groups, mostly qualified by saying 'Black people' or 'people of Black ethnic background' (Gov.uk, 2021).

AFRICAN and BLACK AFRICAN: Within scientific research, the term 'African' in relation to race and ethnicity refers to a person with ancestry from the continent of Africa and has more recently been used as a prefix to qualify specific groups of Black people around the globe, such as African Americans, African Canadians and African Caribbeans (Agyemang et al., 2005). However, the term has been debated, as some North Africans, such as Algerians and

Moroccans identify more as Arab than African (Bhopal, 2004). The same debate is common among people of Somali background (Elam et al., 2000).

Black African, on the other hand, is the term made in reference to people of African ancestry, particularly of sub-Saharan African descent. Within this study, the term Black African is used to refer to participants of sub-Saharan African ancestry.

AFRICAN CARIBBEAN: This term is used in the UK as a descriptor for Caribbean people who have partial or full ancestral origins from sub-Saharan Africa (Cruickshank et al., 1991). Having distinct cultural values, language, and migration history from people from Africa (Elam et al., 2000), this population has often been grouped together with people of Black African background under the BAME/BME (Agyemang, Bhopal, Bruijnzeels, 2005), ignoring the uniqueness and diversity within the various groups.

1.8 THESIS STRUCTURE

A brief outline of the structure of this thesis is provided below:

Chapter One explored mental health inequalities in the Black community, the issue of mental illness stigma and the negative pathways to mental health treatment that people of African and Caribbean backgrounds experience. Shedding light on the mental health landscape in the UK, particularly in the delivery of mental health services, this chapter further elucidated the racial inequalities that are perpetuated through the BAME term, which may gloss over the impacts of structural and institutional racism on access to mental health. The need to adapt a salutogenic, asset-based approach to the co-production of mental health services for Black African and African Caribbean communities despite these groups being considered as 'hard to reach' by such services. The rationale, aims and objectives for this study as well as a brief introduction on appreciative inquiry were also discussed, with particular focus how this approach is used in the co-production of culturally sensitive mental health services for community members and mental health service providers in the Birmingham.

Chapter Two will explore further, the growing body of public health literature that recognises the importance of considering the critical role the salutogenic approach to positive health promotion plays in improving mental health and well-being. A review of relevant policies which have been developed by the UK government to address inequalities in access to mental health services will also be included in this chapter. A critical evaluation of the much-debated topic of cultural sensitivity and cultural competency will also be explored in this chapter, in relation to how this translates to service delivery. Having explored the gaps that exist in culturally sensitive service delivery among Black African and Caribbean communities, this chapter will further emphasise the need for paradigm shifts from pathogenesis to salutogenesis, in addressing mental health and stigma within these communities.

By investigating and identifying the use of salutogenic approaches to mental health promotion and service delivery, this chapter delves into an argument for the use of appreciative inquiry, an organisational development model, as a salutogenic mental health promotion framework. It also explores the role of service users and community members in mental health promotion, by identifying what works best, and recognizing the relevance that resilience, culture and community values contribute to mental health. This sets the stage for the use of appreciative inquiry in the current research context, in a further attempt to improve culturally sensitive mental health services in Black African and Caribbean communities in Birmingham.

Chapter Three provides a general overview of the philosophical background and data analysis approaches used in this research by outlining the theoretical framework utilised in this study. Further insights are provided into the conceptual framework of appreciative inquiry, social constructionism, and critical theory that guide the epistemology and ontology of AI's methodological approach. It also broadly introduces the qualitative methods of online interviews and focus group discussions utilised for data collection, shedding more light on the sampling process, the role of gatekeepers in the recruitment of participants. It delves into the how the data analysis method of thematic analysis lends itself to the strategy of data triangulation used in this study to strengthen its interpretive rigour. Lessons from a pilot study undertaken are also discussed, especially pertaining to how they helped refine the methods applied to the various phases of this study. However, full details on sampling methods,

instrument development, and data analysis utilised in this multi-phased study will be discussed further in the subsequent phase-specific chapters.

Chapters Four to Six outline the methods and results of this study, corresponding with the 3 phases of data collection, which investigate the various aims/objectives presented above in further detail, and corresponding with the 4D Cycle of Appreciative inquiry. They also delve into the discussion of results obtained from this study in relation to the relevant literature explored, based on the phases of AI.

Chapter Seven culminates all the results and critical analysis done in the previous chapters using methods of data triangulation to create a clearer picture of the relevance of the data gathered to the current discourse on health inequalities and, salutogenic approaches to improve the co-production of culturally sensitive mental health services. The limitations of the study are also briefly discussed.

Chapter Eight draws the study to a conclusion with a summary of the entire research journey, and provides recommendations for future research, policy and practice, especially on the use of salutogenic frameworks, such as appreciative inquiry, to promote culturally sensitive service delivery and reduce health inequalities among Black African and African Caribbean populations in the UK. Additionally, it presents a valuable and novel contribution as a product of this research in the form of a checklist for service providers, serving as a roadmap to enhance inclusivity and effectively address the needs of the diverse populations they serve.

1.9 CHAPTER SUMMARY

This chapter offered an introduction to the contextual evidence available on health inequalities in among Black African and African Caribbean populations in the UK. The evidence provided justifies the need for culturally sensitive and equitable mental health services that acknowledge and respond to the diverse needs and perspectives of these communities. The chapter also examined the limitations of traditional deficit-based approaches to addressing health inequities and presented the need to explore the adoption of asset-based frameworks that empower these communities and build upon their strengths and resilience. For this

reason, the salutogenic approach of appreciative inquiry was introduced a viable methodological approach for engaging communities as equal partners in the co-design and implementation of mental health services. To situate this study in the current research context, the research gaps are highlighted in line with the aims and objectives of this study, towards addressing mental health inequalities and proposing appreciative inquiry as a salutogenic approach to tackling these concerns.

CHAPTER TWO

LITERATURE REVIEW

"Gratitude makes sense of our past, brings peace for today, and creates a vision for tomorrow". - Melody Beattie

2.1 INTRODUCTION

This literature review chapter begins by expounding on the existing body of literature on the current efforts in place to address inequalities in the mental health service delivery in the UK, especially concerning the Black African and African Caribbean populations. Drawing on various policies proposed and implemented over the last 2 decades, this chapter offers a critique on the effectiveness of these policies to properly tackle concerns around structural racism, cultural competence, and efficient mental health service delivery. An overview of the scope of cultural competence training in the UK and its effectiveness in bridging the gaps in service delivery are also explored. As earlier stated, this research aims to employ a salutogenic, critical appreciative inquiry approach to co-design culturally sensitive mental health services for Black African and African-Caribbean communities in the UK, by engaging community members and service providers as equal collaborators in addressing systemic issues and health inequities. This chapter, therefore, further explores Antonovsky's theory on salutogenesis, highlighting the relevance of appreciative inquiry as a salutogenic approach, in a bid to evaluate its significance within evolving trends in public health and mental health promotion discourses.

Finally, an in-depth synthesis of empirical studies on the background of the Appreciative Inquiry (AI) framework and its principles is explored.. A critical review of studies that have applied appreciative inquiry as a salutogenic research methodology in various settings are analysed to consolidate existing knowledge in the area and identify the gaps that this study will seek to explore. By analysing the methods used in the studies identified and the exploring methodological rigour applied in the implementation of AI across the various research contexts, this review seeks to offer further justification into the need for a critical appreciative inquiry approach tailored to the needs of the research population.

Identifying these key strengths and limitations from various studies that adapted the AI process within diverse research settings closely mirroring the aim of engaging communities and identifying the transformative change of communal efforts, further sets the stage for positioning AI as a valuable tool for co-production in the present study. Identifying the relevance of the appreciative inquiry framework through a critical lens is also examined to determine its application as a transformative, action research methodology, towards the co-production of culturally sensitive mental health service delivery within Black African and Caribbean communities in Birmingham.

2.2 UNDERSTANDING HEALTH INEQUALITIES AND THE IMPACT OF MENTAL HEALTH POLICY IN THE UK

A range of studies have highlighted the effects of health inequalities, such as the unfair distribution of healthcare resources, poor access to and lack of cultural sensitivity in mental health services and other structural inequalities have on people of Black African, African-Caribbean, and Mixed heritage backgrounds. A wealth of evidence has been generated in the UK, over the last two decades which has critically evaluated past policies and the resolutions presented to tackle this public health concern (Busfield, 1999; Lowenthal et al., 2012; Fernando, 2017; Hussain, Hui, Timmons and Nkhoma, 2022). This empirical evidence has shown that there are many areas of healthcare and service delivery, especially in the mental health sector, where there is much dissatisfaction expressed by various stakeholders (service users, voluntary sector deliverers) on the inadequacies in the implementation and execution of policy (Hussain et al., 2022; Buzelli et al., 2022).

Researchers (Fernando, 2004; 2017; Bernal & Saez-Santiago, 2006; Dein and Bhui, 2013; Lazaridou et al, 2023) have presented evidence of the influence of racism and discrimination in the field of psychiatry and the delivery of statutory mental health services. Yet, scholars like Singh and Burns (2006) have rebutted this controversial assertion and are of the view that the high rates of diagnosis and detention within minority ethnicities in the UK have nothing to do with racism, and that such claims are misleading and counter-productive to improving

service delivery. Their assertion, based on a meta-analysis of nineteen studies, was that there were no significant differences highlighted in rates of detention between white and minority ethnic groups, stating that the evidence to support the claims regarding racism and misdiagnosis was still unclear. Rather, they argued that the high rates in diagnosis among these groups, especially in Black African and Caribbean populations, were due to delayed help-seeking behaviour because of the mental illness stigma within these communities. They also maintained that the mistrust in services only led to a self-fulfilling prophecy and resulted in late access to services and heightened symptoms, claiming that confirmation bias could be implicated in the high statistics generated within these populations.

On the contrary, Vernon (2011) and Nazroo et al. (2020) and other researchers, as evidenced in the previous chapter, have suggested that cultural and racial bias do indeed, play a role in the misinterpretation of mental illness symptoms within this population, leading to the high detention rates. Kamali (2010) and a report by The Synergi Collaborative Centre (2017) have both asserted that, historically, mainstream services, that were set up on systems of power that permitted racism and discrimination (Hargeaves and Leaman, 1995; Wieviorka, 2010; Nazroo et al., 2020), still function with these power dynamics entrenched in their operations. Therefore, even with the current focus on equality, diversity and inclusivity, there is still evidence of institutional and structural racism within healthcare practice and policy which impedes access to a wide range of socio-economic and healthcare resources for people of minority ethnic backgrounds in the UK. Kamali (2010) has suggested that the pervasiveness of these structural inequalities affects the delivery of healthcare by well-meaning practitioners, who may unknowingly perpetuate standards historically set to reinforce these discriminatory practices, contributing further to the disparities highlighted in service delivery.

Owing to the fast pace of globalisation, which has led to an increase in migrant populations that form minority populations within the UK, the government is consistently striving to revise policies to include the needs of the rising population. A range of policies have been implemented in the UK to address these gaps in mental healthcare delivery and address health inequalities. Over the last 2 decades, policymakers have paid greater attention to the outcry surrounding health inequalities in the UK, especially following the Independent Inquiry into Inequalities in Health by Acheson (1998). This report emphasised the effects of disparities in income, education, employment and material environment on the health and well-being

of people of minority ethnic backgrounds, and stressed the need for holistic, life course approaches to policy design and implementation within various sectors.

Following this report, the National Institute for Mental Health in England (2003) acknowledged that one of the reasons why many challenges remained prevalent in the delivery of mental health care to minority ethnicities was that service evaluations and reforms had not considered various characteristics their cultural and ethnic identity in service and organisational design. The Inside Outside report highlighted the pitfalls of the NHS plan and Mental Health National Service Framework (MHNSF, 1999) in improving the quality of life of minority ethnic population. Evidence shared in this report also revealed many inequalities in service delivery and the high rates of compulsory detention of members of minority ethnic groups which was said to be due to the influence of institutional racism within the mental health care services. It was clear that at the time, no national policy or strategy existed that explicitly addressed the needs of minority ethnic communities (National Institute of Mental Health in England, NIMH, 2003). The recommendations proposed, therefore, sought to eliminate these inequalities using a two-sided approach: addressing the 'inside' of services through an increase in training and education on cultural competence and engaging with communities on the 'outside' of mainstream services (NIMHE, 2003; Adamson, Warfa and Bhui, 2011). The proposals from this report identified the need for collaborations between the third sector and voluntary organisations who were already addressing the cultural needs of minority groups within the community, as a critical component of the plan to reduce and eliminate health inequalities in mental health services. This 'Inside Outside' approach led to suggestions that members of minority ethnic communities must be included in the planning and design of services that supported their well-being.

Following the Inside Outside report, the verdict on a case review concerning an incident in a secure mental health facility in 1998 led to the development of the Delivering Race in Equality policy (Department of Health (DH), 2005). The unfortunate incident was the demise of David Bennet, an African-Caribbean patient with schizophrenia, who died after being restrained by nurses (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003). Following a racially abusive altercation between the victim and a fellow patient, and a subsequent attack on a nurse, a prolonged prone position restraint to calm him down led to his collapse and, subsequently, his death. Further investigations into this unfortunate incident led to findings

that there was some evidence of institutional racism within the mental health facility, where he was receiving treatment (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003).

This incident led to an extended inquiry and the launch of the 5 year Delivering Race Equality (DRE) Mental Health Policy, geared towards improving mental health services and ensuring that they addressed the needs of the UK's diverse population. With the goal of promoting equitable access to mental health services, enhancing service user experiences, and improving health outcomes, particularly for service users of minority ethnic background, an action plan was formulated based on the recommendations presented during the extended inquiry. All these efforts were made in a bid to transform service provider attitudes, improve cultural competency in service delivery and alleviate the health inequalities experienced by racialised communities. The development of culturally competent services, an increase in community engagement and improvements to the collecting and sharing of key information regarding services, were recommended as key to the success of this 5-year strategic plan (DRE, 2005). To attain the goal of developing culturally competent mental health practitioners by 2010, recommendations were also put forward for the revamping of current race equality and cultural competence training, particularly the need for organisation-wide Race Equality and Cultural Capability (RECC) training (DRE Review: Wilson, 2009).

Also, building on the recommendation to improve community engagement (Inside Outside, 2003), a proposal for the training of a workforce that would facilitate multi-agency collaboration led to the rise of Community development workers (CDWs). These CDWs, who were to be posted at 17 focused implementation sites (FISs) across various mental health trusts, were to facilitate this multi-agency agenda by bridging the gap between both mainstream and voluntary service providers, and service users from minority ethnic communities (HM Government, 2005). The mandate of the CDWs to fill the gaps identified included providing support and capacity-building resources to third and voluntary sector organisations, as the policy recognised the crucial role these organisations played in facilitating the delivery of culturally sensitive mental health support to their communities. Enhancing the communication channels that amplified the unheard voices of the communities represented in these FISs was another area of concern, and CDWs were tasked

with collating the experiences and opinions shared and providing feedback to services on how to improve the experiences of minority ethnic communities (Department of Health, 2006).

Following these reforms, some success was reported on the impact of the engagement the CDWs fostered within communities and their role in providing liaison support between statutory services and the community. However, a few concerns were raised regarding the efficient utilisation of CDWs. First, the lack of uniformity in pay, job description and availability of training and resources for the CDWs across the 17 FSIs, were highlighted by Allcock and Hollingsworth (2009) as concerns that led to the poor execution of this element of the DRE. RAWOrg (2011) highlighted that, even though the presence of CDWs was only one element of the DRE, much of the expectations of its success towards improving pathways to recovery, advancing community support, and enhancing primary care rested heavily on the efforts of these workers. Yet, evidently, much greater emphasis needed to be placed on the shift in organisational culture and the reduction of other socio-economic and political barriers that influenced statutory mental health service delivery. Craig and Walker (2012), in their evaluation of roles allocated to the CDWs, highlighted that these workers were often placed in marginal roles within the structure of the local mental health trusts they were assigned to and, therefore, had very little influence in implementing the changes that were suggested from their work within the community. Sardar (2004) and McKenzie and Bhui (2007) also criticised the policy's over-reliance on voluntary and community sector organisations to meet most of the socio-economic and healthcare needs of minority ethnic communities without providing the funding and resources for them to assume these responsibilities.

Keating (2007) maintained that the time for focusing on needs assessment had elapsed and that the DRE's mandate to allow CDWs to reassess this gap in service delivery, which had already been covered extensively in past reports, was obsolete. He advocated for the focal point for future policy to be on the implementation of strategies aimed at meeting the specific needs of minority ethnic communities, where mental health service delivery was concerned.

Sewell (2009) proposed the locked hexagon model in response to the DRE, stating the need for an approach that allowed for a simultaneous, multisystemic strategy for addressing inequalities in mental health service delivery. In his model, he proposed that concurrently integrating the promotion of service user input, carer and community engagement, staff, and management training in cultural competence, as well as providing volunteering and

employment opportunities for communities was essential to delivering race equality in mental health. He also added that engaging the use of more strength-based narrative approaches, for shaping service user engagement, as well as embedding locally based target outcomes when designing services, were pertinent to improving mental health services.

Another assessment by Bowl (2007), conducted among Black service users evaluating how the DRE policy implementation had met their needs, highlighted concerns regarding the lack of aftercare support, where service users still dealt with employment and financial issues, without support from mainstream services, following their discharge from secure services. They complained that this affected their re-integration into the community post-discharge and contributed to the revolving door phenomena, which is the rise in re-admissions of discharged patients into secure mental health services because of relapse of mental illness. This further emphasised the need to promote more collaborations between statutory and community organisations to provide aftercare support for patients post-discharge. The Count Me in Census (Care Quality Commission, 2011) that also surveyed patients' experiences over the period of DRE implementation showed very few changes in detention rates and care disparities in the treatment of persons of minority ethnic descent in secure services.

Furthermore, evidence of the impact of the implementation of cultural competence training was still lacking. A year into the implementation of the DRE policy, an audit conducted by the Healthcare Commission (2006) indicated that 40% of NHS trusts in England still had not published the Race Equality Scheme in their organisational policy, while close to 99% of NHS trusts did not meet the conditions outlined in the amended Race Relations Act (2006). The Commission for Racial Equality (CRE, 2007) expressed increased concern for the Department of Health's inability to regulate compliance with the Race Equality duty, given the evidence that still existed of racism and discrimination in mental health services. Even before the implementation of this policy in 2005, Bhui et al. (2004) insinuated the premature failure of the policy, based on the homogenic classification of Black and minority ethnic groups. They criticised the failure of the policy to acknowledge the varied needs of the diverse ethnicities encapsulated under the 'BME' umbrella, highlighting the danger of neglecting the specific needs of specific groups, such as Black African and African Caribbean communities. Among many other factors, the issues outlined here are said to have contributed to the failure of the DRE to effectively meet the needs of the minority ethnic populations they sought to serve.

Following the shortfalls of the DRE policy, more efforts have been made to involve service users in the co-design of these policies, as has been the case in the design of the "No Health Without Mental Health Campaign" (DH, 2011), and the 'Mental health and prevention: Taking local action Campaign' (Goldie et al., 2016; Mental Health Foundation, 2016). Yet still, there is a long way to go in achieving race equality in mental health care (Hui and Stickley, 2007; Lammy, 2017). The evidence on discrimination and racism in the delivery of mental health care to members of Black and minority ethnic heritage in the UK (Cabinet Office, 2017; Race Equality Foundation, 2022) still suggests that few changes have been enforced in a bid to bridge the health inequality gap (HM Government, 2018). The DHS (2019) supports this evidence from a review of the Mental Health Act, demonstrating that people of Black African and Caribbean heritage are still 'too often and in too many areas, either excluded or detained'. The current NHS long-term plan and the Whitepaper: Reforming the Mental Health Act, following a review of the Act in 2018 (Department for Health and Social Care (DHS), 2021) states that one of the mandates in the next phase of rolling out mental health policy will be to support the efforts of advocates and community champions and representatives of the various ethnic groups to act as a voice for the community.

Given that a similar approach was adopted in the past with the Inside Outside (2003) and Delivering Race Equality (2005) policy frameworks, evidence is yet to be provided on the effectiveness of these new strategies. Nonetheless, considering the recent NHS Long-term Plan (2019) and its call for greater action on alleviating health inequalities, Raghavan and Jones-Nielsen, (2021) are of the view that future policy must focus on bridging the gaps which still exist between addressing the lived experience of service users, formulating equitable policy and implementing it in practice. They refer to the guidelines outlined in the Joint Commissioning Panel of Mental Health (2014) which laid out strategies for implementation, service user engagement and the use of data in policy, highlighting the paucity of evidence of good practice countrywide in the delivery of mental health services. In agreement with Adamson, Warfa and Bhui (2011), Raghavan and Jones-Nielsen (2021) indicate that if services are to truly improve, inputs from service users and community members of minority ethnic groups must be evident in the commissioning process from the onset, and subsequent evaluation processes must include the views of these groups to monitor progress. Opie and Roberts (2017) were of the view that if mental health services are still riddled with service

providers whose racially biased worldview and individual beliefs still shaped policies meant to alleviate racial and health inequalities, there was bound to be a disconnect between policy development and implementation. Simply put, if the workplace culture was still a reflection of structural racist systems they are built on, not much change would be seen. It is, therefore, crucial that an overhaul of operational and ideological practices be implemented to address the social and political foundations that perpetuate these inequalities (Moffat et al., 2009; Hui et al., 2020; Vernon, 2020).

As highlighted by Hussain et al. (2022) in their systematic review on mental health policies in the UK over the last two decades, there is still a lack of clarity on the implementation process for strategies that efficiently meet the needs of service users from minority ethnic communities. Following their evaluation, they have highlighted the discrepancies between policy implementation on paper and in the real world, stating that there are no clearly outlined processes that address changes systemically within higher levels of leadership where these policies are drafted. They have called for a paradigm shift in the structural culture of healthcare policy making, advocating for frameworks that adapt an asset-based approach to policy implementation, by taking stock of the financial and human resources available within implementation sites before policies are executed. Taking into consideration austerity and the restructuring of the NHS (Solar and Smith, 2020), which have been highlighted as some of the constraints to the proper implementation of policy in the last decade, it is important to acknowledge the complexities associated with alleviating health inequalities in mental health service delivery, as highlighted in the Framework for Mental Health Research (Department of health, 2017). There is, therefore, an urgent need for a multifaced strategy that takes into consideration the socio-cultural, economic, and political determinants of health in the design and implementation of mental health policies, aimed at promoting cultural sensitivity in service delivery and, consequently, alleviating health inequalities (HM Government, 2011; Wilkinson and Pickett, 2017; Castillo et al., 2018).

2.3 CULTURAL SENSITIVITY AND CULTURAL COMPETENCE IN SERVICE DELIVERY

To effectively promote and implement culturally sensitive mental health service delivery, it is crucial to promote cultural competence among healthcare professionals and ensure they have an awareness of the unique needs of the diverse populations being served. Though the definition of cultural sensitivity has been highly debated among clinicians and public health experts (Ridley et al., 1994; O'Donohue and Benuto, 2010; Benuto et al., 2021), Zayas et al. (1996), following an in-depth study on clinicians' definition of the term, attempted to conceptualise the term. They, thus, described cultural sensitivity as the continuous process of developing an awareness of the culture of a group of people by consistently acquiring knowledge on the norms, values, and lifestyle of specific cultures to apply this knowledge in treatment and care, to avoid mistaking aspects of culture as signs of pathology. Resnicow et al. (1999) further distinguished cultural sensitivity under surface-level and deep-level classifications. They described surface-level cultural sensitivity as the process of basing interventions on the superficial and tangible aspects of culture, such as food, music, language, among others, that are especially suited to the target population, to increase acceptability and familiarity. Deep-level cultural sensitivity, on the other hand, requires exploration of the in-depth, social, historical, psychological and value systems of a particular culture, to convey significant information that specifically targets and potentially transforms health behaviour. Brooks et al. (2019) emphasised the need for self-awareness and cognisance of one's own beliefs, values, and biases as a crucial first step to engaging people from diverse cultural backgrounds. Following a systematic review exploring the concept of culturally sensitive communication in clinical practice, they proposed that fostering open and sensitive communication with patients and their families was key to promoting collaborative patient care that supported flexibility in adapting services to the cultural needs of patients. These attributes of self-reflection and adaptability, therefore, are the bedrock for fostering cultural competence training.

The term, cultural competence, as defined by Cross et al. (1989) is a system of implementation comprising specific values, behaviours, policies, and approaches adopted to improve effective service delivery for organisations and professionals who work in multicultural settings. Other notable scholars like Campinha-Bacote (2002) and Leininger (2002) have described cultural

competence as the consistent efforts made by healthcare professionals to integrate cultural awareness, skills, and knowledge into service delivery through sensitive and innovative strategies in order to provide optimal levels of care to meet the diverse needs of clients within a specific context.

The structure of race-related, cultural-competence training in healthcare services in the UK has been influenced by philosophical frameworks, such as that proposed by Tamkin et al. (2002). Classifying these approaches under four ideological categories, they recommended that cultural competence training, targeted at improving the cultural sensitivity in service delivery, needed to address the impact of racism on service delivery and work to eradicate it (transformational change), as well as promote reflective practices that focused on addressing personal prejudice (reformative). They also emphasised the need to work towards integrating minority communities into the majority society (assimilationist) and still promote learning and respect for their culture (pluralist).

Cultural sensitivity can, therefore, be seen as the process of acquiring and improving one's knowledge and awareness of how to support people from diverse backgrounds. Cultural competence, in turn, is the practical application of this knowledge in healthcare delivery. For instance, when working with people from Black African and African Caribbean cultures, an awareness of expressions of animated body language in communication may help prevent the erroneous misinterpretation of these actions as aggression and violence when supporting such populations. As society evolves, it is important to acknowledge that as culture is dynamic, so will the ways in which cultural values and norms shape our perspectives and behaviours and, consequently, the transmission and redefinition of cultural knowledge.

The scope of cultural competency, nonetheless, goes beyond simply possessing an awareness of the cultural values of a group of people, but also emphasises the need for respect, and the ability to demonstrate skills that meet diverse needs in various situations and settings (Cross et al. 1989; Orlandi 1995). Focusing on behavioural transformation, the goal of cultural competence training applied at various levels is to deliver interventions that transform the attitudes of individuals, organisations and policy makers towards matters related to race and ethnicity (Bennet, 2015). Cultural competence is informed by the amount of cultural sensitivity one possesses to meet the needs of the populations they serve. Thus, cultural

competence training for healthcare professionals is encompassed in a range of continuous educational and training activities aimed at strengthening cultural awareness, sensitivity, and knowledge of diverse ethnic minority communities. These specialised capacity-building activities help to develop confident, self-aware healthcare professionals who are willing to adopt a pragmatic approach to caring for and serving clients of minority ethnic backgrounds, without seeing culture as a 'variable' that needs to be controlled (Kumas-Tan et al, 2007; Bennet and Keating, 2008).

Several scholars have criticised the concept of cultural competence as lacking a transformative approach as it does not effectively address power imbalances and structural inequalities (Abe, 2020). Others have raised concerns around the tendency for a rise in cultural essentialism (Fischer, 2011), where culture is used as a substitute for ethnocultural identity, reducing the culture of racialised groups to fixed and static traits that lack diversity and dynamism (Kumas-Tan et al., 2007; Kirmayer, 2012; Good & Hannah, 2015). Another criticism of cultural competence training is the tendency to attribute incompetence or lack of cultural sensitivity to a lack of mastery over the culture of others, further favouring the acquisition of cultural knowledge over understanding and embracing the experiences of others (Fisher-Borne et al., 2015; Danso, 2018; Agner, 2020). Despite these critiques, there is still a need for promoting cultural competence in healthcare service delivery in a manner that promotes patient-centred care that ensures equitable care and respects the diverse needs of various populations.

Over the last 2 decades, researchers have highlighted the history on the various levels of commitment of the UK Government to address race equality and promote cultural competence training and education in the healthcare setting (Luthra & Oakley, 1991; Brown and Lawton, 1992 cited in Bennet, 2006; Mirza, 2005; 2018). Even though some success has been achieved in getting service deliverers to embrace cultural competence training, certain discrepancies still exist between the processes of implementation and evaluation of the impact of this training (Bennet, 2006; George et al., 2015). Beach et al. (2005) and Govere and Govere (2016) drew attention to the lack of evidence surrounding the effectiveness of cultural competence training in improving health equity in their systematic review of studies that evaluated the success of previously delivered training to healthcare professionals. Even though their evaluation demonstrated evidence of its potential to increase cultural

knowledge, improve services and transform attitudes, data on the long-term effects of cultural competence training for improving service user adherence to treatment was still lacking. In agreement with other researchers, such as Brach and Fraser (2000), Betancourt et al. (2016) and Lekas et al. (2020) concluded that there was still a paucity of evidence surrounding the process of implementation of cultural competence training and the specific techniques that proved effective. Kleinman and Benson (2006) expounded on the misunderstanding surrounding the term 'culture' in cultural competence, proposing some factors that still influenced stereotypical and, sometimes, racially controversial delivery of such training. The first and second concerns are that cultural competency has been reduced to a one-time skill that can be acquired, rather than a dynamic process of growth that embraces intra-cultural diversity that exists within various ethnic groups and leaves behind assumptions of cultural homogeneity. For instance, discussions surrounding the understanding of language, cultural values, and the intersectionality of ethnicity, especially within Black African and African-Caribbean communities, are still absent in deliberations around cultural competence.

A study conducted by Bennet et al. (2007) exploring the views of mental health service providers on the Race Equality training scheme, found that many practitioners disclosed that there was an overemphasis on legal issues and policy relating to racism. They stated that this was at the expense of a focus on providing skills training relevant to delivering culturally competent services that are sensitive to the needs of minority ethnic populations, perpetuating what they referred to as, an 'us versus them' mentality (George et al., 2015). Papadopoulos (2003) advocated for a system of equal partnership in service delivery, where service users were as equally involved in their care as healthcare professionals. In this regard, cultural sensitivity will be achieved when a system of trust and respect is established between practitioners who genuinely seek the holistic well-being of patients and patients who feel accepted and respected. Muaygil (2018) suggests that, in an increasingly multicultural society, there is a heightened need to uproot and re-evaluate Western medical standards and values that forcefully deny people of other races and cultures their rights to proper healthcare, because of detrimentally entrenched notions of racial superiority. The pertinent need for training in cultural competence in healthcare systems, therefore, transcends political agenda,

making it a subject of morality, aimed at decreasing the gap in health inequalities rather than a tick box activity.

In every society, individuals tend to view the world through the lens of their cultural background, and their very identity, along with their interpretation of life goals and expectations, form a key part of the basic principles that govern every life. Therefore, in a multicultural society like the United Kingdom, the approaches taken to promoting cultural competence in service delivery should be aimed at understanding a community's view of and interactions with the world around them as well as recognising and respecting their values and beliefs (Kirmayer, 2012; Edge, 2018; Kirmayer and Jarvis, 2019). Many researchers have argued about whether the best approach to achieving cultural sensitivity and reducing health inequalities is to provide separate pathways of healthcare delivery for individual ethnic groups (Bhui and Sashidharan, 2003; Bhui et al., 2015; Grzanka et al., 2017). Winters and Patel (2003) on the other hand, highlighted that the resources needed to develop a framework or database holding data relevant to and representative of individual cultural needs of minority ethnic groups is impossible. The complexity of navigating the intricacies of the cultural and sub-cultural norms that exist within these groups, requires a multifaceted approach that is, in many ways, a herculean task to navigate. Bowl (2007) argued that the danger with this system is that it posits individual cultural differences as the cause of mental health problems when the systems of care which perpetuate these inequalities still exist. There is a place for specialised services within the community, that meet the cultural needs of specific ethnic groups, and many third sector and voluntary organisations exist to bridge this gap in service delivery. But in mainstream services, even though a 'one-size-fits-all' approach cannot be adopted, there are ways to offer support that meets and respects the basic needs of individuals, regardless of race, gender, ethnicity or age. Scholars like Anderson et al. (2003), Kirmayer (2012) and Olaniyan and Hayes (2022) have stated that the lack of clarity on the parameters for measuring culturally competent services called for what they describe as an 'ethnic matching approach'. While the validity of these arguments stands, and while enhancing knowledge about diverse cultural practices is vital for improving competence, an even more crucial approach is bridging the gap between clinical support and the socioeconomic, political, and historical factors that have long perpetuated health inequalities (Olaniyan and Hayes, 2022). Healey et al. (2017) recommended that future studies aimed at

improving cultural competence in healthcare service delivery first take into consideration the effects of acculturation, by examining in-depth, the various cultural adaptations already in place and their role in enhancing efficiency in service delivery. This practice of isolating what works, and what is effective for a specific population, will bring clarity to how cultural competence training can promote health and well-being in multi-ethnic settings. There is, therefore, a need for salutogenic approaches that work collaboratively with service users to identify and promote systems that support the inclusion of minority ethnic populations and offer culturally sensitive services, delivered by culturally competent practitioners.

In lieu of the disagreements on the use of terms such as cultural competence or sensitivity, the introduction of alternative concepts, such as cultural safety (Papps & Ramsden, 1996) and cultural humility (Tervalon & Murray-Garcia, 1998), are becoming increasingly accepted and may offer new insights into the debate on cultural competence. Cultural humility has been defined as the respectful consideration of the culture of others, where healthcare professionals are aware of their own cultural worldview and express an openness and genuine interest in understanding and supporting those from other cultures (Tervalon and Murray-Garcia, 1998; Hook and Watkins, 2015). Papps & Ramsden (1996) and Downing, et al. (2011) have described cultural safety as the means of addressing the impact of entrenched colonial systems and institutional racism on healthcare delivery, and how these systems perpetuate health inequalities which are detrimental. Cultural safety and cultural humility highlight the influence of power imbalances around cultural competence training, and advocate for a system where the focus is no longer solely dependent on the acquisition of skills by healthcare deliverers. Beyond the scope of institutional culture and long-standing practices of systemic racism, cultural safety encourages a system of dialogue and accountability, where power is shared equally between healthcare providers, policymakers and those who encounter these systems (First Nations Health Authority, 2013)

As the need to address disparities in healthcare service delivery is increasingly recognised globally, scholars are striving to develop transformative and innovative evidence-based approaches which offer sustainable solutions for filling the existing knowledge gap on the effective development of asset-based interventions to promote mental health in minority ethnic communities (DeLuca et al., 2018). There is a particular focus on the need to capitalise on protective factors and coping strategies to enhance mental health and well-being through

asset-based approaches, and the further exploration of salutogenesis may lend itself to facilitating this process.

2.4 EXPLORING THE SALUTOGENIC PARADIGM

At the core of the growing emphasis on mental health promotion and prevention is the focus on asset-based interventions that encourage the involvement of various stakeholders in the co-production of services. The much-needed transformation in mental health service delivery would, therefore, benefit greatly from a strength-based approach that takes into consideration the opinions and experiences of the target community. Some scholars were of the view that such strength-based approaches helped to foster a safe space for cooperation and collaboration that looked beyond deficits within a particular context and rather placed emphasis on mutual respect and a community's inherent ability to strengthen their resilience and increase capacity building (O'Connor et al., 2008; Francis, Pulla and Goel, 2014).

Extensive attention has already been paid to deficit-based approaches, that focus solely on the 'worst of what is' in the delivery of healthcare. While this system of inquiry serves its purpose, there is an opportunity to tackle the issue of health inequalities from a different, more positive angle, as evidence of the gap in service delivery continues to widen (Marmot, 2020). As research evidence on the negative correlation between inequality and poor mental well-being outcomes increases, the need to prioritise the use of available resources for mental health promotion and improved service delivery for minority ethnic groups is pertinent (National Institute for Mental Health in England, 2003; Friedli, 2009; Kobau and Seligman, 2011; Cresswell-Smith et al., 2022).

The field of medicine, psychiatry, and affiliated healthcare disciplines, have long focused on the pathogenic component of health, examining health and well-being solely from the angle of what makes an individual ill. The framework of salutogenesis (Antonovsky, 1979), however, explores health through a salutary lens, and seeks to identify the origins of health, as well as emphasise the need for the use of resources present within an individual's environment to facilitate their well-being. Antonovsky (1987; 1996) challenged this long-standing dichotomic

concept of pathogenesis, which placed excessive emphasis on deficits and impediments to health and well-being, by conceptualising health on a continuum. In his opinion, the appraisal of and emphasis on protective factors for health and well-being, rather than risk factors, was the best way to promote health, even in the face of stressful conditions. He was of the view that a person should be assessed beyond their visible pathology and disability, proposing that the conditions that affected a person's health and well-being were best viewed within the context of their community and their view of their interactions within this environment.

Given this, Mittlemark and Bauer (2017) conceptualise salutogenesis as a holistic approach to addressing the health and well-being of an individual or a group by taking into consideration what makes them healthy, by focusing on the resources that facilitate their well-being. Antonovsky (1979) spoke of General Resistance (GRRs) which he referred to as the components that constitute a person's ability to categorise life experiences and events as beneficial or meaningful, allowing one to view the world in a comprehensible manner (Lindstrom & Erikkson, 2005). Some of these GRRs include one's intelligence, mutual social support, a sense of control, a flexible coping system developed through interactions on cultural, religious, and philosophical levels, as well as an adaptable precautionary approach to health (Lamprecht & Sack, 2003; Lindstrom & Eriksson 2005). The availability and identification of these GRRs serve as a determinant of an individual's internal and external motivations and ability to tackle the stressors and challenges an individual may be faced with. The ability to identify these GRRs is what Antonovsky refers to as 'sense of coherence', an inherent tendency in individuals that occurs at varying levels, which allows them to categorise life's events in a manageable, meaningful, and comprehensible viewpoint (Antonovsky, 1987). Capitalising on this enduring disposition of a sense of coherence, according to Braun-Lewensohn et al. (2011a), allows an individual to identify their inherent ability to face a stressful situation with fewer feelings of anxiety or despair, thereby, facilitating resilience and coping.

The concept of sense of coherence which is at the core of Antonovsky's salutogenic theory (1987) posits that, irrespective of cultural background, an individual with a strong sense of coherence can cope at varying stages of stressful situations. Braun-Lewensohn & Sagy (2011) further assert that specific cultural values, norms, and other resources are at the core of understanding how this strong sense of coherence is developed. Antonovsky (1979; 1987)

proposed that there were three factors necessary for the development of the behavioural, cognitive, and motivational components of Sense of Coherence (SOC), namely, comprehensibility, manageability, and meaningfulness. Comprehensibility is determined by how an individual understands and reacts stimuli within their context that may present as stressful. Their ability to cognitively assess the situation in a structured and consistent manner, which increases their ability to handle the same situation if encountered in the future, determines how high or low they score on this feature. Behaviourally, the feature of manageability, speaks to how a person can assess the resources available to them during this stressful situation, and how they can efficiently control these resources. Finally, the feature of meaningfulness resolves the issue of whether the stressful situation will be viewed as a challenge rather than a burden. A person's emotional perception of a problem, thus, determines the motivation behind their ability to solve it. Antonovsky (1987) held the view that some aspects of culture and religion facilitated the development of a strong sense of coherence by encouraging a viewpoint of discovering meaningfulness in life experiences. This meaningfulness then motivates a cognitive evaluation of a person's view of the world, and the strengths available to them to react to various events (Lindstrom & Eriksson 2005; Harrop et al., 2006).

A range of studies have investigated cross-cultural differences in the sense of coherence among minority ethnicities in many countries and have presented varying results (Braun-Lewensohn & Sagy, 2011; Volanen et al., 2006; Ying & Akutsu, 1997). Braun-Lewensohn & Sagy (2011), for instance, attributed these differences, especially lower SOC in minority ethnic groups, to lower socio-economic factors and other political and structural issues. On another hand, Birman et al. (2005) presented a different perspective, stating that the discrimination and racism individuals from minority ethnic communities faced rather contributed to a strong sense of identity which reinforced a strong SOC. To address the debates on the role of culture in determining SOC, Antonovsky developed various scales (e.g., Item Orientation to Life Questionnaire), that measured these three components of the Sense of Coherence. He developed the scales in 49 different languages across 48 countries, to determine the cross-cultural validity of this concept (Lindström and Erikson, 2005). This led to findings that proved that SOC in salutogenesis is a multi-dimensional and multi-cultural construct (Mittlemark, 2017). However, Antonovsky still maintained that some aspects of SOC could not simply be

measured on a scale, but needed to be unearthed by digging deeper, using in-depth interviews and storytelling of life histories that could bring to light, the complex nature of the development of individual and collective sense of coherence.

Lindström and Eriksson (2005) were also of the view that a strong sense of coherence could be linked to positive mental health, based on their findings from a systematic review of 471 scientific studies published between 1991 and 2003. Their evidence demonstrated that there is a positive relationship between psychological resources, such as coping, resilience, confidence and optimism and a sense of coherence, which serve as protective factors against depression, anxiety, despair, and burnout due to stress. They predicted that facilitating the development of a stronger sense of coherence from childhood to adulthood could enhance good health and well-being as well as alleviate mental illness.

Mittlemark (2017) shared their views on salutogenesis as a broad, umbrella framework, composed of many other theories and strategies, one of these being Bourdieu's theory on social capital (1986), which expands on how social and environmental connections can foster the mobilisation of other resources necessary for the development of psychological and social wellbeing. The mutual trust and mutual benefits present within these environments were said to set a foundation for forming patterns of solidarity and social participation among a group of people with common socio-cultural and economic backgrounds (Putnam, 2000). When these connections were well established within a group, it led to the development of expectations and, consequently, the shared value of a sense of individual and social responsibility for the well-being of others (Sartorius, 2003). These associations and bonds formed could be advantageous to the promotion of health and well-being within these settings, especially when the social connections people make are sustainable. The spread of information through these networks could also influence decisions related to mental health and well-being, particularly, those that best aligned with the values relevant within these contexts (Ziersch et al., 2003; Scheffler and Brown, 2008).

Healy et al., (2003) proposed that social capital be examined in three different stages. Firstly, they focused on bonding, which emphasised the influence of an individual's personal beliefs and value systems on the nature and strength of the relationships established. Consequently, through bridging, which is the second stage, one's personal beliefs and values then lead the individual to connect with others inside and outside of their immediate communities, based

on shared interests. The final stage of building social capital, linking, then lies in how people make use of these social connections to gather resources that support their social, economic, and psychological development within a particular context. This process, according to Cooperider (1999), is fluid and continues over different phases of life and is constantly regenerated and applied to different scenarios. The process of generating social capital, like any other life process, needs to be nurtured as who we relate to and how we relate with others are at the crux of human existence. Lemyre and Orpana (2002) and Calabrese (2006) maintained that the sum of a person's social capital and the value of resources acquired at the various stages had a direct correlation to the individual's health and well-being. Social capital can then be said to be critical in promoting health, as social networks play a pivotal role in disseminating healthcare information, both formally and informally, thus, improving access to essential resources and support for well-being. Taking all this into consideration, it is prudent that in attempts to promote health and well-being, as well as alleviate health inequalities using salutogenic approaches in collectivist cultures, such as Black African and African Caribbean communities, understanding the importance of social capital is deemed crucial. Within this social capital exists the values of trust and mutual support, that amalgamate a group of people in such a way that they can offer collective opinions and partake in decision-making that affects their well-being and guarantees their safety.

In line with social capital, Bourdieu's concept of cultural capital (1986) is another theory under salutogenesis, that draws attention to the influence cultural values, beliefs, and systems in shaping the outcomes of health and well-being. Categorised as objective, institutionalised, and embodied cultural capital, this theory was developed to investigate the influence of culture on the social class system and how this impacted the formation of relationships within educational settings (Bourdieu, 1986; Lamont and Lareau, 1988). Thus, the assumption was that the environment one was socialised in greatly influenced their behaviour, skills, values, and habits (embodied), their sense of prestige and power (institutionalised), as well as the format in which they acquired and shared knowledge of culture and traditions (objective). Within the context of health, some researchers have suggested that institutionalised capital is key to understanding some of the social determinants of health as there is evidence of the correlation between social status and health inequality (Muntaner et al., 2003; Abel, 2008). Nonetheless, as a salutogenic theory, the identification and appreciation of how embodied

and objective cultural capital such as art, music, cultural values as well as health literacy and lifestyle have been used as currency to foster health and well-being within various communities (Jeannotte, 2003; Abel, 2008; Pinxten and Lievens, 2014; Bhugra et al., 2021)

Empowerment is another concept encompassed in salutogenesis (Freire, 1970; Eklund and Eriksson, 2011). Some scholars have conceptualised empowerment as a social and dynamic process where an individual's personal capabilities and knowledge enable them to have an active position of control over a situation to make decisions that best serve their interests (Ashkiem and Starrin, 2007; Freire, 1970; Eklund and Eriksson, 2011). Characterised from a psychological and structural standpoint, empowerment in healthcare facilitates the enhancement one's self-efficacy by providing the resources necessary to make informed decisions for change and promoting a sense of autonomy over their own health and well-being (Gibson, 1991; Ashkeim, 2012). Kaplan et al. (2009) have argued that some communities, especially historically excluded minority ethnic groups tend to engage in the process of empowerment, to counteract the adverse effects of poor socioeconomic outcomes and discrimination on their health and well-being. The potential to stand one's ground in the face of adversity and advocate for self and others, as well as show hope and courage whilst enduring adverse conditions contribute greatly to the empowerment process (Kaplan, Skolnik and Turnbull, 2009). Empowerment, therefore, offers the opportunity for marginalised groups to have a voice and be positioned as equal and active collaborators in decision-making processes surrounding their health and well-being (Akpotor and Johnson, 2018).

Finally, resilience (Rutter, 1985; Lindstrøm, 2001) is also a key concept under the salutogenic umbrella. Defined as one's ability to bounce back and cope in a stressful situation without breaking down, resilience has been conceptualised as an interactive process between one's environment and internal, psychological protective factors that help mitigate one's reaction to various stressors (Rutter, 1985; WHO, 2004). Within the context of communities, resilience highlights the process by which a group of people capitalise on their capacity to access various resources to facilitate coping in the face of adversities. This dynamic process is evident in the way these communities utilise the social support systems and other assets to achieve positive outcomes, especially within stressful environments (Norris et al., 2008; Panter-Brick & Leckman, 2013). Several studies around resilience in Black communities have proposed resilience as a fluid process that can be evaluated as an expression of one's behaviour or

identity (Payne, 2011; Teti, 2012; Jones, 2023). Thus, resilience cannot be assessed accurately independent of a historical perspective (Payne, 2011) and should be analysed as a process of relational coping (Gladwell, 2008) which can be determined by understanding the interactions between the complex interpersonal relationships and social backgrounds. Evaluating resilience from a cultural and historical standpoint, therefore, requires gaining insights into the impact of culture on resilience at individual, family, and community levels (Kirmayer et al., 2009; Frounfelker et al., 2019). Within the salutogenic framework, and in the context of cultural sensitivity and mental health promotion, it is crucial to have an in-depth understanding of the role cultural values, beliefs and practices play in enabling communities to access and efficiently utilise resilience resources (Kirmayer et al., 2009; Panter-Brick, 2015; Ungar, 2015).

In this regard, adopting alternative approaches that capitalise on the impact of empowerment, social and cultural capital, as well resilience in the community offers a more robust approach to promoting mental health and well-being, while preventing mental illness within minority ethnic communities, such as the Black African and African-Caribbean (WHO, 2004, Barry, 2009).

2.4.1 Health Promotion and Salutogenesis

One public health framework that supports Antonovsky's theory on salutogenic-inspired healthcare approaches is the Asset Model proposed by Morgan and Ziglio, (2007), and further developed by Mittlemark et al. (2017) demonstrate the value of this approach in view of the shortcomings of the risk-oriented framework when it comes to addressing health inequalities and the equal distribution of healthcare resources. They agree that public health approaches must start to explore assets and protective factors for health rather than focus on risks and how to prevent them. The nurturing environment the asset model of public health creates, according to Foot (2012), fosters a balance between addressing the healthcare needs of people and exploiting the availability of assets are already at their disposal. Adding to Kretzman and McKnight's (1993) asset-based community development framework, Morgan and Ziglio (2007) demonstrate that there are many advantages to adopting this asset-based

approach in public health, in this case, mental health service delivery. Central to the asset-based approach is the attention to the values, skills, knowledge, and cultural and social capital that already exists within a group or community and the ability to capitalise on these to build capacity and promote growth. Particularly within minority ethnic communities, which have often been described as resource-poor, there is the potential to promote a process of empowerment, by encouraging a sense of ownership, even in the face of scarcity of public resources. Recognising the value these groups place on elements of culture, norms and connections restores dignity, where there has previously been a history of discrimination and inequality. For this public health practice to be sustained, a realistic evaluation process that incorporates such assets as indicators of a healthy community should be considered as a measure of the effectiveness of community health initiatives (Morgan and Ziglio, 2007).

It is evident that the need for salutogenic, asset-based approaches to mental health promotion and the development of culturally sensitive services is crucial, especially given the impact of health inequalities on quality of life. However, the reality is that addressing the subject of mental health promotion and culturally sensitive service delivery in the Black community, especially from an asset-based perspective, can be quite complex as there are still pervasive concerns around inequalities that hinder progress in the promotion of mental health and well-being. Stigma and discrimination surrounding mental illness may also hamper conversations around promotion when the very evidence of the existence of mental illness is denied within these communities. Public health theories, such as Bauer et al.'s (2006) Health Development Model have highlighted that, even though schools of thought for both pathogenesis and salutogenesis are on extreme ends of the spectrum in the healthcare practice, both frameworks could still be equally integrated into policy and practice. The Health Development Model, therefore, proposes a more balanced approach to healthcare delivery, demonstrating the need for recognition of the salutary and protective factors in healthcare, in addition to traditional medical risk-factor-oriented approaches. In view of this, mental health promotion in Black communities requires a consolidated approach that addresses the multi-factorial concerns surrounding mental illness treatment, prevention, and education, all aimed at promoting mental health and well-being.

A good example of the need to capitalise on assets within these communities lies in the exploration of the effectiveness of faith-based health promotion programmes (Johnson et al.,

2014). It has become apparent the need for shedding light on the value certain cultures place on faith and religion as well as the role religious faith leaders and spirituality play in promoting mental health and emotional well-being among ethnic minority and immigrant populations (Pandya, 2018). Faith-based organisations (FBOs) have long since proved to be a vital asset within the Black African and African-Caribbean community. According to Codjoe et al. (2013), many studies have shown a positive correlation between faith and wellness among members of these communities. These religious bodies, especially the Black Church, have a history of being a haven for spiritual growth and wellness for many members of Black African and African Caribbean communities. Mantovani, Pizzolati and Gillard (2014; 2015) have recognised the many vital roles the church has played in the past, in bridging the gap between culture and healthcare, highlighting them as a key asset for promoting healthcare interventions and disseminating health messages. Yet still, the issue of stigma that stems from religious and spiritual interpretations of mental illness remains and further perpetuates the culture of silence, making this a taboo subject (Khalifa et al, 2011; Codjoe et al, 2019). Nonetheless, the recognition of such religious institutions as key assets in the promotion of culturally sensitive mental health services is crucial in the development of inclusive and accessible support.

Given the increase in the use of asset-based approaches to address the gap in service delivery, there is already a wealth of knowledge being generated around advancing changes in service delivery for minority ethnic groups in the UK. Yet, there is still very little evidence on how such approaches benefit the health and wellbeing of specific groups like the Black African and African Caribbean community. The use of a salutogenic framework, such as Appreciative Inquiry offers much potential for the advancement of knowledge around mental health and fosters a collaborative environment for the co-production of culturally sensitive service delivery. For a service or intervention to be useful to the recipients, it needs to contain elements of their values, thoughts, and ideas about what works best for them. Bridging the gap between knowledge generation and practical application of such insights can be achieved by actively seeking the views of the individuals these opinions are held about. The social constructionists' school of thought proposes that knowledge has a place in history and culture and the relevance of these influences on a particular context or situation will only become apparent upon consultation with the stakeholders of this knowledge. Once it is identified that

stakeholders can effectively contribute to the discovery of knowledge in a particular cultural or historical context, the door is open for dialogue and progressive inquiry, which generates greater opportunities for implementing change (Doane & Varcoe, 2005).

By bringing individuals together in an environment that fosters mutual learning and empowerment, appreciative inquiry's strength-based approach identifies the value of community assets as well as cultural norms and practices and their role in promoting mental health and wellbeing within these communities (Duncan and Ridley-Duff, 2014; Clarke, 2021). Within this collaborative environment, members of the Black community are positioned as experts whose lived experiences and knowledge of the community are valuable towards challenging the systems that perpetuate inequalities by generating solution-focused approaches that effectively meet the needs of the community. Utilising this solution-focused framework presents a myriad of opportunities to obtain knowledge on the significance of assets, such as cultural and social capital, alongside resilience and empowerment, in promoting health and well-being within this population.

2.6 APPRECIATIVE INQUIRY

Figure 2: Deficit-focused vs Asset-based AI approach

There are various methods to investigate the protective factors that influence the health and well-being of an individual or a group and to identify what works best for the person or group of interest, the right questions must be asked. Appreciative Inquiry's (AI) emphasis on 'life-giving properties', as well as its focus on how organisations, individuals or groups function 'when they are at their best' distinguishes it from other traditional action research models and has the potential to promote optimism within the context in which it is applied (Bushe, 2012; Bhattacharya & Chakraborty, 2019; Clements, Morgan, and Harris, 2020). Bushe (2013) asserted that AI's life-giving properties offered the opportunity for a collaborative approach to problem-solving, which Cooperrider et al. (2008) refer to as AI's generative capacity. As a positive collaborative approach, AI is capable of challenging traditional problem-solving practices by restructuring discussions around actionable solutions, derived from new insights based on already existing assets (Bushe, 2013).

Having been described as both a philosophy and a generative process (Watkins, Mohr and Kelly, 2001), AI has received increased attention across education, healthcare, sports and other disciplines, following its original focus of inquiry as an organisational development tool when it was first proposed by David Cooperider and Suresh Srivastva in 1987 (Sekerka et al., 2006; Roddy et al., 2019). Many studies that have since applied the framework of AI have made reference to it being "*a new mindset or perpetual lens*" (Stetson, 2008), as well as "*a way of being"* that has the potential to reshape the overall culture of an organisation or community as it offers participants new ways of approaching specific situations (Lewis, Passmore and Cantore, 2016). Appreciative inquiry's reflective approach is emerging as a powerful platform for supporting affirmative and optimistic thinking in diverse settings beyond its origins in organisational development and has proved to be particularly useful for fostering collaborative and learning-oriented approaches to evaluation (Coghlan et al., 2003; Moore and Charvat, 2007; Trajkovski et al., 2013). As an asset-based framework, it creates avenues for consolidating the experiences of stakeholders from a positive, strength-based perspective and is adaptable to various contexts towards overcoming barriers to change.

2.6.1 Assumptions of Appreciative Inquiry

As with much other action research-focused frameworks, there exists a set of principles and expectations within AI for which scholars have presented some factors which set the foundation for the implementation of the model in any given context (Hammond, 1998; Cooperider, Whitney and Stravos, 2005). Categorising these factors under 8 distinct assumptions, they set the tone for the expectations that guide and define the language used and format the framework is applied in, regardless of the context.

To begin with, the first and second assumptions of AI state that every society, group, or organisation has a set of systems that work (1), and whatever the group focuses on over time becomes their reality (2). Understanding these initial assumptions set the stage for fostering a sense of respect for the organisational or group culture, even before the inquiry begins. Consequently, the language utilised within these systems becomes the reality of the group or society (3), and as the group progresses, this reality multiplies (4). For this reason, to identify the multiple realities that work within the group or organisation, the right questions need to be asked, as the style of questioning can influence the group's approach to the inquiry (5). In addition, Hammond (1998) highlights the importance of carrying forward parts of the past, as this encourages confidence to embrace the future (6), however, with the emphasis that whatever is carried forward is 'the best of the past' (7). This demonstrates that it is not always necessary to reinvent the wheel to address an issue. Finally, the value of acknowledging differences in realities and how groups approach the subject of what works best and what gives life to their organisation or groups, is key to keeping them invested in this appreciative process (8).

By building on these foundational assumptions, the AI practitioner or researcher may be able to advance into the inquiry setting with an appreciation for the multiple realities that may exist within this context as well as effectively identify the generative opportunities that could be derived from engaging with these experiences. There is much to learn about Black African and African Caribbean culture and values using this approach, which offers a platform for promoting mutual respect, acknowledges the influence of appreciating the past, while embracing the future and appreciates how the interactions within various systems can foster change.

2.6.2 Principles of Appreciative Inquiry

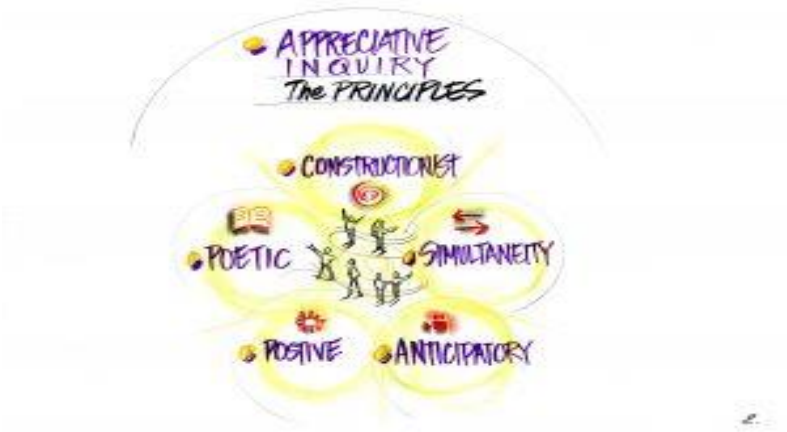

Figure 3:Principles of Appreciative inquiry

In addition to these foundational assumptions of AI, other researchers offer more insight into the rules of engagement within this framework, which they refer to as the foundational principles of conducting an appreciative inquiry (Cooperrider and Srivasta, 1987; Barrett and Fry, 2002; Whitney and Trosten-Bloom, 2003). For the first principle, the constructionist principle, they propose that the knowledge and skills embedded within an organisation and the destiny of that organisation are interconnected. Underscoring Hammond's (1998) assumption that language creates realities, the constructionist principle, based on social constructionism (Gergen and Gergen, 2003), sees language and communication as one of the driving forces behind the socially-related realities that an organisation may exist in. Therefore, the key to effecting change and developing capacity requires a thorough understanding of the organisation and its success, within the frame of the human and social capital it is comprised of. In this vein, the multiple realities of the various individuals who come together to form an organisation are at the heart of its development and identifying them as key players in this solution-focused process is the first step to achieving success.

The simultaneity principle then speculates that change and inquiry occur simultaneously, and that the change expected is not simply a product of the inquiry process, but offers a continuous outcome of transformation, right from the beginning of the dialogue (Watkins et al., 2011). Therefore, the affirmative topic that is highlighted at the beginning of the AI process sets the tone for a discourse that is based off the principle of acknowledging strengths and assets.

The next principle, which is the poetic principle, speaks to the notion that a process of evolution exists as people begin to change within an organisation, and this births the opportunity for limitless interpretive possibilities. This principle expounds on the generative theory and posits that when people focus on a particular thing, it grows (Whitney and Trosten-Bloom, 2003), and every interpretation of this experience is a valid contribution to the advancement of that system. Consequently, when groups focus on what works best and are confident about sharing their experiences regarding this, an environment for growth, learning and inspiration is nurtured.

The fourth principle, which is the anticipatory principle, directs attention to the limitless scope of imagination a group of people may possess. Even though imagination may not necessarily translate to reality, it is a good place to start discovering how to gather ideas on expectations for the future, while still acknowledging some of the strengths that already exist to make these imaginations come to reality. Hence, one's vision of the future has the potential to direct one's behaviour. In the AI process, an amalgamation of the different views, hopes and stories present guide the narrative for the potential change that can occur in the future (Barret & Fry, 2005).

Finally, the principle of positivity borrows concepts from social and positive psychology (Fredrickson, 2001; 2009), which emphasise openness to positive emotions. This principle suggests that, even in the face of complex and difficult situations, a substantial amount of positivity goes a long way to facilitate change, when organisations focus on a common goal. In the appreciative inquiry process, positive emotions and thoughts are highlighted, given the strengths, skills and experiences that already exist within the context to which it is applied (Barrett and Fry, 2002). Therefore, the change expected is not proposed in a vacuum, oblivious to the many other constraints and barriers that may exist in relation to that situation. The human potential present within the group or organisation is rather seen as a positive force, capable of enacting long-term change (Richer, Ritchie and Marchioni, 2010). In addressing areas of concern, such as health inequalities and poor mental health service delivery, proposing this process is simply the first step in engaging organisational change. Cooperrider (1987) emphasised the need to re-imagine human systems not as 'problems-to-be solved' as this perpetuates the deficit-narrative that has not always been successful at offering lasting solutions to issues, such as health inequalities (Hammel & Zanini, 2016).

The application of these principles is instrumental in this study towards addressing health inequalities in mental health service delivery, as it fosters a recognition of the significance of language, relationships, and collective dialogue in creating an equitable platform for sustained transformational change. Embracing the principles of appreciative inquiry is therefore, pivotal in ensuring that the development of culturally sensitive mental healthcare for Black communities is rooted in empowerment, collaboration, and a genuine appreciation of their unique strengths and experiences.

2.6.3 4D Stages of Appreciative Inquiry

Figure 4: 4D Stages of Appreciative inquiry

To ensure the efficient execution of the principles proposed above, proponents of appreciative inquiry have proposed that the process be implemented in four distinct stages, which they refer to as the 4D stages. Central to the Appreciative inquiry process and 4D stages is the affirmative topic, which Cooperider and Whitney (1999) consider to be the seeds of change that begin the generative process of AI. Other studies have adapted this systematic

procedure to include the affirmative topic as a 5th element, referring to it as the Define stage (Priest et al., 2013; Stavros et al., 2015). Unlike the conventional approach of problem-solving models, which is to begin with the question, '*What is not going well'*? the affirmative topic is at the crux of ensuring that the AI process is, indeed, solution-focused. AI then makes use of the 4D Cycle (Discovery, Dream, Design, Deliver/Destiny), which encourages reflection and appreciation of the past and present, as well as creates the scene for inspiring action and motivating change. Some AI studies (Priest et al., 2013; Stavros et al., 2015) choose to refer to it as a 5D Cycle, stating that the first phase denotes the 'Define' phase, which sets the foundation for the definition of the purpose and content of the topic to be explored, however, this study will align with the original 4D approach.

By asking what the purpose of the inquiry is, the guiding question is, *'What generative topic do we want to focus on together?'* By recognising the value of an experience and investigating its relevance, AI embraces and encourages the exploration of the past and present by identifying assets and strengths *(*Whitney & Trosten-Bloom, 2003). The discovery phase then explores past events that are of value to the group of interest, encouraging positive reflection on the circumstances surrounding the events and the factors that made them memorable. With a focus on affirmative stories, the Discovery phase offers the opportunity to describe experiences and share knowledge of a phenomenon, based on the varied interpretations individuals may offer regarding a particular situation. The question posed at the beginning of this phase '*What is*?' offers a blank canvas for participants to begin the process of highlighting the strengths and assets that exist around them, through storytelling (Cooperrider et al., 2008).

In line with the first objective of this study, the Discovery phase seeks to explore the cultural strengths, resilience narratives, and protective factors that contribute to the mental health and well-being of Black African and African-Caribbean communities. Following on from this, the Dream phase allows them to envision an ideal future; in the case of this study, for instance, one characterised by better healthcare experiences and improved treatment outcomes from culturally sensitive mental health services. By gathering the ideas and imaginations of what the future looks like or might be, an ideal vision is created, based on insights generated in the Discovery phase. Thus, building on the foundation of what already is and what is working well, provocative propositions are used to provide a strategic focus on

what the future would look like (Dream phase), if one were to capitalise on the strengths and assets that already exist (Trajkovski, Schmeid, Vickers & Jackson, 2012). However, imagination is inadequate for effecting change and, therefore, in the Design phase, the participants can extend this imagination into practical, real-life settings, discussing how these ideas can be acted upon and the role they play to make this materialise. By discussing what should be, groups have the chance to co-produce the future they have created, taking account of past successes and how these accomplishments came to be (Cooperrider et al., 2008). The provocative propositions made in the Dream phase are, therefore, made actionable and planning for the future is more achievable, considering the life-giving properties and strengths the group possesses. The final phase, the Destiny phase, emphasises the role others play in helping them realise their dream, encouraging and empowering them to act on their ideas and put the resources available to good use. This Destiny phase was formerly known as the Deliver stage (Cooperider and Whitney, 2001) and the name change followed the discovery that the momentum for change was more fast-paced and sustainable when the idea of rigid, one-time action plans and immediate implementation was abandoned. Thus, the Destiny stage is more inclined to succeed when approached from the angle of encouraging and nurturing systematic action that ensures that there is sustained interest and endorsement from those whose interests need to be considered in the design and development of interventions. Cumulatively, efforts are directed towards bringing the visions generated in previous phases into reality, by breaking these down into smaller and more feasible tasks and processes. The focus here is on sustaining the vision and creating a system of advancement where creativity, collaboration and positive actions foster the change that is desired (Carter, 2006). The goal of these phases is that through communication and dialogue, individual visions and ideas become part of a shared vision, that benefits the community and offers hope for continuity of change (Lewis et al., 2016). All these principles and systematic approaches, though beneficial for guiding the success of this AI process, are not without criticism and a critical assessment of the proposed framework must be undertaken to profit the aim of this study.

2.6.4 Does AI Really Need to Focus Only on Positive Narratives?

As previously stated, as with many other asset-based frameworks, AI draws the attention of many critics, particularly for its over-emphasis on positivity at the expense of a more balanced and critical approach. Patton (2002), for instance, posits that one drawback of the AI approach is the unrealistic and one-sided nature of the positive stories which the AI process proposes. Rogers and Fraser (2003), also offered their opinion on this perspective, describing AI as a *"seductively plausible causal model",* which could have detrimental effects in the context within which it is applied, stating that the positivity emphasised in AI could lead to shallow outcomes if applied wrongly. In their view, the over-emphasis on positivity could promote unrealistic expectations and unfounded optimism, especially when there is an avoidance of discussions on the problems, particularly within a context with a history of toxic systems and power imbalances. Another common criticism pointed out by Bellinger and Elliot (2011) was that AI lacked the practicality of supporting continuity, as the stages of inquiry may involve many different groups along the way, depending on the population being studied. There was, therefore, the potential for 'voices to get lost' along the way, which according to Reed et al. (2002) breaks the consistency of the AI process. However, others have argued that there is a need to view AI as a continuous fluid process rather than a final product or a means to an end (Watkins et al., 2011). This way, the contributions and reflections of individuals collected along the way can be viewed as an essential part of a larger framework. In the process, no one's story is left behind, but rather the various narratives are harnessed to develop a feasible action plan that can be tailored and altered to fit best practices (Bellinger and Elliot, 2011).

In Clouder and King's (2015) contribution to this dialogue, they highlight the danger of the appreciative and highly positive nature of AI, being identified as uncritical and obstructive, especially in the academic and research settings, not allowing for critical discourse that engages both the pros and cons of a situation. They further refer to Trajkovski et al.'s (2013) findings from their methodological review of the AI 4D cycle, which highlighted AI's potential to gloss over problems and fixate only on the positives.

Aldred (2011) has also drawn attention to the fact that the nature of AI has the potential to restrict already marginalised groups from participating in a positive-focused approach that does not consider the problematic socio-economic and political contexts where these groups are situated. Aldred (2011) critiqued the model as one that claimed to offer transformative effects that can suddenly cure deep-seated structural issues, thus, overly simplifying the

rigorous process of social change. Other researchers, such as Barge & Oliver (2003) and Egan & Lancaster (2005), had previously shared similar sentiments regarding AI's potential to dismiss meaningful contributions because of the negative narratives that participants in the process may want to share, especially in the discovery phase. In Cram's (2010) study on the use of AI among indigenous communities among the Māori tribes in New Zealand, she held the same concerns surrounding the positive nature of AI, stating that it had the potential to portray a sense of arrogance and naivety of the problems within the community being researched, conveying a sense of dismissiveness. Another major concern she had was the lack of information on the outcomes of research, where preconceived notions on the values, norms, and beliefs of success within a particular group, further perpetuated an already common narrative about the said group. She highlighted that this had the potential to be detrimental to the support these groups may receive from external organisations. Nonetheless, her findings demonstrated that the indigenous people were not discouraged from voicing their concerns and discussing the problems within their community, which was contrary to her previous beliefs. This further establishes that the AI process, though very positively oriented, has the potential to be flexible and adaptable, and holds promise for facilitating complex conversations on wellness and health among marginalised groups, taking into account both salutary and risk factors present within the context.

Other arguments presented by Bushe (2007) and Grant and Humphries (2006) suggested that an insistence on positive conversations alone led to contributions that lacked true conviction and hid the true emotions of the storyteller. They further argued that the AI literature did not efficiently engage the issue of the influence of power dynamics that existed in social systems, and how these influenced the positive narratives expected in the AI process. Grant and Humphries (2006), therefore, advocated for a critical appreciative inquiry approach that takes cognisance of the wider societal context within which the AI process is being applied. Here, they indicated that combining the strength-based ethos of AI and critical theory's acknowledgement of social, historical, and ideological structures that exist within a context has the potential to generate more realistic outcomes for the AI process. Grant and Humphries, (2006), therefore, maintained that, in the application of appreciative inquiry, it was important to acknowledge the influence of history, culture, socio-economic and political contexts in the shaping of an individual or a group's reality. Given these suggestions, the goal

of this study is, therefore, to produce a transformative narrative within the Black community that stems from the identification of strengths and resilience, while acknowledging the importance of 'negative' stories as a critical element to fostering generative change.

Since its inception almost 40 years ago, Appreciative inquiry, which was initially designed as an affirmative organisational development tool, has incorporated the use of positive and creative narratives to enforce constructive change in organisations and communities. Cooperider, Whitney and Stravos (2005) state that the process of AI is based on this simple principle: "*Things that are affirming engender a force toward them".* They imply that, the affirmative approach which AI employs seeks to decipher what works best within an organisation, group or community, and is the driving force behind progressive, positive change. Adapting a positive psychology viewpoint, AI facilitates strength-building by inspiring creativity and positive dialogue. Building on this notion, Oliver (2005) has stated that, in this case, the goal is to still acknowledge the inevitability of negative stories, while taking advantage of these comments to foster conversations around ways to improve upon these problems, by encouraging the ideas and opinions of the group from a solution-focused perspective. Thus, by replacing the deficit-focused approach to community development with a salutogenic approach, AI envisions a group of people or concern within a community as more than a problem to be fixed. By introducing a possibility mindset from the onset, AI makes use of a narrative inquiry that allows the appreciation and valuing of skills and resources present within a group, encourages dreams and visions of what the future might look like and supports practical efforts towards the creation of these dreams.

Consequently, Grant and Humphries' (2006) proposal to use a critical approach to appreciative inquiry in a manner that is sensitive to the socio-economic and political contextualisation of the group it is being applied in, while still maintaining a generative and solution-oriented focus, is crucial. In evaluating the social context, where AI is being applied, a critical appreciative process would seek to offer an inclusive perspective to bridging the gap between positively focused action research and the complex realities of the population and context being explored (Ridley-Duff, Rory and Graham, 2015).

Cooperider and Whitney, (2000) and Mezirow (2000) maintained that the identification of the power of positive dialogue makes way for the co-creation of resources that can influence mindsets and support the transformation of perspectives aimed towards organisational and

societal change. With this idea in mind, the goal is to acknowledge the power of positive dialogue while utilising a critical appreciative approach to address the issue of health inequalities within Black African and African Caribbean communities and promote a solution-oriented approach to co-designing culturally sensitive mental health service delivery.

2.7 APPRECIATIVE INQUIRY AND SALUTOGENESIS

Seligman (1991; 1992) in his advancement of positive psychology, made a hard case for the use of appreciative inquiry as a salutogenic approach to healthcare and service delivery. He argued that the AI process is well placed within current health promotion and prevention literature, which emphasises the need for increased focus on protective factors and asset-based healthcare delivery and, in this case, mental health service delivery. He was of the view that deficit-laden narratives enforced negative patterns of unconscious learned helplessness, which weaken the construction and implementation of empowering processes which are at the core of development. Thus, the generative dialogues that AI encourages, which promotes the idea of identifying life-giving properties within a group or community, help to build a system based on strengths and creative reflection on what works best.

Studies by Morgan et al. (2005) and Mantovani et al. (2014; 2015) have highlighted the lack of content relating to suitable mental health promotion and culturally sensitive service delivery that are specifically aimed at catering to the needs of minority ethnic populations. Asset-based mental health promotion should be aimed at finding protective factors that encourage resilience among these groups, engaging them to further understand how the cultural and environmental systems foster these mitigating factors. Therefore, carefully considering the social and cultural foundations on which the mental and emotional functioning of these communities or groups are built is necessary for enhancing positive mental well-being (Miller and Rasco, 2004). Interventions, aimed at positive mental health promotion and improvement of services, should, therefore, seek to emphasise the need for collaborative community efforts that foster a mutual goal of bridging health inequality gaps. Some scholars have stated that promoting collaborative efforts by fostering community

engagement in the design and implementation process has the potential to greatly influence the success of health promotion programmes (Thompson and Kinne, 1999; Russel-Mayhew, 2006; Jansen et al., 2022). They facilitate the building of confidence, by actively involving the members of the community in the design and implementation process, and change is more likely to occur when community members play an active role in the planning process (Jane-Llopis et al., 2005; Friedli, 2009; Kobau et al., 2011). This ensures greater chances of sustainability, knowing that the main stakeholders played a part in contributing to the impact and success of these initiatives (Assay and Lambert, 1999; West Midlands Mental Health Authority Commission Report, 2017). In this regard, the appreciative inquiry approach employed in this study seeks to facilitate the exploration of these cultural competencies and skills that support mental well-being and resilience among Black African and African-Caribbean, which is crucial to promoting culturally sensitive services.

Military services , businesses and non-profit organisations, communities and healthcare services have all made use of appreciative inquiry, gaining positive results and feedback, by empowering people and encouraging nurturing environments focused on positive change (Liebling et al., 2001; Finegold et al.,2002; Lavender & Chapple,2004; Powley, Fry, Barrett & Bright, 2004; Carter, 2006; Havens et al., 2006; Trajkovski et al., 2013). AI has been used extensively to facilitate organisational development for service providers and healthcare practitioners in some studies, for example, in the NHS, for conducting care and quality assurance research (Wright et al., 2005; Richer et al., 2010).

Robinson et al. (2013) draw attention to the evolution of the literature on the use of the AI methodology, from simply being a traditional process of inquiry to becoming an action and participatory research approach that consciously engage research participants in the transformative process of AI. They highlight the work by Liebling (2004) in a study on prisoner-staff relationships as a pioneering piece of research that motivated a new wave of AI-related studies in the UK. As a salutogenic research tool, AI motivates and encourages individuals to focus on the aspects of their social context they place value on. It also highlights the need to identify their own strengths in ensuring their personal and communal well-being and contribute to the improvement of their circumstances through positive action. Other mental health promotion interventions focus on helping people identify the barriers to their mental health to encourage proper coping skills and facilitate well-being (Christodoulou and

Kontaxakis, 1994; Hayes et al., 2006). However, in addition to promoting coping, AI takes the focus away from the illness-representative and conventional problem-seeking and solving methods to a more strength-based system (Ludema et al., 2001). Raeburn & Rootman (1998) drew attention to the factors necessary for developing successful health promotion models that sought to encourage individuals and equip them with skills to take charge of their own well-being. They suggested that proper mapping exercises should be undertaken to have a clear summary of the needs and historical structure of the community the study would be conducted in. In addition to this, researchers needed to have an idea of the resources that were available within these settings and how best they could be utilised. Also, in partnership with community members, researchers needed to establish ground rules in accordance with the values and beliefs of the communities, jointly coming to an agreement on how plans would be carried out, implemented and monitored. All these factors were carefully considered in the design and development of this research, details of which will be discussed in Chapter 3 (Methodology).

Seligman et al. (2005) assert that good mental health cannot simply be equated to feelings of satisfaction, happiness, or optimism. Rather, it encompasses an appreciation of the improvement of social, interpersonal, and culturally accepted skills, qualities, and virtues. In this regard, the use of AI in this study is profitable for engaging participants who are already actively involved in various health promotion initiatives within their communities to shed light on the importance of their roles in contributing to their positive mental health and well-being (Reason & Bradbury, 2008). The fostering of collective dialogues, which affirm shared values and open new possibilities for facilitating change, contributes greatly to social cohesion, which is vital to such community engagement processes (Whitney and Frederickson, 2015). AI presents more opportunities for fostering discussions around the availability of social capital within the research setting, which allows participants to share visions on how these resources contribute to health and well-being, particularly in response to highlighting the value of social connections within collectivist cultures, such as Black African and Caribbean communities.

In adapting a salutogenic approach to addressing service delivery and promoting mental health, using appreciative inquiry, this study has focused on the aspects of culture that act as generalised resistance resources (GRRs) and enhance mental health and well-being. It also

sought to encourage discussions on the perceived barriers and facilitators to the effective delivery of culturally sensitive mental healthcare, with the aim of engaging various stakeholders to generate solutions for improved access and quality of care. AI, as applied within this study, also guided discussions on how the appreciation of cultural and social capital, as well as resilience could be an effective starting point for the promotion of solution-focused dialogues around the co-production of services.

In pursuit of these goals, a critical assessment of recent scholarly works was needed to identify how other studies had carried out the implementation of the AI process.

2.8 LITERATURE REVIEW STRATEGY

The relevance of the application of Appreciative Inquiry (AI) as a salutogenic tool cannot be effectively assessed without a thorough and critical analysis of the existing literature surrounding its utilisation in various fields of research. As earlier stated, appreciative inquiry, since its inception has been used within a wide array of organisational and research settings and has proven to be a viable tool or methodology for assessing the strengths of a group and offering a solution-focused approach, tailored to the needs of those engaged in the generative process. This review of relevant literature focused specifically on identifying studies that have utilised the AI process in a manner that aligns with the salutogenic ethos of the current study, which aims to promote culturally sensitive mental health services for marginalized communities. By evaluating the methodological rigour applied in these studies, the review sought to understand how best to link the AI approach to the present study on cultural sensitivity, while also addressing any potential gaps or limitations that may arise in applying AI to this specific context. The literature reviewed served as a foundation for understanding the strengths and challenges of utilising AI in the development of culturally responsive and empowering mental health initiatives. Some of the overarching questions guiding this literature review therefore were:

1. How have appreciative inquiry techniques been successfully adapted and implemented, especially among minority populations, to capture lived experience and

identify actionable steps aligned with community priorities and foster community engagement?

2. What gaps or limitations in the existing literature on appreciative inquiry's application to addressing inequalities in various settings?

This process helped to narrow down the inclusion criteria and key words for the search strategy and strengthen the process utilised in this literature review. A thorough search of keywords in the abstracts and titles, as well as full text review of relevant articles helped to narrow the search. The reference lists from various studies were also searched to identify research that did not appear in initial searches.

Understanding the processes employed in the implementation of AI within these settings and their outcomes helped to expand the knowledge base on what has already been studied in this area and how it can be improved. An identification of the gaps and limitations of these studies further emphasised the need for this study, especially as there is a dearth of studies that have applied AI as a salutogenic tool for the co-production of culturally sensitive mental health service delivery. Particularly within the UK context, there is a small evidence base for the effectiveness of asset-based participatory research methods that are solely focused on Black African and African and Caribbean populations. As earlier stated, the BAME classification, which has often been used in research addressing health inequalities, obscures the distinct experiences and needs of various ethnic groups which may lead to limited application of research findings. Identifying how various studies have addressed similar concerns was necessary for guiding the design and development of this research. Evidence from this review therefore, serves as further justification for the relevance of this study and addresses a meaningful gap in the current literature on health inequalities, and the co-production of culturally sensitive mental health service delivery.

Several databases, such as CINAHL, Medline, Proquest Central, EMBASE, PsycINFO SCI (Science Citation Index), as well as grey literature, were used to identify studies that best addressed the above factors.

The keywords included in the search strategy are outlined below:(Appreciative inquiry OR Critical appreciative inquiry OR Critical appreciative processes) (community engagement OR impact OR community development) AND (health OR mental health OR mental wellbeing)

AND (education* OR school) AND (service deliver* OR service user* engagement) AND (setting* OR system* OR service* OR institution).

The literature included was restricted to studies published over the last two decades (2003-2023), to ascertain the most recent advancements in the field. Only research published in English were included for convenience and feasibility, due to resource limitations and interpretation concerns. All types of studies were included in the search, e.g., quantitative, qualitative, and mixed method studies, randomised-controlled trials (RCTs) and quasi-experimental studies. Yet, due to the participatory and dialogical nature of AI, many of the studies reviewed were purely qualitative. Studies that applied AI in corporate and business organisational contexts were excluded, although briefly highlighted, to distinguish this body of literature from the focus of this study, which is its application in healthcare and community settings. Also, studies, where AI was applied in educational settings were briefly addressed, specifically if they were conducted with the goal of promoting community engagement. A discussion of the relevant studies is presented below.

2.8.1 Appreciative Inquiry applications in educational settings and community engagement

The AI process has been applied by Shuayb, Sharp, Judkins and Hetherington (2009) in a study, aimed at including young people in conversations on community cohesion, in two localities in the South-East of England. Having the young people participate as peer researchers empowered them and provided a heightened sense of ownership. Collington and Fook's (2016) application of AI in a Higher Education (HE) setting was a case study that explored the need for the use of a less deficit-oriented approach to change in staff engagement and improvement of organisational structure in the UK. Considering the socio-economic context and government policies on austerity, they found that AI offered resolutions that promoted staff and student collaboration, improved morale, and reduced tension in the power dynamics between staff and managers. They further highlighted AI's role in improving trustful communication within a highly bureaucratic climate in HE, where presenting a systematic process of empowerment and change was timely.

Taft, Woods and Ford (2020) also investigated the role of Educational Psychology Services (EPS) in working in 63 primary and 22 secondary schools in England and the part they played in fostering community cohesion within the locality. Their findings demonstrated that AI provided a generative context for promoting the work of EPS in schools and allowed reflective practices. However, the challenge highlighted was that the ideas and reflections could not be efficiently translated into concrete, active plans. They noted the limitation of methodological flaws in timings for participation in discussions, which may have disrupted the AI process. Clouder and King (2015), conversely, highlighted the same concerns about AI reflections from the Discovery and Dream phases to the operational planning stages in the design and destiny stages. In a case study on the use of AI to engage professional bodies in supporting the needs of students in HE with disabilities, they noted that tensions arose when the reality and lived experience of the students, even though articulated in the AI positive frame, could not be efficiently relayed to funders. Earlier findings from Shuayb et al. (2009) already addressed the argument that the positive nature of the AI process limited the scope of engagement on challenging social issues, such as racism or where participants did not have enough experience on the topic to contribute efficiently. Some of the challenges highlighted in the above studies demonstrated the need for this study to address concerns surrounding the translation of AI's positive ideas into actionable and sustainable change. It also highlighted the need to tackle systemic and social inequalities like race, socio-economic status, and disabilities, which cannot be glossed over even when using asset-based approaches like AI that focus on the positives.

As a community engagement tool, AI has been used to investigate the experiences of older people in four different countries, in developing well-being strategies and resilience. Moyle, Clarke, Gracia et al. (2010), designed an AI study with adults over the age of 65 from four different countries -- Australia, Germany, South Africa, and the UK. This multi-national study sought to identify the factors relevant for improving well-being and the strategies employed within this population to respond to perceived risks to well-being, from a strength-based perspective. Having considered that the population of study was classified as an at-risk population due to age and other factors, they sought to highlight stories of resilience, which they considered a neglected and undermined resource within this population, especially around mental health. Drawing on the transformative principles of AI, they identified what

works best in exploring the temporal dimensions of aging (Coupland, Coupland, Giles and Henwood, 1991) that deviated from traditional ageist narratives (Lynott and Lynott, 1996), and allowed for transformative dialogue. Opportunities to situate the experiences of elderly people in both current and future contexts (Biggs, 2006), demonstrated greater sensitivity and respect for the resilience prevalent within this population.

A small-scale study by Kevany and MacMichael (2014) applied AI in a bid to understand rural well-being, as well as to improve partnerships between a university situated close by and community members in two rural towns in Nova Scotia, Canada. By asking questions, such as, *'What local environmental actions bolster your community pride?'* and *'What further cultural resources or events may add to community wellbeing?',* they sought to identify how qualities, such as resilience, and values, such as respect and hard work, were preserved and sustained. They found that the positive framework derived from the AI process facilitated healthy dialogues, as participants highlighted that the deviation from traditional problem-solving questioning led to more honesty and less reluctance to share their stories. They noted that when they focused more on what mattered to the community rather than presenting their own preconceptions on rural living, they found a community of people who were willing to be equal partners. The inclusion of community members as co-researchers further highlighted the respect for local knowledge the university demonstrated, thus meeting the aim of strengthening relationships between the academic and local communities.

The study that most closely aligned with this research was Graham and Ridley-Duff's (2014) 3-year action research project on the use of AI to support marginalised Pakistani women in Sheffield, UK. This longitudinal study followed the learning journeys of 39 female migrants from Pakistan, with the aim of providing an emancipatory outlet for sharing stories of resilience and survival within a new cultural context. Their study is significant because throughout applying the 'positive AI lens' to the participants, to transform the negative narratives around learning and education within this minority ethnic context, they were open to the flaws of the AI framework at an early stage. Noting the influence of power dynamics and the importance of identity within their research context, they were quick to adopt a critical appreciative inquiry approach, which they consider having greatly influenced the turn-around in initially uncommunicative participants. They admit that their naivety and rigorous attempt to only hear the positive stories glossed over the social influences at play, leading

them to constantly steer participants towards a positive narrative each time they attempted to share stories on hardship and painful memories, was counterproductive. Thus, adopting a critical appreciative inquiry approach, as utilised in this supported the generation of positive results. Even though they noted that their study met a few challenges due to the traditional context of their research (women within Pakistani communities in the UK), they were still able to adapt their research in a critically appreciative frame to address issues of diversity, community cohesion and multiculturalism. This further reinforces the need to adopt a critical lens to assess how well the AI process can be used to engage minority ethnic groups in the UK and yield sustainable outcomes for developing culturally- sensitive mental health services, as well as addressing health inequalities in service delivery.

By adopting a more critical complex epistemology (Kinchloe, 2008), their study embraced the full scope of 'appreciation' as earlier proposed by Grant and Humphries (2006). Recognition of the socio-cultural context these research participants came from and tailoring the positive and affirmative AI process to accommodate conversations around cultural dynamics of control within the Pakistani community, oppression and other dialogue gave a voice to this marginalised group. By appreciating both negative and positive stories, their findings demonstrated that the AI process was still successful at creating a transformative, inclusive, and empowering environment where participants were able to recognise the life-giving properties of strength, determination, and hope. Their data led them to propose other elements of appreciation that were pertinent to advancing the critical appreciative process, especially within already marginalised groups where social issues, such as racism and health inequalities, are the focus of research.

In the Discovery phase, they suggested that appreciation requires stressing the value and respect attached to every narrative and every identity presented by participants. Once this foundation was set, appreciation in the Dream phase needed to respect the distinctive imaginations and creative ideas that participants might present, allowing them to build an awareness of their capabilities from a strength-based perspective. The Design phase called for a transformative appreciation that allowed participants to critically assess and commit to the positive change they hoped to see, where they were allowed to challenge the status quo and map out new possibilities for the future.

This empowering process of embracing challenges from a solution-focused lens, would then lead to appreciation as the Destiny phase, where participants could begin to embody the change, they wanted to see, and translate new possibilities into physical actions. The evolution to a critical appreciative approach demonstrated responsiveness to the socio-cultural and political needs within their research context, which is what this study sought to do in addressing health inequalities and cultural sensitivity within the Black African and African Caribbean communities in Birmingham.

In a qualitative study on the use of the AI methodology with a hardly reached population, Lambdin-Pattavina et al. (2020) reported their findings on the perceptions of empowerment among homeless people in a day shelter in Florida, USA. The initial groundwork before the actual study required various acts of service and informal learning within the research context to establish trust with participants, given the history of conducting research within such vulnerable populations (Magwood, 2019). One major finding was the movement away from traditional definitions of empowerment within the homeless population, where the assumptions were that such individuals felt empowered when their basic needs were met and when they felt seen. On the contrary, having an external locus of control where they felt at home within the homeless shelter, being able to network with other resources and organisations that offered support, as well as having a voice and a choice, were the themes identified as their definitions of empowerment. These themes, generated from the Discovery and Dream phases, led to the action plan to include environmental enhancements within the local shelter in the Design and Destiny phases, where a suggestion box was used to allow service users to share their ideas with staff. A key addition to this study was the follow-up survey one-week post-study to gather reflections on environmental enhancements suggested. However, participants reported no indications of changes in perception of empowerment, leading to the recommendation that there is a need to consider timeframes between the original study and post-study evaluations aimed at measuring the sustained impact of the AI process. Nonetheless, they reported that appreciative inquiry is a useful methodology for engaging historically- marginalised communities and encouraging the co-construction of supportive environments for service users and deliverers alike.

The addition of a follow-up survey to assess sustained impact is a good indication of methodological rigour, which this study sought to replicate as one of the products of this

study. These studies, thus, provided vital insights into how the AI process could be effectively adapted to address contextual and systemic structures, while seeking to reframe deficit-focused narratives and facilitate collaborative and sustainable change.

2.8.2 AI in healthcare settings

A recent study by Uys and Cloete (2020) involved the use of AI to explore the perspectives of service users on the perceived benefits of an Occupational Therapy craft group for out-patients in a mental health institution in South Africa. Using the 4D stages of AI, they were able to gather information on the maintenance of best practices in occupational therapy services, by including service users as co-researchers. Themes of safety, empowerment and acceptance were also highlighted, in line with findings from other AI studies conducted within similar populations. Being co-researchers in this AI study created the opportunity for service users to appraise and evaluate structures and models for recovery and offer suggestions for the improvement of the current out-patient craft groups. The authors, however, noted that the duration of the AI process and the amount of time needed to conduct such in-depth evaluation of an intervention could not be feasibly implemented within those clinical services, due to time and resource constraints. This concern was considered within this study, particularly following a pilot study conducted as part of this study, which is discussed further in the methodology section (pg. 96-98). Even though this study was not conducted within a clinical setting, the constraints experienced in fully implementing the AI process advised the design of this study, details of which will also be addressed in the next chapter (Methodology).

A more contextual example of the application of AI in the UK was a study conducted by Randall, Tayleur and Allamby (2022), aimed at developing a gender-informed drug treatment service as part of the Fulfilling Lives Lambeth Southwark Lewisham (2020a). Conducted during the pandemic, the project made use of online workshops, where women with lived experience of drug and alcohol addiction were given the chance to reflect on the process of co-producing an intervention tailored for them. The innovative application of AI, using the structured 4D AI Cycle, helped to engage marginalised service users as experts in the co-

production of this drug treatment service. The inclusion of diverse stakeholders, ranging from service users to executive leadership, led to the actionable outcomes that facilitated the re-design of the treatment space and other service practices. However, as a case study, undertaken within a single service setting with 12 participants, there may be limited generalisation of results, as well as potential bias given that the study was conducted internally by invested organisational stakeholders. This may have made it difficult to truly identify if the study addressed the power dynamics between staff and service users. Nonetheless, it also demonstrated that the co-design of effective interventions, recognising service users as equal players, whose strengths and lived experience could be applied to enhance mental health support was feasible, using the appreciative inquiry approach.

2.9 GAP IN LITERATURE

The findings so far have shown that there are a substantial number of studies that focus on exploring the use of AI as a transformational participatory research method in Australia, USA, South Africa, and the UK, on mental health services (mostly, primary, and secondary care). The studies discussed above provided a synthesis of key findings as well as theoretical methodological approaches from prior appreciative inquiry studies relevant to examining how these studies successfully engaged marginalised groups and service providers in co-designing solutions, in a bid to identify lessons applicable to the current research. The studies reviewed demonstrated that beyond AI's evaluative function, the drive to introduce and influence change takes it beyond the scope of traditional participatory research methodology, with evidence that the 4D Cycle promotes a culture of commitment and responsibility over the implementation of ideas and solutions generated during the inquiry (Shuayb et al., 2009). Shendell-Falik et al. (2007) was of the view that AI worked well to help stakeholders and service providers to express their core values through their experiences of success in a complex healthcare system where the probability of 'losing one's voice' and 'feeling overlooked' is common. Their study with a group of nurses saw improvements in steps taken to enhance patient safety and foster an encouraging working environment for others. All the

studies reviewed for this study aligned with these themes of empowerment, hope, transformative practices, and a sense of belonging.

Nonetheless, as highlighted in the review by Trajkovski, Schmeid, Vickers & Jackson (2012), many studies lack the rigour relevant for the full application and utilisation of the 4D Cycle in the AI process. However, this notion is somewhat debatable as opportunity must be given for the exploration of diverse applications of the framework, whether in part or holistically to contribute to the critical positioning of AI as a feasible tool for multidisciplinary action research. Nonetheless, if studies state that they will be using the 4D Cycle, yet fail to clearly define the scope of use, then there is a gap in the implementation of the AI process.

Another gap is the lack of emphasis on the need for a critical appreciative inquiry approach. Except for the study conducted by Graham and Ridley-Duff's (2014), which stands out as one study that effectively offered a critical, transformative approach to applying the AI process, especially in a minority ethnic context, none of the other studies make this distinction. They all acknowledge the need to be wary of the 'positive lens' of AI, but do not fully outline how their process allowed for a more critical approach to respecting the cultural and socio-political dynamics at work within their research context. While AI focuses on highlighting strengths and positive attributes, it also makes space for underlying problems to be brought to the forefront, without downplaying the relevance of existing strengths and efforts in place to manage these problems (Carter, 2006). There is also a lack of clear linkage of the AI principles to the implementation phase of the process. An identification of how the various principles guided the design and adaptation of the studies to meet the needs of the target population would have helped in identifying how language and generative dialogue, as well as an appreciation of contextual dynamics, guided the implementation of AI and its application within diverse settings.

Overall, this review has highlighted the strengths of the appreciative inquiry process as applied within various settings, demonstrating its value as a collaborative methodology. While these studies shed light on the transformative and empowering impact of AI, there was a dearth of evidence on the long-term outcomes and implications of the implementation of this framework. Having still focused extensively on the positives, many of the studies failed to adopt a nuanced and flexible approach that permitted a more critical balance of both barriers and facilitators present within the research setting. The need for a critical

appreciative approach supports the idea that many more opportunities exist to strengthen the evidence base on the use of appreciative inquiry to address issues, such as health inequalities, within minority ethnic groups. Finally, the lack of application of the AI as a salutogenic framework within minority ethnic communities, such as the Black African and African population in the UK, further justifies the need to bridge the evidence gap on the use of this model to promote the co-production of culturally sensitive mental health services.
This study, therefore, intended to contribute to addressing the gaps highlighted by adapting the salutogenic framework of appreciative inquiry in a critical and culturally- relevant manner for addressing health inequalities and promoting culturally sensitive mental health service delivery within Black African and African Caribbean communities in Birmingham, UK.

2.10 CHAPTER SUMMARY

This literature review chapter has provided evidence on the background and context of this study, addressing the aims and objectives of this research by highlighting the key concepts, such as salutogenesis and appreciative inquiry, and their role in addressing concerns around health inequalities and culturally sensitive mental health service delivery in Black African and African Caribbean communities in the UK.

To situate this study in the broader literature, a critical examination of the effectiveness of policies implemented to address health inequalities in mental health within the target population was addressed. Drawing on various studies that had addressed the shortcomings of such policy, the need for asset-based community participatory frameworks was discussed, highlighting the gaps in the existing body of literature. The need for salutogenic approaches, such as appreciative inquiry, was then discussed, with further justification provided on the need for the use of a critical strength-based, solution-focused framework that fostered collaborative engagement, for addressing concerns around health inequalities in the UK. Having discussed the pros and cons of the AI approach, a literature review was conducted on the application of the model within various settings, highlighting the areas that aligned with the current study, as well as identifying the gaps needed to be addressed. By discussing key findings and methodologies from prior studies on the use of appreciative inquiry in various

healthcare, educational and community settings, the review highlighted how AI had been successfully applied as a tool for engaging various marginalised groups and service providers in co-designing solutions. By identifying gaps in existing literature, specifically around the application of the principles of AI outside the scope of its exclusively positive approach, this review assesses the relevance of previous studies to the specific focus on these communities in Birmingham, offering insights for improving the design of this study.

These findings further justify the need for this study and, as the studies evaluated, except for Graham and Ridley-Duff (2014), provide limited evidence on research conducted among minority ethnic groups, particularly Black African and African-Caribbean communities in the UK. This dearth of evidence underscores the pressing need for further inquiry that specifically explores the application of appreciative inquiry principles and practices within these underrepresented and marginalised populations. The next chapter provides further insights into the methodology, methods, theoretical and philosophical frameworks that guided the design and development of this study.

CHAPTER 3

METHODOLOGY

"I hope it will become clear in due course that my concern is no mere semantic quibble and that (here), as in all of science, how one poses the question is crucial to the direction one takes in looking for the answers"- Aaron Antonovsky, 1979.

3.1 INTRODUCTION

This chapter presents an in-depth exploration of the methodology utilised within this study to address the application of the critical Appreciative Inquiry (AI) as a salutogenic framework for addressing health inequalities and promoting culturally sensitive mental health service delivery within Black African and African-Caribbean communities in Birmingham. A detailed discussion of the philosophical social constructionist paradigm applied within the appreciative inquiry framework explicates how this paradigm reinforces the utilisation of AI as a salutogenic approach. Drawing on connections between critical theory, critical race theory, relational constructionism and appreciative inquiry, this section provides further justification for the use of this participatory research approach to address the aim and objectives of this study. Further insight into how AI aligns with the principles of a community-based participatory research, yet differs in some respects, is also addressed. As stated in the previous chapter, a brief discussion of the pilot study, conducted as part of the larger study, is explored to address how this multi-phased study encompasses the adaptations made to fit the study context and population. Further details on the study population and sample, data collection and analysis methods, as well as ethical concerns are also addressed in this chapter. This chapter thus details the factors considered in the design and development of this critical appreciative inquiry study within the context of Birmingham, UK. Subsequent discussions centre on the multi-method qualitative approach utilised to effectively implement the 4D stages of appreciative inquiry in this study. This chapter provides a general overview of the different methods employed in the three phases of this study, emphasising the need for

utilising distinct qualitative approaches at each stage to effectively address the research objectives. However, to provide a more comprehensive outline of the how these qualitative methods have been applied and correspond to each phase of the study, the specific methods used in the Discovery, Dream, Design and Destiny phases are detailed in Chapters 4-6. These are accompanied by the results for each phase of data collection, to provide transparency and a deeper appreciation of the methodological rigour employed in this study. As stated in the literature review section, one area of concern was to identify key findings and methodological approaches from previous appreciative inquiry studies that were relevant or closely related to the coproduction process being undertaken.

3.2 THE RESEARCH DESIGN

Guided by the philosophical social constructionist underpinning of appreciative inquiry, as well as the aim and objectives of this study, a qualitative research design was selected as the most suitable approach for understanding the multiple realities surrounding the health and well-being of Black African and African Caribbeans, particularly in the current political and social climate. The implementation of an exploratory participatory research approach was, thus, developed to evaluate the factors identified by the Black African/African-Caribbean community and service providers as important in the design and development of culturally sensitive mental health services, using a salutogenic, critical appreciative inquiry process. With the goal of evaluating the aspects of culture and community that supported mental health within the target population, the chosen qualitative methods were relevant to gaining an understanding of the facilitators and barriers to the effective design and development of culturally sensitive mental health services. The research questions for this study were therefore: ***How can a critical appreciative inquiry approach facilitate the engagement of community members and service providers as equal collaborators in the co-design of culturally sensitive mental health services for Black African and African-Caribbean communities in the UK, towards addressing health inequities?***

In accordance with the 4D stages of Appreciative inquiry, the qualitative research design used in this study was carried out in three distinct phases that sought to address the following sub-questions:

Phase 1: What are the cultural values that indicate resilience, strength, and coping abilities that foster mental health and well-being among Black African and African-Caribbean communities in Birmingham?

Phase 2: How can community members be effectively engaged in the co-design of culturally sensitive mental health services that build upon the identified strengths and assets of Black African and African-Caribbean communities?

Phase 3: How can sustainable solutions be collaboratively designed and implemented with mental health service providers to promote equitable, culturally sensitive mental health service delivery for Black African and African-Caribbean communities in Birmingham?

To address the research questions outlined above, this research utilised appreciative inquiry as a community-based participatory action research methodology (Mertens et al., 2009). Each of these questions are addressed as objectives in subsequent chapters where the phases of this study are discussed in depth. Having been described as both a philosophy and a process (Watkins, Mohr and Kelly, 2001), Appreciative Inquiry lends itself as both a theory and methodology (Herington et al., 2013), suitable for application in a wide range of transformative contexts (Cooperrider and Srivastra, 1987; Elliott, 1999; Ludema et al., 2001; Robinson et al., 2013; Roddy et al,, 2019). Employing this methodology as a salutogenic approach for addressing health inequalities and promoting culturally sensitive service delivery, though novel, is a feasible approach to contributing to *"a cooperative co-evolutionary search for the best in people, their organisations, and the world around them"* (Cooperrider et al., 2008, p. 3).

Appreciative Inquiry adheres to many of the principles of the community-based participatory research (CBPR) approach (Israel et al., 2005) in that, it enables social change and improves personal and communal well-being by employing a positive representative approach to practical problem-solving. Green et al. (1995) defined community-based participatory research as that which offers the opportunity for collaboration with those most affected by the phenomena being investigated, to offer a systematic approach to effecting change and

taking action. The principles of social justice and equity, as well as communal willpower and determination are the philosophical starting points of any CBPR process (Cornwall & Jewkes, 1995; Minkler and Wallerstein, 2011). By encouraging partnership with the community or group being researched, CBPR eliminates some of the barriers of trust experienced in researching underserved communities by providing an environment for autonomy (Minkler, 2004).

Over the last three decades, CBPR has evolved to encompass various research orientations that have reversed the roles formerly popular in scientific research, including participatory action research (PAR), where the community members are now positioned as co-researchers, and the researcher, a co-learner (George, 1996; Wallerstein, 1999; Minkler, 2000). PAR, therefore, is research where the democratisation of the research process offers a transformative approach to addressing pertinent issues, where the community members are recognised as the experts, thereby promoting an empowering process (Vallianatos, Hadziabdic and Higginbottom, 2015). Wallerstein and Duran (2010; 2017) have pointed out the increase in the use of the CBPR approach when investigating health disparities in public health, nursing and allied health and social care fields. Other studies have provided further evidence regarding the use of this methodology for promoting greater external validity and potentially influencing practice and implementation processes aimed at alleviating health inequalities (Hernandez, Rosenstock and Gebbie, 2003; Julian et al., 2022).

Appreciative Inquiry and other PAR methods, though epistemologically distinguishable, share some similarities as asset-based approaches tailored towards providing a sense of empowerment and capacity-building support aimed at promoting sustainable change, especially among marginalised populations (Tolman and Brydon-Miller, 2003; Moody et al., 2019). For instance, in line with the key principles of participatory action research (Reason & Bradbury, 2006; Koster & Lemelin, 2009), appreciative inquiry also acknowledges the vital role of every participant as a co-researcher by emphasising mutual respect for the unique skills and strengths represented in a team, community or group. The particular emphasis that PAR places on the involvement of marginalised groups is well placed with appreciative inquiry's objective of facilitating the generation of practical results to social justice issues, in the case of this study, health inequalities in mental health service delivery (Schneider, 2012). Egan (2005) and Boyd and Bright (2007) pointed out a slight, yet significant difference between AI

and PAR stating that, whereas the latter methodology tends to focus on amending community concerns using a problem-solving approach, AI pays attention to a solution-focused and radical view of dealing with challenges. McIntrye (2008) was also of the view that, whereas PAR research focused on collaborative action, AI addressed collaborative and solution-focused analysis of issues before moving towards actionable plans and ideas. Whitney, Trosten-Bloom and Vianello (2019), also shed light on some differences between AI and PAR-oriented social change and community action interventions, by identifying appreciative inquiry as a more opportunity-centric and positive action research methodology. Nonetheless, as earlier stated, like the foundational principles of CBPR, the AI process concentrates on community relations and strengths in a manner that identifies these strengths as an extension of a community's capacity to effectively solve a long-standing issue and reshape community perspectives.

A range of research designs has been applied to studies that have utilised appreciative inquiry, including qualitative (Moyle, Clarke, Gracia et al., 2010; Clouder and King, 2015) and mixed methods designs (Thibodeau, 2011; Louw et al., 2018), aimed at addressing various topics within the fields of education, healthcare, and organisational development (Trajkovski, 2013). In several studies (Martyn et al., 2018; Glanz and Heimann, 2019; Venter and Moolman, 2022) AI was used in conjunction with other PAR methodologies, such as photovoice, which used creative techniques, such as photography as a tool for social change (Wang and Burris, 1997; D'Alonzo and Sharma, 2010; Keating, 2021). Nonetheless, in line with AI social constructionist underpinnings and to efficiently address the principles of AI, the importance of the story-telling process is crucial to the transformative process. The nature of inquiry required within this study, as justified above, necessitated the use of a multi-method qualitative mixed methods study (Morse, 2010; Mik-Meyer, 2022), that utilised a combination of two sampling and data collection techniques to address the research questions of this study. The multiple qualitative methods included focus group discussions and individual interviews to meet the objectives of exploring the cultural strengths, resilience narratives, and protective factors among the study population, as well as addressing concerns surrounding health inequalities and culturally sensitive mental health service delivery. In addition to enhancing the richness of data obtained, multiple or supplementary qualitative methods allowed the researcher to systematically engage participants during three distinct phases of data collection to gather

their perspectives on the topic of interest. Guided by the 4D stages of Appreciative Inquiry, this rigorous approach utilised in this multi-phased study helped to build up, as well as cross-validate the comprehensive insights generated within each stage.

To further justify the use of multiple qualitative methods to guide the knowledge derived and evidence presented in this study, the epistemological and ontological underpinnings of appreciative inquiry are discussed.

3.3 PHILOSOPHICAL APPROACH

To effectively evaluate the fundamental features of appreciative inquiry and its assumptions about reality and knowledge, it is important to assess its philosophical underpinnings. Having its roots in organisational development, Appreciative Inquiry has been referred to as, '*a philosophy of knowing, and a methodology for managing change'* (Cooperrider and Srivastra, 1987; Cooperrider and Whitney, 1999). Grounded in social constructionist theory, appreciative inquiry presents a generative view of how positive conversations can encourage the strengthening of the belief systems within an organisation or group.

Having its roots in social history, hermeneutics and existential, as well as social psychology, Berger and Luckmann (1966) and Gergen (1985) define social constructionism as a school of thought that emphasises the role social and interpersonal influences play in shaping a person's existence and outlook on life in general. The knowledge derived from an individual's interaction with their social, cultural, political, and historical context is constantly evolving, based on time and place, and has the potential to strategically reposition their cognitive and behavioural functioning within that context. However, outside of simply providing an analysis of a person's personality and attitude, social constructionism is interested in how change occurs within these social and political contexts, and how that translates to the construction of reality for the individual or the group of interest (Burr, 1995, p. 12). In this regard, according to Schutz (1967), the nature of the social context within which a person exists contributes

greatly to the meanings they attribute to information construction and processing, consequently leading to the generation of multiple realities.

McLeod (1997; 1999) identified five main features of social constructionism which critiqued the use of positivist paradigms, going on to propose what Gergen (1985) refers to as 'the need for postpositivist research'. The first two features proposed that social constructionists adopt a distinct style from the non-reflexive positivistic methodology, by applying a critical lens to life and perceptions of how a person's reality of the social world is formed, which hitherto, were taken for granted in more positivist paradigms. The third underlying feature of social constructionism assumed that basing our understanding of the world within the context of history and its interaction with various groups allowed us to effectively appreciate the different realities presented. The fourth feature is that this sense of appreciation of historical processes then opened the door for exploration of research from an acquiescent point of view, one that is not rigid and may not be considered universally applicable but re-affirms the experience of the one sharing their reality. The final feature proposed by McLeod (1997) was that social constructionists adopt a postmodern and redefined view of individualised psychological constructs of self, mind, and emotion, by acknowledging these constructs within the context of social discourse and relational frameworks. He proposed that this postpositivist approach is a means for interpreting the multiple realities constructed, to derive meaning from the experiences shared.

Social constructionism, therefore, acknowledges the role language plays in the creation of reality, based on the view that knowledge and an understanding of the value systems of a group of people within a particular context are generated through conversations and dialogues. In understanding that the use of words is not simply suited for the description of objects but demonstrates the reality of the person it is spoken by or to, we must identify the power of dialogue and incline ourselves to ask the right questions, within the right contexts. Appreciative inquiry lends to this narrative, in that it allows for a collaborative process of knowledge generation based on the recognition of skills and strengths that are available within the context of study (Roddy et al, 2019). A central element of the human experience and functioning rests on our ability to create dialogue and communication. The construction of social realities may occur in a relational context through social interactions, and according to Burr (2003), "*seeing knowledge simply not as something someone has, but something*

people do together", emphasises the continuity of generation of knowledge. If language plays such a significant role in the creation of social realities, the use of positive, generative, solution-oriented dialogues should be encouraged (Hosking and McNamee, 2007; Galbin, 2014). Cooperider and Whitney, (2000) and Mezirow et al. (2000) purported that the identification of the power of positive dialogue made way for the co-creation of resources that could potentially influence mindsets and support the transformation of perspectives aimed towards organisational and social change. Thus, the foundational social constructionists' notions have permitted the adaptation of other relational frameworks into this framework, such as relational constructionism, critical theory and critical race theory. This process of adaptation has given rise to a more comprehensive approach which some scholars have referred to as critical appreciative inquiry. Understanding how these relational frameworks enhance the generative process of AI is essential for encouraging a change-oriented narrative that acknowledges the influence of systemic and sociopolitical structures in addressing health inequalities among minority ethnic communities, such as the Black African and African Caribbean community.

3.3.1 Appreciative Inquiry and Relational Constructionism

As the AI process has gained recognition and has been applied to many fields of research outside of positive and social psychology as well as organisational development, there has been an evolution in the foundational social constructionists' ontology and epistemology initially proposed by Cooperider and Whitney (2000). Van de Haar and Hosking (2004), for instance, proposed a relational constructionist approach to applying the AI process. They posited that the ontological basis of constructionism that allowed for the appreciation of multiple realities was a suitable justification for why a positive-focused model like AI should also make room for the inclusion of negative experiences. In their view, AI's aim of gathering and understanding multiple realities from a strength-based perspective served as a basis for acknowledging the negative factors that existed within the positive context of the topic being evaluated and its further implications to the study. Strictly highlighting the positive narratives while disregarding the concerns and barriers within the research context only hindered the open and safe space for generative, life-giving dialogues, that AI purports to offer.

Consequently, by encouraging relational narratives, AI promotes the inclusion of a multiplicity of local ontologies, opening the possibility of generating strategies and interventions that are fostered within an environment of collaborative ownership and power balance (Bass and Hosking 1998). The reflective nature of the AI process is also an important element that further encourages the construction of relational realities, in that the inquiry encourages a power balance that shifts the locus of control from the inquirer to the community being researched (Alvesson and Skoldberg, 2000). Hosking (2011) was of the view that this shift in power relations in the AI process began the process of change, where the relational process became both the unit of analysis and the locus of stability in change, which is in line with the principle of simultaneity that states that inquiry is an intervention. The shift from purely positive constructionist narratives to a more relational perspective is, thus, easily achievable, given that the principles of AI highlight the value of flexibility and reflexivity towards fostering the process of change.

3.3.2 Appreciative Inquiry, Critical Theory and Critical Race Theory

Following on from the reflection on relational constructionism in appreciative inquiry, another dimension of social constructionists' theory that aligns with and can be incorporated into the appreciative inquiry framework is critical theory. Based on the shared epistemology that language is central to the construction of realities, both theories offer participants and researchers the chance to negotiate the meaning of language and transform the discourse around problem-solving in action research (Alvesson & Deetz, , p. 55). They further highlighted the reflective process, which is at the centre of both theories, which offered the opportunity to address the power dynamics between participants and researchers, which in their view, could often be determined from the use of specific language.

Grant and Humphries (2006), thus, maintained that, in the application of appreciative inquiry and the recognition of the role of language, applying critical theory was important for acknowledging the influence of the history, culture, socio-economic and political contexts in the shaping of an individual or a group's reality. Earlier work by Alvesson and Sköldberg (2000) offered a different opinion to the notion that critical theory is fundamentally negative and

only highlights the undesirable elements of society (Blake and Masschelein, 2003). They asserted that it rather offered a more analytical lens to influence the social context of the phenomenon being studied had on promoting an emancipatory cognitive interest. They, thus, proposed the use of a critical application of appreciative inquiry in a manner that is sensitive to the socio-economic and political contextualisation of the setting it was being applied in, while still maintaining a generative and solution-oriented focus. Instead of presenting appreciative inquiry in a manner that assumes systems within the context are already functional (the best of what is), Grant and Humphries (2006) also proposed a less intrusive line of questioning, where asking 'what is' and 'what might be' had the potential to generate a more accommodating response.

To support an inclusive and, in this case, culturally sensitive approach to the techniques employed in AI, Ridley-Duff, Rory and Graham (2015) recommended a more nuanced approach that acknowledged the existence and impact of the lack of control in specific aspects of social, economic, and political contexts participants found themselves in. In their view, acknowledging the cognitive dissonance that may exist, for instance, in finding out 'what works best' in a system where race and ethnicity are significant barriers to accessing mental health support, the researcher could appreciate the social realities surrounding an issue, while still maintaining an appreciative line of questioning. Cunliffe (2008) and Hosking (2011) pointed out that the process of AI requires navigating the complexities of multi-systemic contexts and decoding varying interpretations to maintain a relational, "other-oriented" approach to supporting and improving groups and organisations. AI offers a progressive prospect to traditional problem-solving practices, especially around healthcare, in that it does not ignore the presence of problems but adopts a creative and salutogenic attitude towards fostering action-oriented growth. Reason & Bradbury (2001), thus, highlighted the similarity of the AI process to critical theory, in that they both aim to contribute to the growth and development of systems and 'human flourishing'.

In this same vein, Bushe (2013) and Ridley-Duff, Rory, and Graham (2015) recommended the application of a critical theory lens in the implementation of the appreciative inquiry framework. They indicated that by offering participants the opportunity to share their lived experiences, albeit traumatic, their inquiry began the life-giving, generative process that brought value to the lived experiences of research participants. In their view, what they

referred to as critical appreciative processes or critical appreciative inquiry, respectively, brought an appreciative lens to the experiences of participants, sharing the value of what gives life to the community or group within the research context (Van der Haar and Hosking, 2004, p. 1019). By respecting the narratives of participants, whether positive or negative, there still existed an awareness and appreciation for the life-giving systems that remained at the core of the processes for positive change, which further justified the need for the critical appreciative inquiry process (Grant and Humphries, 2006). The term, 'critical appreciative inquiry', therefore, integrates the application of critical theory to AI, in a way that balances the acknowledgement of power influences and the social context with the positive, generative appreciative process.

Critical Race theory also plays a key role in facilitating the incorporation of more interpretive frameworks in the AI process. Taylor (1998) defined critical race theory as a theoretical framework the challenges racial narratives that posit the experiences of white populations as the standard for understanding and evaluating social reality, while grounded in acknowledging the unique perspectives and lived experiences of people of colour. Delgado and Stefancic (2001) maintain that the social construct of race has wide-reaching influence into every society's makeup, and thus, challenging racial hierarchies and systems that perpetuate historically oppressive power dynamics is crucial for promoting social justice and achieving equity. As an emerging transdisciplinary, race-equity methodology, critical race theory has been used in conjunction with other frameworks to address the issue of health inequalities and the impact of race in the delivery of healthcare (Simien, 2005). By actively engaging the narratives of racialised and minoritised populations, CRT's ontological and epistemological stance challenge existing power structures and advocate for the inclusion of voices from marginalised communities as a central component of the knowledge generation process that leads to sustainable change.

On face value, the positive ethos of AI and the purported pessimistic outlook of CRT (Posner, 1997; Subotnik, 1998) offer quite contradictory worldviews and theoretical lenses. However, in adopting a critical appreciative inquiry approach to addressing health inequalities and promoting the co-production of culturally sensitive mental health services, there is scope for encouraging a more nuanced perspective in exploring where these theories converge.

Even though CRT is not explicitly the foundational theory in this study on the need for utilising a salutogenic appreciative inquiry approach in addressing mental health inequities, it is worth noting that it could prove beneficial as a lens for centring the voices and experiences of marginalised Black African and African Caribbean communities, as they emerge in this study. CRT, therefore, sheds light on the need to evaluate the social construct of race in matters of healthcare delivery and significantly limit its impact on the health and wellbeing of individuals. When aligned with appreciative inquiry it encourages a shift in focus from deficit-based approaches to healthcare towards a more asset-based, collaborative model that values the knowledge, experiences, and resilience of minority communities (Ponder, 2017; Thompson, 2019; Gebhard, 2023).

One of the assumptions Hammond (1998) highlighted was the importance of carrying forward parts of the past, to have confidence to embrace the future, which Grant and Humphries (2006) agreed with, in that it facilitated the navigation of the emancipatory process of AI. However, the emphasis on carrying forward mainly the positive and best of the past is what has been disputed here. Duncan and Ridley-Duff (2013) drew attention to Arendt's (1994; 2013) argument on the need for a selective approach to acknowledging not only the positive parts of the past, but to acknowledge how this further explores the influence of power within the research context. They argued that redeeming the past, both the good and bad aspects of it, within a positive, change-oriented framework like AI, promoted the preservation of the values evidenced within these narratives, by treasuring and acknowledging the significance of these lived experiences. Furthermore, the reappropriation of the past in line with the present, and in view of the future was key to initiating the process of change that the AI framework encourages. In reference to the simultaneity principle of AI, the intervention and change we seek begin the moment we ask a question, therefore, validating the past is key to inspiring future change.

Reason & Bradbury (2001) and Grant and Humphries (2006) further proposed that, in addition to the emancipatory objectives of AI, appreciation of the narratives presented within the inquiry also signified being conscious of the context within which the inquiry took place, which is at the core of the critical theory. In their opinion, full recognition of and highlighting the importance of the power dynamics within the socio-political and historical context of the inquiry is pertinent. There is more scope to explore the hidden dynamics that help the

researcher gain an in-depth understanding of the phenomenon being studied, which in turn gives value to the narratives of the co-researchers.

A few scholars have proposed that, viewing the appreciative inquiry process as a mechanism for redefining problems is crucial to reshaping problem-solving approaches in the light of positive possibilities (Whitney et al., 2002; Adams, Schiller and Cooperrider, 2004; Bright and Boyd 2007). By taking this approach, the likelihood for change is not situated in the diagnosis of the problem, but rather in the collaborative discovery of answers to pertinent issues, from a solution-focused perspective. Applying a critical appreciative inquiry lens to this, while encouraging the discussion of what may be deemed negative conversations in AI, encourages the appraisal of problems in a manner that is reflective of the context within which they occur, thus, promoting the potential for higher engagement with research participants.

Galbin (2014) posited that the social constructionists' school of thought was essential for understanding the way people interacted with their environment in an ever-evolving world. In his opinion, this epistemological stance provided the opportunity for researchers to explore and engage with new methods and interventions that generated rich information using narrative approaches, which is a deviation from traditional positivist research. He added that the shift from research predominantly based on rational thinking and result-focused models to collaborative, participatory and action-oriented research also had potentially positive ethical implications.

There is, therefore, an evolution of epistemological and ontological stances as the influence and use of the AI framework spreads to other disciplines. The foundational principles of collaborative action-research which are maintained, therefore, set the tone for the research strategy employed in this study on resilience and cultural sensitivity within mental health service delivery in Black African and Caribbean communities in Birmingham, UK.

3.4 LESSONS FROM THE PILOT STUDY

To effectively implement a critical appreciative inquiry process, a pilot study was conducted to refine the research design and tailor the salutogenic framework to effectively address the aim and objectives of the study. Given that there is a lack of research evidence on the application of the AI framework as a critical, salutogenic tool, there was the need to test the feasibility of the model and evaluate the key parameters for ensuring its proper implementation within the chosen research context. The pilot study, thus, optimised the design of the larger study by helping to address logistical issues, such as question clarity, participant burden, as well as interview duration (Van Teijlingen and Hurdley, 2002). Conducted within the first few months of the COVID-19 pandemic and the ensuing lockdown measures (July 2020), this study engaged representatives of four (4) Black-led voluntary sector organisations, to identify the measures put in place to adapt their services to meet the health and well-being needs of various service users during the pandemic. Implementing the 4D process of appreciative inquiry, the pilot study fostered constructive discussions around leveraging the strengths and assets available within the various organisations towards a collaborative approach to service delivery during those uncertain times. Since these service deliverers actively supported the Black African and African Caribbean communities, their perspectives on the impact of health inequalities on mental health service delivery were particularly essential for gaining further insights into the strengths and assets, as well as barriers to service access.

Using the qualitative method of online focus groups, participants shared experiences on how they had quickly adapted their services using technology and the fostering of collaborative partnerships to help sustain their services during the pandemic. Engaging with the 4D process of AI, participants, during the Discovery phase, reflected on the significance of resilience, good leadership, and support systems, and how their identity as members of the communities they served helped foster a better understanding of the needs present at the time. During the Dream and Design phases, their visions of expanding access to digital technology within the community to widen access to services, particularly because of the digital poverty within these areas were enhanced. Participants further suggested that the AI tool could be used to promote capacity-building and empowerment initiatives within the community, placing particular emphasis on the need to pool together resources through inter-organisational collaborations. The results of this study, thus, demonstrated that AI could be implemented as

a participatory, collaborative approach for engaging service deliverers within the Black community on their views around service delivery and their roles in improving community stakeholder engagement. In addition, while the affirmative principles of AI encouraged discussions around the strengths and values shared, participants also voiced their frustrations around the barriers to service delivery, indicating that taking a critical approach enabled a balanced dialogue that constructively highlighted both facilitators and barriers.

The results of this pilot study provided much insight into the considerations that needed to be made to properly implement the AI process in the main study. The first observation made was that the 4D process could not be fully implemented in one session, due to the lengthy nature of the questions asked, particularly during the Discovery and Dream phases, which encourage participants to engage in a significant amount of reflection and introspection. Though this was important for producing rich responses from participants, it increased response time and, consequently, encroached on the time meant to effectively address questions in the Design and Destiny phases. For this reason, adjustments needed to be made to the qualitative methods utilised in the stages that require the deepest levels of introspection, storytelling, and reflection (Discovery and Dream).

Another consideration to be made was around the different groups of participants who would be involved in the study, given that the main study would involve both community members and service providers. Thorough planning was, therefore, needed to determine how both groups could be equitably involved in the AI process, in such a way that power dynamics could be addressed. Nevertheless, though the participants in the pilot were mainly service providers and the focus of the discussions revolved around COVID and service delivery rather than mental health, they represented the proposed study population for this project, as they identified as being of Black African and African-Caribbean origin.

Also, given that service providers were also a population of interest, this initial buy-in into the study facilitated the recruitment process, as these service providers provided signposting to gatekeepers and other potential participants. Engaging these service providers was a crucial first step to building research relationships and establishing networks within the community, which were beneficial for the larger study. Nevertheless, the most important lesson learned was that reflection is key for approaching the AI process with a pragmatic attitude that

allowed for fluidity in adjusting the process to the social context (Graham and Ridley-Duff, 2014).

Ultimately, even though major methodological changes needed to be considered for the main study, the pilot provided initial insights into the potential of the AI methodology to engage various stakeholders within the target population. It also demonstrated that the critical AI approach was flexible and adaptable for effectively addressing the aim and objectives of the main study.

3.5 METHODS

Based on the lessons gleaned from the pilot study, there was scope to refine the research design, as well as improve the quality and rigour of the data collection and analysis process implemented in this current study.

Prior to the pilot study, other CBPR research methods were considered for this research. To support the emancipatory ethos that underpinned this research on coproduction, other methods such as storytelling and narrative analysis (Adelson, 2005; Greenlagh, 2016) aimed at capturing and analysing personal narratives, anecdotes, and life stories shared by community members were deliberated. Other methods like Community Asset Mapping (Lightfoot et al, 2014; Turin et al, 2019) aimed at collaboratively identifying and mapping community resources, strengths, and assets relevant to the research topic or community needs also supports such participatory research approaches were also taken into account. After a thorough review of a few CBPR approaches, appreciative inquiry seemed to combine the various elements of storytelling and narrative processes along with the ability to support the acknowledgement of community assets and strengths which are at the heart of AI, which seeks to identify what works within a group, organisation, or community and how best to capitalise on these assets.

The sampling, data collection and analysis techniques applied in this study are, therefore, discussed below.

3.5.1 Sampling and Recruitment

The history of migration of Black African and Caribbean people began after the end of the Second World War when the need arose to fill the labour gap that had been left and to rebuild parts of England, which had been affected by the war (Myers and Grosvenor, 2011; Historic England, 2023). Given that many of these Caribbean islands, Asian and African countries were still colonies under British rule, the recruitment drive for skilled and unskilled labour took place within nations, such as Jamaica, India, Ghana, and Nigeria. However, the move into the UK from these regions was not as pleasant as sold, and many of these immigrants were forced to live in some of the poorest areas in Birmingham, London, Manchester, and other cities in England (Historic England, 2023). They also had to deal with overt and covert racism and were classified within a homogenous group and referred to as 'coloureds' (Corbally, 2015).

In Birmingham, some of the areas where Black African and Caribbean people settled are Holyhead, Handsworth, Handsworth Wood, Newtown, Lozells, Nechells, Perry Barr, Erdington, and Aston. Even though there has been intercity and inter-regional migration, many of these Black African and African-Caribbean communities still reside within these regions. There have also been recent migrations of other African and refugee settlements into these areas, such as the Ethiopian, Eritrean and Sudanese communities. The socio-economic conditions within these areas are, however, still in states of severe deprivation. The area of West Birmingham (Aston, Holyhead, Handsworth, Handsworth Wood, Newtown, Lozells, Nechells, Perry Barr) where recruitment for this study began, has a significant number of its population identifying as BAME, 22.4% of whom are Black African or African Caribbean (ONS, 2019 projections). Being among some of the most deprived wards in Birmingham, there is a mental illness prevalence of 1.3% as compared to the national average of England, which is 0.8% (Birmingham City Council, 2019). Birmingham holds 8% of the total population of Black Caribbeans in the UK (over 96,000), making it the largest settlement area for this demographic (UK Government, 2019; BLACHIR report, 2021). With a considerably young population as compared to other cities in the UK, 46% of people living in Birmingham are below the age of 30, with 22% of this figure, being 15 years and below, making it the youngest city in the UK. The Socio-economic deprivation and health inequalities within these communities underscore the suitability of this study aimed at addressing these inequalities and improving mental health and well-being through community-based collaborations within this area.

Given the scope of this study, and the participants of interest, sampling and recruitment were undertaken mainly within these regions.

Morse (2000) proposed that a few factors be considered in determining the number of participants needed to reach data saturation in qualitative research. He suggested that the nature of the topic of interest, the study design and method of data collection used, the amount of information generated from each participant, based on the number of interviews each one participated in, as well as the quality of information generated, were important. Malterud et al. (2016) further suggested that properly defining the scope and the aim of the research to participants was critical to producing results that justified the information power, even within a smaller sample. They went on to propose the model of information power as a framework for determining sample size outside of simply justifying saturation as the standard for concluding data collection. The model suggests making considerations for the theoretical background of the study and its alignment with the aim and objectives, as well as analysing the quality of the dialogues to increase the potential for greater information power. Another parameter for defining sample size in qualitative research is that N (which is the number of participants) should be large enough to encompass and effectively reflect the aims of the study (Kuzel, 1999; Marshall, 1996; Patton, 2015). Using the factors proposed by Morse (2000) and Malterud et al. (2016), the sample size was determined to comprise 24-30 participants of Black African and African Caribbean backgrounds, to first ensure diversity as well as accommodate the recruitment and ideal number sufficient to achieve data saturation (Clarke & Braun, 2013). Taking all these factors into consideration, the non-probability sampling methods of Purposive and Snowball sampling were found to be the most suitable.

Non-probability sampling methods have been used extensively in qualitative research, as the process is less resource intensive and has been known to be successful for enlisting a wide range of participants within a specific research context (Valerio et al., 2016). Purposive sampling, also referred to as judgemental sampling, is targeted at recruiting participants who possess specific characteristics that are relevant to meeting a specific research goal. In this case, the characteristics were specific to ethnic descent (Black African and African Caribbean) and geographical location within Birmingham. The other type of sampling utilised in this study was Snowballing, also referred to as chain referral sampling, which has been described as a method applied when recruiting among hardly reached communities, where conventional

purposive sampling may not yield as many respondents (Johnston and Keith, 2010; Heckathorn, 2015). One kind of snowball sampling is linear snowballing, where a chain of recruitment is set up when one potential respondent invites other interested individuals, who meet the inclusion criteria to take part in the research, until the intended number of participants is reached. It has been described as less rigorous and, consequently, less expensive, and time-consuming (Valerio et al., 2016; Bhardwaj, 2019). Here, the researcher makes use of already established relationships within a specific research context to access hidden populations who could provide relevant information to the topic of interest (Neille and Penn, 2015). One disadvantage, however, is the high probability of generating a homogenous sample, with the risk of leaving out others, in which case, this lack of heterogeneity could further lead to limitations in generalisability of research results to the larger population (Valeria et al., 2016). The combination of both purposive and snowballing sampling methods, was therefore, essential for addressing this limitation by helping to increase the heterogeneity of the sample in order to improve the generalisability of the research results to the larger population.

The population of interest as earlier stated, were community members and service providers living and serving within the West Birmingham area. The inclusion criteria for the various phases of this study are listed below:

- **PHASE 1 (DISCOVERY)**: 20-24 community members of Black African, African Caribbean and Mixed heritage background ages of 18-65 and over, living within and around West Birmingham (Aston, Holyhead, Handsworth, Handsworth Wood, Newtown, Lozells, Nechells, Perry Barr).
- **PHASE 2 (DREAM)**: 10-15 consenting participants from Phase 1 (Invitations were sent to all previous participants).
- **PHASE 3 (DESIGN AND DESTINY)**: 6-10 representatives of statutory and voluntary sector services who provided mental health and well-being support to Black African and African-Caribbean communities, as well as the wider population in Birmingham.
- Members of the community who were non-English speaking were excluded because of lack of resources to engage translation services. Participation in this study was entirely voluntary. Refusal to participate did not affect any individuals or organisations within these circles in any way. Participants were informed of the purpose of this study

when invitations were sent out in the participant information sheet via the stated networks.

- £10 Amazon vouchers were presented to participants in Phase 1 and 2 as a token of appreciation for sharing their time, knowledge, and expertise.
- Ethical approval for the commencement of this study was granted on the 17th of February 2021 (Appendix 3; Pg. 376).

In total, **23** participants were recruited and took part in Phase 1 of the study (Discovery, comprised of individual interviews). A total of **12** of these participants from Phase 1 later consented to take part in focus groups conducted in Phase 2 (Dream), even though invitations were extended to all 22 participants. A total of **11** mental health and well-being service providers were involved in Phase 3 (Design and Destiny), representing both statutory **(2)** and voluntary services **(6).** This brought the total number of participants to **34**. The information generated from this study fostered an in-depth examination of key concepts that are crucial to the current conversations around health inequalities and mental health service delivery. Many meaningful themes and generative dialogues were derived from this study, and methodological transparency and rigour were observed (Marshall et al., 2013; Ploutz-Snyder et al., 2014). Additional information on the demographic details of participants as well as sampling and data collection methods as applied at each phase of the study are discussed in subsequent chapters (Chapters 4-6). Below is a summary of the data collection timeline:

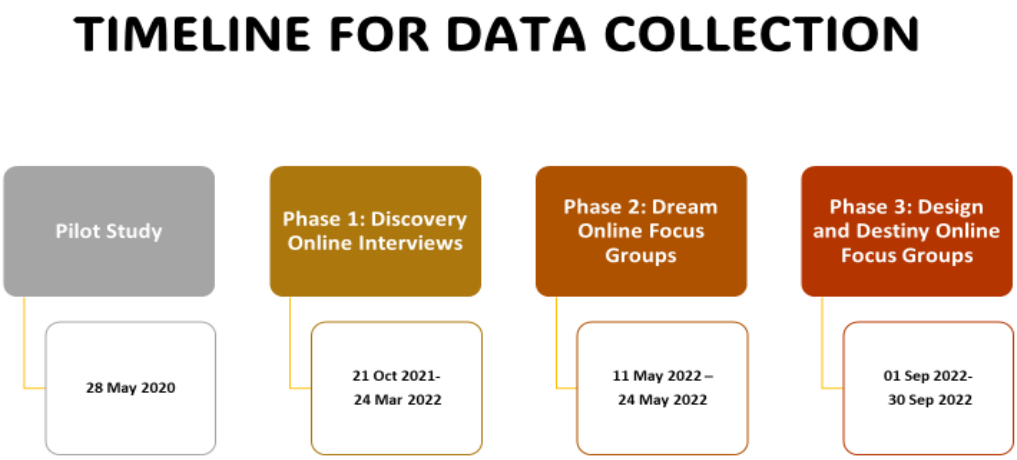

Figure 5: Timeline of Data collection

3.5.2 The Role of Gatekeepers

Engagement with gatekeepers is a crucial element of PAR research, and within this critical appreciative inquiry study, the role of gatekeepers cannot be downplayed. Especially in studies conducted within racialised and hardly reached groups, some scholars have shed light on the role of gatekeepers as cultural brokers, whose role in shaping research engagement and overseeing community priorities is crucial to research progress (Becker et al., 2005; Eide & Allen, 2005; Payne, 2015). Emmel et al. (2007) drew attention to the power gatekeepers had in controlling access to research populations, stating that the inclusion or exclusion of gatekeepers could either facilitate or impede research progress, respectively. They supported this claim by proposing a classification of the various roles of gatekeepers ranging from institutional/formal gatekeepers (e.g., Police officers and school administration), comprehensive gatekeepers (charities and voluntary sector organisations) to informal gatekeepers (respected members of the community). In their opinion, knowledge of this classification helped narrow down the right gatekeepers to engage, particularly in line with the aims and objectives of the study. Wilson (2020), in their study on reaching 'hardly researched' families within a school setting, found that gatekeepers played an essential role in bridging the gap between the community organisations they served within and the community they served. Their well-established connections within these communities over the years proved valuable in the recruitment and consultation process undertaken in this research (Putnam, 2000). Their role was also crucial for dispelling scepticism and establishing trust, especially given the general concerns met when researching underserved and hardly reached communities. Ruhland et al. (2023), in addressing the subject of positionality, intersectionality and power dynamics in CBPR studies in Black communities were also of the view that understanding the role of gatekeepers was crucial to establishing trust among researchers and community members. For this reason, this study took particular care to involve the formal, comprehensive, and informal gatekeepers within these communities during the recruitment and data collection process.

Engagement with various gatekeepers was made possible through my role with the Birmingham City Council, which significantly facilitated the recruitment process through collaborations with the Birmingham City Council via affiliated networks, such as the United Community Activity Network (UCAN) (https://ucanbirmingham.org/), with which I worked extensively during my Ph.D. studies. The Birmingham City Council played a significant role in the development of my PhD research project and studentship, which led to my collaboration with their Neighbourhood Development & Support Unit and the Perry Barr Constituency Neighbourhood Network Scheme, as well as my role with UCAN on the 'This is my City Project'. Being in partnership with organisations like the Birmingham Commonwealth Association, UCAN has a wide reach in the African and Caribbean communities through its engagement with various sports and well-being organisations within Birmingham. UCAN also conducted many health and well-being-related activities within the West Birmingham area, through its flagship, 'This Is My City Project', which aimed to celebrate commonwealth migration through food, music, arts, and sports. Access to the networks within these communities was very useful for sharing information regarding this research and facilitated participant recruitment. Given that the geographical location for this research was narrowed down to the West Birmingham area, a research notice was circulated within the circles of UCAN, seeking the participation of members within the Black African and African Caribbean community. Without the support of these institutions, recruitment, which was already significantly hampered because of the pandemic restrictions, would not have been possible and their influence in spreading information regarding the research was greatly beneficial.

3.6 DATA COLLECTION METHODS

Following the consideration of a range of data collection methods, the evidence evaluated on the connections between CBPR/PAR and Appreciative inquiry as well as the epistemological and ontological standpoint of AI validated the use of a multi-method qualitative study. The pilot study also provided many valuable insights for restructuring the data collection process for the various phases of this study, and the need to adapt a more detailed approach to data collection was considered. Thus, semi-structured interviews and focus groups were the chosen qualitative methods applied in this study. The diagram below offers a visual summary

of the different phases of data collection in sequential order. A brief description of the various methods as applied within the distinct phases of this study are also discussed. Chapters (4-6) present further details into how the various data collection methods were designed, implemented, and data analysed at each respective phase to comprehensively address the objectives of this study, which aligned with the stages of AI.

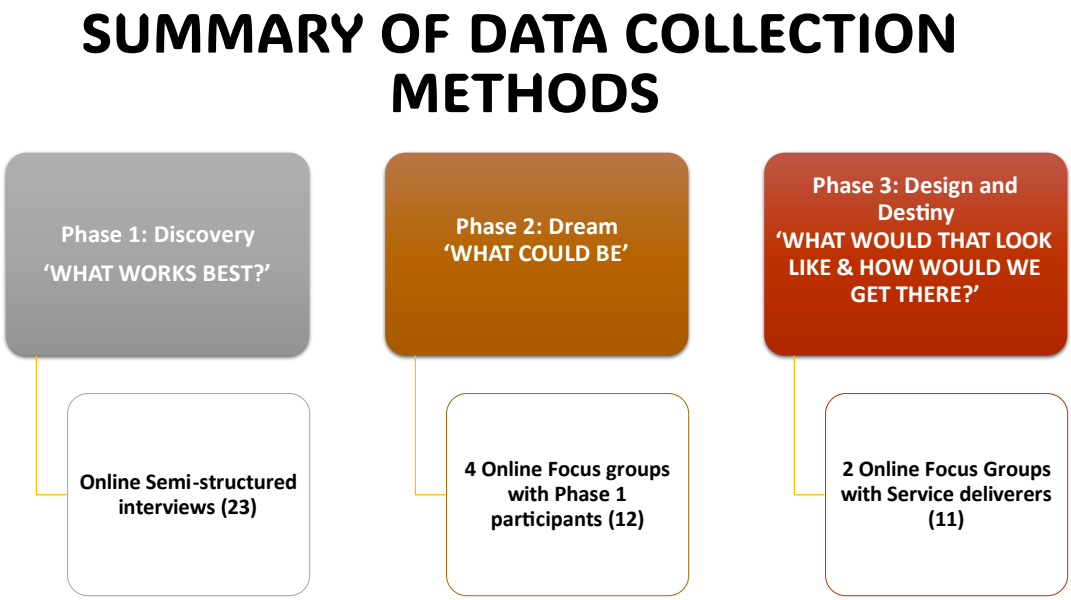

Figure 6: Summary of Data Collection Methods

3.6.1 Phase 1 (Discovery): Semi-Structured Online Interviews

Many qualitative researchers make use of interviews as a data collection method, with semi-structured interviews being the most preferred format, especially in healthcare-related research (Crabtree and DiCicco-Bloom, 2006; Gill et al., 2008). According to McIntosh & Morse (2015), semi-structured interviews are frequently use a predetermined thematic framework is utilised to guide discussions during the study. Kallio et al. (2016) expound on how the use of semi-structured interviews offers the researcher an opportunity to gather in-depth opinions and the experiences of research participants, especially on topics that may be considered sensitive, such as conversations around mental health, bereavement, terminal illnesses, among others. Also, in cases where research participants have limited understanding of or familiarity with the subject of interest, semi-structured interviews are

useful for eliciting their views on their values and ideals, in a manner that positions them as experts within the research context. According to Kallio et al. (2016), the experiences shared by each participant act as building blocks, as a culmination of the data gathered over time reflects a reconstruction of the lived experience of participants within the research context and the meanings attached to these experiences. McIntosh and Morse (2015) further state that semi-structured interviews offer validation and confirmation of existing knowledge, which, eventually, leads to the gathering of newer and richer information. This unique characteristic of semi-structured interviews allows reflexivity in the research process, where the pre-existing knowledge of the research topic is enhanced by the responses of participants (Bartholomew, Henderson & Marcia, 2000). A number of studies have proposed that the duration of online and face-to-face interviews last between thirty minutes to an hour (30-60 minutes), depending on the nature of the interview schedule and participant's familiarity with the topic of interest (Crabtree and DiCiccio, 2006; Krouwel et al, 2019).

In this critical appreciative inquiry, semi-structured interviews aligned well with the Discovery phase as it was well suited for allowing participants to share experiences and perspectives on mental health, resilience, values, and strengths, as well as address other issues around stigma and service provision. Considering the sensitive nature of the topic, these online interviews were essential for establishing rapport with the participants and offering a flexible conversational approach, which mirrors AI's emphasis on human connections and fostering mutual respect.

3.6.2 Phases 2&3 (Dream/Design and Destiny): Online Focus Group Interviews

The qualitative method of focus groups, as utilised in this study, can be described as a method of obtaining information using well-structured group interviews/discussions to understand the perceptions and opinions of participants on an issue of interest in a non-judgmental environment (Krueger, 1994, pp. 6; Robinson, 2020). The use of this method also enables the researcher to observe non-verbal reactions, group dynamics and interactions which are brought to light because of the conversational and socially interactive environment which focus groups foster (Krueger, 1994).

Focus group discussions may comprise of 4-12 research participants, usually of similar backgrounds and interests who also have similar experiences of the topic being studied. Research participants are invited to discuss a topic of interest and are encouraged to share their opinions and ideas on the research issue, without the expectation of reaching a consensus (Hennink 2007: 6). Even though a moderator is present, the dynamic nature of focus groups allows the participants to drive the conversation, giving them autonomy to interact with each other as they share opinions and viewpoints, with the moderator only coming in occasionally to offer guidance, where necessary. Liamputtong (2015) states that this method of data collection gives participants a voice and allows them to share their experiences within a dynamic space of like-minded individuals. The researcher also is allowed to observe how individuals with different viewpoints interact and how the social context of a focus group influences how different opinions are shared, critiqued, and managed, especially through the lens of social and group norms (Kitzinger 2005: 58). Hollander (2004) and Hopkins (2007) voiced their concerns regarding social conformity and desirability which may occur within focus groups, particularly in the case where a dominant personality could potentially influence the outcomes of discussions. The role of the researcher is crucial in such cases, to navigate the research space in a manner that ensures that every voice is heard. Ritchie et al., (2013) proposed that typically, face-to-face focus groups could last between an hour and a half to two hours to accommodate various considerations for participant comfort, proper topic exploration and facilitate group rapport and dynamics. In online focus groups however, a few studies suggest shortening the time to sixty to ninety (60-90) minutes to lessen digital fatigue, which may be caused by extended exposure to screens and online platforms (Daniels et al, 2019; Willemsen et al, 2022).

Focus group discussions have been found to be useful for the collection of data in studies aimed at promoting cultural sensitivity, for instance, in multicultural settings, particularly when conducting research among minority ethnic groups. According to Madriz (2003) and Liamputtong (2015), this enables the researcher to glean information on cultural norms, values, and forms of communication within the research context, as participants engage with each other within the focus group setting. Language plays a significant role in focus group research, and the interpretation of data is centred solely around the quality of information gathered during this phase. The interaction between both spoken and non-verbal language,

the silences, the gestures are all important features of the interactions that occur during focus group discussions and are all to be considered in interpreting the socio-cultural norms and values shared during this data collection process (Hennink 2007; Liamputtong, 2010a). The principles of AI, which emphasise relational and dialogic knowledge generation, favoured this qualitative method, particularly in the Dream and Design/Destiny phases (Phase 2 and 3 respectively), where the gathering of multiple perspectives was essential for facilitating the co-construction of new ideas and visions around cultural sensitivity in service delivery.

As a result of the COVID-19 lockdown and social distancing measures which restricted in-person meetings, online interviews and focus groups were the most feasible alternative for gathering the data relevant to this study. The BCU-approved Microsoft Teams online meeting software was, therefore, used to facilitate the data collection process, and this adjustment came with its advantages and disadvantages. For instance, there is a substantial cutback in the time, energy and costs required in online research as compared to operating face-to-face focus group discussions; this method of qualitative data collection also bridges the barrier of geographical disparity (Cater and Low, 2012; Fielding et al., 2016). Krueger and Cassey (2009) state that between 4-12 participants should be recruited for a face-to-face focus group discussion to encourage interactive engagement. Lobe (2020), however, states that, for online focus group discussion, the ideal number to maintain engagement of participants, allow in-depth discussions and reduce strain on the moderator, is six (6) participants. This study, therefore, aimed to engage 4-6 participants within each of the focus groups held and further details of this breakdown are discussed in subsequent Chapters 4-6. A semi-structured interview guide facilitated discussions following the format of the 4D (Discovery, Dream, Design & Destiny) stages of appreciative inquiry (Refer to Appendices 4-6; Pg. 346-359).

Within this multi-phased critical AI study, it was essential to utilise a systematic and comprehensive approach to build on data gathered from one phase to another, particularly in the design and development of the interview protocol for the various phases. A common criticism of the systematic approach AI adopts is that it lacks the practicality of supporting continuity in the stages of inquiry and may involve diverse groups along the way, depending on the sample. According to Bellinger and Elliot (2011), there is a potential for 'voices to get lost' along the way, which according to Reed et al. (2002), breaks the consistency of the AI process. However, there is a need to view AI as a continuous fluid process rather than a final

product or a means to an end. Thus, to facilitate this fluidity and enhance the depth and comprehensiveness of the inquiry, careful consideration was made during data collection and analysis to engage participants in feedback and feedforward processes, which helped to cross-validate findings and enhance data continuity. The process of iterative data and methodological triangulation was also incorporated into this study design to facilitate the continuous process required to attain a desirable study outcome (Carter et al., 2020).

3.7 ETHICAL CONSIDERATIONS

Adherence to ethical principles and practices is vital in any research for ensuring that the rights and dignity of participants are respected and protected (Khodyakov, Mikesell and Bromley, 2017). Particularly in community-engaged studies within racialised communities, there is a greater need to finetune and tailor the ethical standards to maximise benefits, promote fairness and minimise harm to research participants (Gilbert, 2006). There is extensive evidence of the low representation of minority ethnic groups in clinical trials and health intervention studies, due to suspicion and lack of trust, owing to a history of ethical misconduct against these communities, such as the Tuskegee studies population (Powell, et al., 2008; Bastida et al., 2010). Fouad et al. (2001) and Robinson & Trochim (2007) posit that this mistrust has been further fuelled by experiences with 'parachute' researchers who only required the participation of community members for the benefit of their career advancement, rather than the well-being of the community's being researched. Though CBPR and PAR research, like appreciative inquiry, is positioned to include community members as co-researchers, comprehensive knowledge of the historical context of the community and its influence on their acceptance and engagement with outside researchers is important. Especially in over-researched communities like Black African and African Caribbean communities, being cognisant of and sensitive to the research context is all-encompassed in making ethical decisions that serve their best interest (Bastida et al., 2010).

Particularly with the use of appreciative inquiry, which Carter (2006), points out, could be conceived as quite 'Pollyannaish', it is crucial to approach sensitive topics, such as mental

health and health inequalities, in a manner that is considerate and seeks to promote equitable partnerships which foster mutual respect within the research context (Robinson et al., 2013). Bhutta (2004) clearly outlined a few steps to be considered when inviting community members to take part in research, in an ethically sound manner.

- First off, the most important step is to ensure that any information provided is offered with simplicity and transparency, seeing to it that any details on the nature of the research, as well as the benefits and risks involved in taking part (if any) are clearly outlined before any data collection begins.
- Potential participants are also to be given the freedom to address any confusion before, during and, sometimes, even after the data collection, to ensure that they fully understand the full scope of the research before offering consent.
- Being respectful of the state of mind of potential participants when informed consent is given is also crucial in respecting ethical boundaries. If the aims of the research address a vulnerable population, extra care needs to be taken to ensure that the information is delivered with the duty of care in mind.
- Also, it is important to acknowledge the educational and literacy levels of the members of the community who will be involved in the research, in order not to unintentionally exclude potential participants who may offer a whole array of information, simply based on illiteracy.
- The time spent allowing participants to interact with the research team is essential to building relationships that facilitate the research process, especially in community-based participatory research.

To efficiently observe these considerations, online Consent and Participant Information forms were distributed to participants when invitations were sent out (Appendix 1-2; 368-374). Participants were also permitted to give verbal consent at the beginning of the recording of the session which was then separated from the complete recording of the online discussion and safely stored (Lobe, 2020). The potential risks anticipated in this study did not go beyond those faced in daily activities. Given that all physical contact and personal meeting restrictions were observed in line with COVID protocol, any other risks that could have arisen during this research were brought to the immediate notice of the supervisory team and other parties involved in this research. The principles of justice, respect and beneficence recommended in

research recruitment etiquette (Gyure et al., 2014) were observed to ensure that recruitment was fair and unbiased, as well as considerate and respectful of the choices of participants, regarding participation and confidentiality. All these measures were, thus, put in place to ensure that the benefits of this study far outweighed the risks.

To protect participants' identity when presenting the data participants information forms outlined that all contributions made towards this research study would be anonymous and confidentiality maintained. No names were therefore, used and any personally identifiable information was anonymized to ensure that data in any publications is not traceable to any specific person or organisation. Numbers were given for identification during transcription and analysis of the result of the discussions held in the various phases, both during personal interviews and focus group, and participants were referred to by these numbers all throughout all written elements of the study. Video settings were also officially disabled for each participant on entry into the meeting to facilitate privacy and confidentiality. Participants were given the choice to enable this setting if they preferred but were advised to utilise the background blur function to ensure that no personally identifiable objects in the background were seen by other participants. Other measures taken to ensure anonymity and participants' safety are outlined in the participant information form (Appendix 1: Pg. 368-373).

3.8 POSITIONALITY AND CRITICAL REFLECTION

Reflexivity and critical reflection on researcher positionality are fundamental for any research that seeks to ensure integrity and promote transparency. Chenail (2011) pointed out the need to be aware of the influence of researcher bias on the design and implementation of qualitative research protocols, particularly in studies where the researcher identifies with or has similar characteristics to the study population. Being of Black African background and having experienced life as a minority ethnic individual in the UK, the impact of my worldview, my lived experiences as a Black African woman, as well as my background as a mental health professional on the research process needed to be acknowledged. Having lived in Ghana (West Africa) most of my life, I was conscious of the differences in cultural values and lived

experiences between myself and Black British African and African Caribbeans. Recognising the differences and similarities between both cultures through my work within these communities, I constantly reflected on the process of learning and unlearning I underwent to dispel any preconceived notions and approach this research in the most objective manner possible. Being offered the privilege of collaborating with many individuals who were passionate about community development also helped me to gain insights into the unique perspectives and experiences of the different groups I encountered. Navigating the complexities of my insider/outsider research process required a continuous reflexive outlook, which helped me to manage expectations, and understand my identity and role as a researcher (Rhuland et al., 2023). Discussions with my supervisors, as well as other colleagues, helped me evaluate how best I could integrate these experiences to ensure the study was conducted in a culturally appropriate manner. For instance, learning from one of the gatekeepers that the right term was 'African Caribbean' and not 'Afro-Caribbean' increased my awareness of the importance of using appropriate terminology, which was important for ensuring cultural sensitivity.

My background and training as a clinical psychologist also played a key role in the way I engaged with the various stages of this study. As a clinical psychologist committed to promoting mental health and wellbeing within diverse communities, my professional positionality was bound to influence my approach to this research. While I did not share all the lived experiences and cultural backgrounds of the Black African and African-Caribbean communities at the heart of this study, my clinical training helped me to cultivate empathy and understanding without compromising objectivity. As a clinician, my eclectic approach to therapy and treatment has helped me to develop a deep appreciation for and a pragmatic approach to engaging individuals from different walks of life. In applying this skill within this study, I recognised that exploring different situations often requires employing diverse routes of inquiry by drawing upon multiple theories to develop methods that yield positive impact and align with the specific questions being asked. This flexibility and openness to diverse approaches was invaluable in helping me navigate the complexities of this research.

While my clinical background equipped me with the skills to engage empathetically with participants, I was conscious of the importance of maintaining objectivity and research integrity. I conducted this study with humility and a genuine desire to co-produce solutions

that promote culturally sensitive and equitable mental health services, led by and grounded in the knowledge and experiences held within these communities. My unique positionality as a clinical psychologist and researcher allowed me to strike a delicate balance between detachment and deep understanding, fostering collaborative relationships with my research participants, built on mutual respect and a shared vision for change.

This insider/outsider research approach demonstrates how I navigated the complexities of my dual roles within this research setting. The Birmingham City Council played a significant role in the development of my PhD research project and studentship, which led to my collaboration with their Neighbourhood Development & Support Unit and the Perry Barr Constituency Neighbourhood Network Scheme. As a result of their involvement in shaping the research focus, I supported various projects that initially included a research placement within these units, specifically exploring the cultural sensitivity of mobile health resources in relation to the "This is My City" project. The Council's engagement in the project's conceptualisation and their provision of access to relevant resources and initiatives greatly benefited the successful execution of this aspect of my research. Through my work with Birmingham City Council, I also gained practical knowledge of the various initiatives and dynamics within the communities where I conducted my research. This experience did not only offer invaluable insights but also helped me build trust and credibility as an ally for positive change within the various communities where I served as a community development worker. My involvement in the "THIS IS MY CITY" project, which celebrated the rich cultural diversity in Birmingham because of Commonwealth migration, reinforced my commitment to supporting transformative research and community initiatives that also helped amplify marginalised voices. A podcast I supported on for instance, called ‘This is My Lockdown’, engaged the voices of many prominent people within the community who came together to address mental health, loneliness, faith, physical health, and wellbeing among other key topics that were of particularly interest during the COVID 19 pandemic.

Reflecting on my transition from outside to insider researcher, it was important to acknowledge and address how the nuances of my positionality impacted the research. Merton (1972) highlighted the differences between an outsider and insider researcher, stating the former had little in common with the research population they intended to study, and only gathered relevant knowledge of the group when they gained access and began work.

The insider, on the other hand, may have had prior intimate knowledge of the community they sought to study, because of either being a member of this group or having had extensive interaction with them, to be recognised as 'one of them'. Breen (2007) made an argument for being the researcher in the middle, pointing out how Pitman (2002), Hewitt-Taylor (2002) and Van de Meulen (2011) discussed the advantages and disadvantages of being on both sides of this dichotomy. Pitman (2002), for instance, argued on the disadvantage of the 'illusion of sameness' that may be derived from a sense of familiarity that the researcher has with the research community, which Gerrish (2003) states may lead to a loss of objectivity. On the other hand, Israel et al. (1998) and Farias et al. (2017), agreed that even though accomplishing a balance between objectivity and subjectivity in qualitative research is a daunting task for any researcher, building relationships within the research context was still crucial to the veracity of the study. Fields and Kafai (2009) also highlighted the imperativeness of data that is representative of the experiences of the study population, especially in PAR research. Draper and Swift (2011) also added that a researcher's understanding of their role in the data collection process was central to the way the entire study would unfold. Kerstetter (2012) further proposed that CBP researchers approach the research community as outsiders, to break the traditional barriers between themselves and the study participants by establishing trust and developing a collaborative process between participants and researchers. Stringer (2007) referred to this process as democratising research, where the boundaries between researcher and participants are slowly dissolved, making this a vital stage for sustaining trust and advancing the research relationship. Merton (1972) and Mercer (2007), therefore, intimated that the researcher must critically reflect on how their identities affect the partnerships which will be developed over the entire research process and how this translates to the success of the research. For the critical AI process to be effective, all these factors were considered to ensure objectivity and transparency within this research.

Beyond the scope of insider/outsider researcher, there has been a consensus among social scientists to adopt what Dwyer and Buckle (2009; 2018), refer to as 'the space in-between' outlook, when it comes to dichotomising insider or outsider research (Serrant-Green 2002; Dwyer and Buckle,2009; Probst, 2016). They assert that as research evolves, a researcher may move along the insider/outsider researcher continuum, depending on the scope of the research and how their influence affects the research context. Kerstetter (2012) indicated

that this ‘space in-between’ could be influenced by multiple factors, such as the researcher’s cultural, social, political, and racial background and how this translates to their relationship with the research community and the study context. Breen (2007) also stated that the pros and cons of insider-outsider research should be viewed from the relevance of each side to the epistemology and ontology of the research study. Dwyer and Buckle (2009) concluded that, even though dualism in the insider/outsider debate cannot be fully achieved, once the value of the ‘space in-between’ is truly appreciated, researchers would have more liberty to move beyond the opposing sides' argument, with matters involving positionality.

Therefore, in utilising a collaborative method like AI, my identity as a collaborator rather than as a facilitator, was crucial to the entire research process. Cooperider and Bushe (2013) argued that as an action research model, an inside researcher’s biases played a potentially positive role in advancing the implementation of appreciative inquiry. Duncan and Ridley-Duff (2013) also proposed that a level of insider knowledge was required to place the researcher in a trustworthy position with the research participants, enabling them to effectively translate the lived experience of the research subjects. Taking this stance, the researcher is allowed to explore their role in the study, in relation to how their identity and relations with the participants affect the study. In this vein, the identification of and reflection on my level of cultural competency validated the need for a basic understanding of the psychosocial context of the study population. As I reflected on my identity at each stage of this study, I was cognisant of the fluidity of my movement from being an outsider to being a member of the community, while still striving to maintain objectivity and reflexivity.

3.9 DATA ANALYSIS: THEMATIC ANALYSIS

There is no simplified or right way to conduct a qualitative analysis, given its complex nature. Analysis differs based on the mode of data collection, the philosophical underpinnings of the research topic, the researcher’s positionality, among other factors (de Casterle et al., 2012). For this reason, qualitative data analysis has been described as a process ‘best learnt by doing’ (Froggart, 2001). According to Hunter et al. (2002) and Jennings (2007), even though

qualitative analysis allows the researcher to explore multiple techniques of creativity during this intellectual process, it is imperative that the researcher prepares extensively beforehand to align analysis with theoretical underpinnings of the research.

Even so, there are basic, foundational rules which offer guidance to the qualitative researcher on how to go about the deciphering, coding, and sense-making process of data analysis, determined by the methodology applied. Braun and Clarke (2013), for instance, offer practical steps to conducting one kind of analysis, thematic analysis, which are widely used to offer guidance on how to go about the process of analysing qualitative data. Unlike other methods of analysis, thematic analysis has no epistemological or philosophical underpinnings, and, therefore, allows flexibility in the exploration of patterns and connections that may be obtained from raw data in qualitative research (Maguire and Delahunt, 2017). Braun & Clarke (2006) and Nowell et al. (2017) stated that, in qualitative research where the experiences and beliefs of participants are explored, thematic analysis aids in highlighting different perspectives and unearthing unexpected findings that may be missed in quantitative research. The identification and categorisation of themes generated in thematic analysis, thus, present the data collected as patterns that make connections and provide interpretations of the opinions and ideas shared (Boyatzis, 1998; DeSantis & Noel Ugarriza, 2000).

Several methods and processes for conducting rigorous thematic analysis have been investigated (Braun and Clarke, 2006; Alhojailan, 2012; Vaismoradi et al., 2016), outlining the various steps thematic analysis should engage to ensure the reliability and trustworthiness of interpreted data. Braun and Clark (2006) summarise some key steps relevant to conducting a thorough thematic analysis. First, familiarity with the data is essential to getting an overview of the general threads and patterns after data has been collected. When the researcher transcribes the data, reads over transcripts, and highlights the noticeable ideas, they have an initial idea of the scope of the data. This allows the researcher to make connections in line with notes made during the interview, which then facilitates the second factor, which is deciphering initial patterns and codes, which are, subsequently, classified into potential themes. The third key step of thematic analysis requires reviewing potential themes to identify and classify relationships by mapping out the connections between the various narratives, demonstrating the common ideas and opinions shared, in relation to the research

questions. The final step requires translating these themes in a way that effectively represents the collective ideas presented through the research, giving meaning to the diverse interpretations acquired during data collection. According to Namey et al. (2008), the process of thematic analysis, therefore, transcends counting the frequency of words and phrases, but rather focusses on the reflexive process engaged in identifying and interpreting explicit and implicit information presented through raw, conversational data.

The qualitative data analysis method of thematic analysis was, therefore, used in all three phases to examine the data, employing approaches that delved into the different perspectives and experiences of study participants by generating common themes and insights from the narratives produced (Braun and Clarke, 2006), using the NVivo qualitative analysis software. The common themes that a thematic analysis generates are derived from the conversational and group dynamics that interviews and focus group discussions tend to produce (Kamberelis & Dimitriadis, 2008). The disclosure of opinions, beliefs and ideas brings to light a wealth of information relevant to the research topic, and the patterns observed from the data are classified after a rigorous process of evaluation and interpretation (Rice & Ezzy, 1999, p. 258). In thematic analysis, the rigour of data interpretation and the resultant quality of the information generated relies on the researcher's ability to draw patterns in themes derived from reflections and opinions, backing these with direct quotes from participants to verify authenticity and credibility of interpretations (Rice & Ezzy, 1999; Patton, 2002). The reflexive process of thematic analysis was conducted concurrently with data collection, given that the data acquired from one phase facilitated the design of the interview protocol for the next one.

Tobin and Begley (2004) asserted that this interactive process of data collection and analysis highlights the principle of goodness in qualitative analysis, which ensures that the themes generated are properly grounded in the initial data acquired. The flexibility of thematic analysis has its advantages, in that, it is not bound by specific epistemological guidelines. However, Holloway and Todres (2003) drew attention to the fact that this flexibility and lack of set guidelines could result in a lack of consistency and coherence in the coding and process of generating themes. They, therefore, proposed that, unlike the popular opinion that thematic analysis is not epistemologically grounded, the empirical underpinnings of the study must be made clear before analysis.

In this study, a clear justification has been provided for the use of Appreciative Inquiry within the framework of social constructionism and community-based participatory action research. Further credibility for the process of thematic analysis used in this study is based on Lincoln and Guba's (1985) suggested techniques for enhancing data credibility. Their proposal for prolonged engagement and observation of data was applied in this multi-phased study, where the data derived from one phase prompted the design of the semi-structured interview tool for the next phase. This further facilitated the iterative triangulation of data, converging and providing a clear representation of the views of respondents from one phase of the study to another. The collaborative nature of the 4D stages of AI greatly enhanced the data analysis process, providing more credibility and trustworthiness to the results reported in the next chapter.

Alhojailan (2012) has suggested that thematic analysis serves the greatest purpose for research that seeks to understand a phenomenon through interpretations of the experiences of individuals within the research context. The precision and complexity required for deriving meaning from the narratives of others are managed through intricate and rigorous processes of inductive and deductive reasoning.

3.9.1 Inductive and Deductive Thematic Analysis

Interpretation of data requires a rigorous process of justifying how various interpretations have been derived from raw data, obtained through interviews, focus groups and the opinions and ideas shared on a topic of interest (Rice & Ezzy, 1999). Patton (2002) and Fereday and Muir-Cochrane (2006) highlight the need for interpretive rigour which provides face validity and credibility to the words expressed by participants during data collection, in a manner that adequately links the testimony of participants to the themes generated. Crabtree and Miller (1999) proposed a top-down, a priori, deductive method of analysis where a codebook is developed from a general examination of the data, providing a framework for more in-depth analysis. Fereday et al., (2006) have stated that this codebook is often theoretically founded, based on the research questions, and aims of the study, acting as a data management framework to support the credibility of interpretations made. King (2004) was of the view

that a codebook validates the analysis process by providing a line of evidence on how themes were derived. The codebook is further justified following a bottom-up, post-empirical, inductive analysis (Boyatzis, 1998; Nowell et al., 2017), which is grounded in a comprehensive analysis of the narrative generated during data collection. According to and Braun and Clarke (2020), both inductive and deductive analysis are justified by the theoretical framework of the study. For instance, in this study, the salutogenic theories discussed earlier facilitated deductive analysis that led to the generation of codes and themes on the topics of resilience, empowerment and cultural and social capital. On the other hand, inductive analysis required an evaluation of the relevance of the AI framework to addressing the issues surrounding health inequalities and mental health service delivery. Given that AI provides a dynamic framework as both a theory and a methodology, data collection and analysis, as well as the combination of theory and practice make analysis a more reflective and reflexive process (Denzin, 1970; Clements et al., 2020). The use of both inductive and deductive analysis in this research, therefore, clearly supported the decontextualisation and recontextualisation of data (Starks & Trinidad, 2007), to effectively represent the opinions of participants in a well-structured and organised manner.

The reduction of data into focused and simplified forms, according to Miles and Huberman (1994), is also essential for drawing and verifying conclusions made in thematic analysis. In their view, providing a summary of the larger data helped the researcher to transform the vast amount of information received into more comprehensible portions. After data is reduced, Gibbs (2002) and Patton (2002) encouraged the display of data using thematic maps, tables, and direct quotes, that provide a clear line of inquiry into how interpretations of the ideas and opinions derived line up with the empirical basis of the study. The use of direct quotes was, therefore, employed extensively in this study to share the views of participants.

3.9.2 Data Triangulation

As earlier stated, the multi-faceted nature of this study necessitated the method of data triangulation to ensure methodological rigour in the reporting of research findings. Patton (1999) defined data triangulation as the application of various methods of data collection and

multiple sources of data to provide a thorough interpretation of the phenomena being studied. The convergence created by collating study results by source or methodology has been said to increase the validity and reliability of information generated from diverse sources (Stavros & Westberg, 2009; Fusch & Ness, 2015). Some of these data sources may be provided from participants across various organisations within a community, for example, in addition to other groups that meet specific criteria in line with the research question (Carter et al., 2014; Fusch & Fusch, 2015; Marshall & Rossman, 2016). In this study, the data sources included participants from Black African and African Caribbean communities across Birmingham, as well as voluntary and statutory healthcare service providers. The diversity in data sources ranged from individuals to small and large-scale organisations. Denzin (1989) was of the view that data triangulation connected research participants across space and time, as demonstrated in the various phases of this study. Even though community members did not personally meet service providers, the discussions of themes from previous phases with providers made it possible to observe the interactions between the diverse perspectives shared across both groups. Further exploration of the importance of triangulation in this study will be addressed in the Discussion (Chapter 7).

Another application is method triangulation, which is the use of multiple approaches to data collection (Polit & Beck, 2012) and in the case of this study, the use of both online individual interviews and online focus group discussions. In a study where multiple data collection techniques are used such, method triangulation enhances the depth and richness of information gathered, as it offers opportunities for participants to express their worldviews within different settings (Manganelli et al., 2014; Fusch, Fusch, and Ness, 2018). In the context of this study, participants who took part in the individual interviews and opted to take part in the focus group discussions were given the opportunity to further discuss concerns that could not be fully addressed in the first phase of the study. Also, engaging in conversations with other likeminded participants on issues they were all passionate about, in this instance, culturally sensitive mental health service delivery, allowed them to share thoughts and ideas. This facilitated the collaborative and generative approach that the appreciative inquiry promotes. Eventually, both method and data triangulation allow the researcher to view data from multiple perspectives, permitting reflections on how the various techniques and data sources are inter-related, thus, enhancing the credibility and quality of the study (Varpio et

al, 2017; Stenfors et al, 2020). Given that data was gathered in 3 phases, data triangulation was used to integrate the various sources of data from each online interview and focus group, exploring thoroughly the various representations of culture, values, and norms to gain a richer perspective on their views on mental health and well-being.

There is a need to view AI as a continuous fluid process rather than a final product or a means to an end. This way, the contributions and reflections of individuals collected along the way can be viewed as an essential part of a larger framework. In the process, no one's story is left behind, but rather the various narratives are harnessed to develop a feasible plan that can be tailored and altered to fit best practice (Bellinger and Elliot, 2011). The methodology employed in this appreciative inquiry research, thus aimed to challenge the conventional approaches that other researchers take in the studying community cohesion and diversity especially in minority groups. It also helped challenge established stereotypes of minority ethnic groups such as Black African and African Caribbean populations, by adapting an affirmative approach which is essential to facilitating a collaborative environment that allows participants to share experiences and visions for the future co-constructively (Shuayb et al ,2009).

3.10 CHAPTER SUMMARY

In summary, this chapter outlined the methodological structure of this study identifying the influence of the philosophical paradigm of AI, social constructionism, on the research design. Drawing on other theories, such as relational constructionism, critical theory and critical race also provided further justification for the implementation of a critical appreciative process in this study. With the goal of addressing the aims and objectives on the factors identified by the Black African/African-Caribbean community and service providers as important in the design and development of culturally sensitive mental health services, further justification was provided for the use of a multi method qualitative research design to implement the 4D stages of appreciative inquiry. Leveraging on lessons learnt from the pilot study conducted prior to the design of the larger study, evidence was provided for the use of semi-structured

online interviews and focus groups for the collection of data across the 3 phases of this study. The use of thematic analysis methods was also addressed, with special emphasis on the use of data triangulation methods to converge findings from the various phases. Concerns around ethical considerations and positionality were also addressed in a bid to ensure methodological transparency and research integrity.

As previously stated, the next 3 chapters (4-6) offer extensive insights into the data collection methods utilised during the various phases to address the aim and objectives of this study, particularly surrounding health inequalities and the delivery of culturally sensitive mental health services. Each chapter also presents the results of the data analysis, as well as a discussion on the findings from each phase of this study.

CHAPTER 4: METHODS & RESULTS

PHASE 1: DISCOVERY

"With awareness, we can choose our words. We can decide how to respond, what to say and ask." -Cheri Torres

4.1 INTRODUCTION

To address the aim utilising a salutogenic, critical appreciative inquiry process to engage diverse stakeholders to collaboratively address health inequalities and effectively design and develop of culturally sensitive mental health services for Black African and African-Caribbean community, the first phase of this study was undertaken. To appreciate the differences and similarities in narratives on multiple social realities surrounding resilience, culture, and wellbeing among both Black African and African Caribbean communities, this first stage of the inquiry set the course for this salutogenic inquiry. This opening phase focused on health promoting factors present within the population of interest and sought to understand how culture, cultural values and other societal factors promoted resilience and other coping/protective mechanisms against mental health issues. The goal at this stage was to gain insight into affirmative stories which are at the core of the transformative process of AI. This initial phase of the inquiry, therefore, corresponded with the first stage of the 4D Appreciative inquiry process, the Discovery stage and engaged a diverse group of members of the Black African and African Caribbean community living in West Birmingham. In answering the research question aligned with this phase, the aim was therefore, to address the first objective of this study:

OBJECTIVE 1: To identify cultural values in the demonstration of resilience, strength and coping abilities that foster mental health and wellbeing among Black African and African Caribbean communities.

The Discovery stage of AI is focused on appreciating best practice, strengths, and skills of an individual, organisation, or community. Centred on the question, **'what works best?'**, this opening stage focuses on the appreciation the life-giving properties within an organisation or group (Cooperider, 2008). Typically, at the core of the discovery stage is the affirmative or positive question, which sets the tone for discussions surrounding the practices and principles

that have fostered positive outcomes as well as group or organisational growth. (Trajvoski et al, 2013). This positively framed topic guides generative conversations around the identification of the strengths and values present within a group, in this case, within the frame of healthcare research, and identifies the determinants of optimal health and wellbeing. Despite being at the centre of the AI framework, the affirmative topic has been criticised in studies where the overly positive focus has limited researchers' willingness to engage discussions around weaknesses or challenges within the AI study context (Trajkovski et al., 2013). However, as the AI framework has evolved, researchers such as Bushe (2007) and Carter et al (2007), have argued that beginning the process of positive, solution-focused transformation in AI can be achieved without focusing on a solely positive, affirmative question. Bushe (2013), Ridley-Duff and Duncan (2015) and Oliver (2017), in drawing on the concept of critical appreciative inquiry, proposed that researchers consider **'what is'** and **'what might have been'**, before addressing the **'best of what is'** within the research context. In Bushe's (2001a; 2013) opinion, this offers a more generative and provocative approach to introducing participants to the concept of AI, especially when discussing sensitive issues within marginalised groups. The generative process, therefore, begins by recognising and respecting the social, cultural, and political climate within which the research topic is being discussed. Once participants are assured of the genuine interest of the researcher in how social systems influence the phenomenon being discussed, then the likelihood of engagement in the research process is increased. In this regard, the affirmative topic/question for this study was '**What role do culture and cultural values play in promoting resilience and coping against mental illness within your community?**'

In identifying the elements of culture and community that supported resilience and wellbeing in lieu of the sociocultural structures that stood as barriers to accessing mental health support, the objective was to foster generative conversations which addressed health inequalities and cultural sensitivity in service delivery. While identifying these life-giving strengths and values was significant, engaging discussions around the impact of racism, discrimination, and stigma on mental health within the Black community was imperative for this critical appreciative inquiry. However, in adapting a strength-based approach, the initial focus was to highlight the positive strengths and capabilities, digressing from the traditional problem-solving approach of 'what's wrong and how do we fix it'. This line of inquiry thus,

shifted the focus from the negative narratives on stigma and discrimination, which are often the initial subject of conversation when discussing mental health within the Black community. Rather, in paying more attention to the evaluation and strengthening of protective factors that foster empowerment and resilience, participants were encouraged to share insights on the positive elements that can be leveraged to address some of these challenges. Hammond's (1998) proposal that every group, organisation, or community has systems, values and practices that work for them, therefore, also guided discussions on the intra-cultural differences that exist within these communities in their perspectives on what promotes resilience and coping. A clearer understanding of the unique diversity represented within the various sub-cultures of Black African and African Caribbean communities presented opportunities to identify how various individual and communal strengths may foster a collaborative approach to addressing health inequalities and cultural sensitivity in service delivery. These initial dialogues were the bedrock of the entire process, thus, the reflexive method of inquiry applied at this stage sought to engage participants on an interpersonal level, to foster rapport as well as gain subjective insights into their lived experiences. Positioning participants as experts and co-producers of knowledge (Ospina and Dodge, 2005), the goal was to prompt further conversations on ideas and visions for the co-design and development of culturally sensitive mental health services, which were addressed in the ensuing Dream, Design and Destiny stages.

4.2 METHOD

Understanding and appreciating the unique narratives and socially constructed realities surrounding mental health in the Black African and African Caribbean community was the first step to encouraging generative conversations towards the co-construction of culturally sensitive mental health services. Proponents of appreciative inquiry are of the view that questions are fateful, and therefore, the generative and transformational change an inquiry seeks to achieve begins by asking the right questions (Bushe and Kassam, 2005). To optimise participants' engagement in the co-creation of knowledge, the qualitative data collection method of semi-structured interviews was employed.

Many AI studies have employed the use of interviews, focus group discussions and other storytelling techniques to understand the strengths, values, and life-giving properties within their research context (Uys and Cloete, 2020; Stulz et al, 2021; Merriel et al, 2022). Using a predetermined thematic framework, semi-structured interviews offered a deeper exploration of the positive experiences, strengths and capabilities that laid the foundation upon which the other pieces of the generative AI structure would be built. In the case of this study, the experiential narratives shared on the meaning of mental health, mental health promotion, resilience and cultural values were the building blocks for identifying how these factors could be integrated within mental health services to promote cultural sensitivity. With the knowledge that the narratives shared in this stage, as well as the dream stage, would be fed back to service providers during the Design and Destiny stage, participants had the opportunity to spear head discussions that would shape the inquiry process and its outcomes.

The period within which this phase of the study was conducted (COVID-19 pandemic and lockdown), necessitated the use of innovative techniques such as online interviews to engage participants. Online video conferencing software such as Microsoft teams and Zoom were thus the only ethically acceptable means of conducting these interviews. Technological advances over the last two decades have contributed to a growth in internet/online based research methods, especially within qualitative research, alleviating some of the concerns face-to-face interviews brought such as access to research venues, recruitment concerns, among others (Hooley, Wellens, & Marriott, 2012). Over the last 2 years (2020-2022), the COVID-19 pandemic has necessitated a drastic shift in the way academic research has been carried out, where restrictions placed due to lockdown and social distancing have led to a surge in the use online data collection methods (Lobe et al, 2020). Even after the pandemic, the ease of access that online research has afforded has allowed many researchers to adopt a blended approach, utilising both in person and online methods, where convenient. In consequence, the ethical considerations to be factored into such research designs are constantly being reviewed to ensure confidentiality and uphold beneficence (Pocock et al., 2021).

The pilot study which was conducted prior to this study played a key role in optimising the design and development of this, and subsequent stages of this study. The findings were particularly useful for the development of the interview protocol, evaluating aspects of

question clarity and advising a more culturally sensitive study design (Van Teijlingen and Hundley, 2002). One significant finding from the pilot study that was undertaken with service providers from Black led organisations at the height of the pandemic was the reality around digital poverty and the lack of access to and knowledge of the use of digital platforms that were essential for maintaining communication. The evidence of lack of technological know-how, particularly among minority ethnic communities (Eruchalu et al, 2021) and the elderly meant special considerations needed to be made to accommodate the needs of the various populations. One change that was made to this study was the use of Zoom, which was not a university authorised data collection software at the time yet needed to be included to include participants who had little knowledge of using MS Teams. Permission was thus sort from the ethics committee (17/02/21) to include this software, to support the study and pre-interview training was also offered to participants who needed support using MS Teams.

Another lesson learned from the pilot study was the need to restructure the interview protocol and its contents. Although predetermined interview schedules from past AI studies guided design of that used in the pilot study (Whitney et al, 2002; Moore and Charvat, 2007), the questions needed to be tailored to effectively highlight the strengths and capabilities of service deliverers, whiles also engaging discussions on the difficulties faced. In efforts to allow a balance between positive and negative narratives in all 4 stages of the AI study, the questions were densely populated. This put constraints on the 2-hour focus group discussion and made it difficult to allow for a free flow of conversation, which began to happen nearing the end of the study when participants were more engaged. These findings thus, justified the breaking down of the stages of AI into 3 phases, to allow for the richness of narratives and stories to be discovered, devoid of the time constraints that conducting the four stages at once would have demanded. Also, to ensure the inclusion of questions that prompted more critical, in-depth discussions around both positive and negative narratives around mental health and service delivery, changes were made to the interview structure. This restructuring facilitated the process of learning from stakeholder experiences as their responses were essential for formulation of subsequent phases. According to Alvesson and Deetz (2000) and Grant and Humphries (2006), the type and quality of questions posed in AI greatly influence the scope of responses, especially regarding expressing the social reality of respondents. It was, therefore, pertinent, during this research, that a reflexive and critical process was

applied to evaluating the interview guide before data collection began. The insights shared by these service providers, along with those shared by other community partners facilitated the design of questions that empirically and theoretically reflected the constructs this study sought to assess. The pilot study, thus, helped refine the interview schedule to fit the study context, further highlighting the rigour applied within this study to ensure content and construct validity (Israel et al, 2005).

The interview schedule focused on discussions around exploring the meaning of and facilitators for the development of resilience, especially within the context of the Black community. The purpose was to understand experiences of resilience and appreciate the assets and resources available within the community which fostered mental health and wellbeing and improved resilience, especially in the face of crisis. Further discussions were had on the nature of service delivery within the community, to learn people's experiences of both statutory (government run) and voluntary sector services, whether this was a personal lived experience or a third-party experience. This stage of the inquiry also focused on some of the cultural values that were important within the Black African and Caribbean communities, shedding light on how specific elements of culture such as food, music, arts, and dance helped to improve mental health and wellbeing. Recognising the importance of these values and resources was also tied into discussions around Black identity and the significance of affirming sources of cultural pride. All the insights gathered played a crucial role in the design of the dream stage of this study, which focused on how these values and resources could be integrated into mental health services to promote cultural sensitivity in service delivery.

4.2.1 Sampling and Recruitment

Participant recruitment for this phase of the study began once ethical approval was granted for the study (17/02/21: Appendix 3. Pg 376). Participants were recruited from the target areas in West Birmingham area, which was chosen because of the population of Black Africans and African Caribbeans living within those areas as compared to the rest of Birmingham (Birmingham City Council, 2023). With the support of gatekeepers and other key

stakeholders, invitations and flyers were shared via email and other social networking platforms, such as WhatsApp, across the various networks within the city. This snowballing technique facilitated the recruitment process, as participants were able to invite others within their networks to take part in the study. In 2021, when some of the COVID restrictions were lifted, permission was obtained to undertake in person participant recruitment within the West Birmingham area, in addition to the online advertisements that were already being circulated. It is important to highlight the nature of conducting research among hardly reached groups, where trust is a valuable commodity that has the potential to greatly affect any type of research. Therefore, visiting these areas was key facilitating the building of trust and subsequently, the success of this recruitment. Even though the uptake was still low after the visits, conversations had during this period with different individuals further justified the pertinent need for such a study within this area. Many discussions revolved around the mistrust of mainstream services, the need for more safe spaces for Black men to discuss mental health, as well as the value of informal settings such as barber shops, coffee shops and salons where Black people found community support and a safe space to share ideas. Also, this process shed light on the need to include new migrant Africans within these areas in mental health research, especially, the Ethiopian and Eritrean communities. Many of them, although interested in discussing concerns around mental health, did not meet the inclusion criteria due to language barriers. Nevertheless, the informal opinions gathered during this recruitment stage were recognised and further enhanced the richness of this study, as they helped broaden the specific subjects to be discussed within the main study. Recruitment ended once saturation had been reached (21st October 2021- 30th March 2022). The final sample was comprised of participants of different ages, gender, and religions, all of Black African, African-Caribbean and Mixed Heritage background. Below is a table summarising the demographic information of the participants represented in this study:

PARTICIPANT	ETHNIC BACKGROUND	AGE	GENDER
1	AFRICAN CARIBBEAN	65+	MALE
2	AFRICAN CARIBBEAN	65+	MALE
3	MIXED HERITAGE	65+	FEMALE
4	AFRICAN CARIBBEAN	18-24	FEMALE
5	AFRICAN	55-64	MALE
6	AFRICAN CARIBBEAN	55-64	MALE
7	AFRICAN CARIBBEAN	35-44	MALE
8	AFRICAN CARIBBEAN	18-24	MALE
9	AFRICAN	18-24	FEMALE
10	MIXED HERITAGE	25-34	FEMALE
11	AFRICAN CARIBBEAN	55-64	FEMALE
12	AFRICAN	25-34	FEMALE
13	AFRICAN	35-44	FEMALE
14	AFRICAN	18-24	FEMALE
15	MIXED HERITAGE	55-64	FEMALE
16	AFRICAN CARIBBEAN	25-34	MALE
17	AFRICAN CARIBBEAN	25-34	MALE
18	AFRICAN	35-44	MALE
19	AFRICAN CARIBBEAN	35-44	FEMALE
20	AFRICAN CARIBBEAN	25-34	FEMALE
21	AFRICAN	18-24	FEMALE
22	AFRICAN CARIBBEAN	25-34	MALE
23	AFRICAN CARIBBEAN	25-34	MALE

Table 1: Demographic Information of Phase 1 Participants

As the objective of this phase was to explore the cultural strengths, resilience narratives, and protective factors that contribute to the mental health and well-being of Black African and African-Caribbean communities, it was essential to recognise the distinctiveness between both groups. Identifying the similarities and differences in cultural values that foster resilience and mental health inter and intra culturally was also one of the secondary objectives of this phase. Many lines of similarity run between Black African and African-Caribbean culture and the assumption has often been made that both groups are "*culturally homogenous*" (Daley 1998, Owusu-Kwarteng, 2017). However, each group has a unique set of values and beliefs that need to be explored to appreciate the distinctive cultural values and practices that supported resilience and mental wellbeing. The reference made to Black Africans in this section, thus represents the population migrants of African ancestral descent from the sub-

Saharan African region (Agyemang, Bhopal and Bruijnzeels, 2005). African Caribbeans are those, also of African ancestry, who are migrants from the Caribbean islands. Even though they are of African descent, their traditions and aspects of culture, beliefs and migration history differ from the culture of people from the continent of Africa (Elam, McMunn and Nazroo, 2001). This consideration in the sampling process was key to maintaining the culturally sensitive ethos of the study.

4.2.2 Data collection

The mode of inquiry for this first phase was also critical to the entire process and individual interviews were chosen over focus groups during this stage for many reasons. First, attempts were made to hold separate focus groups for Africans and African-Caribbeans respectively, in order to provide the opportunity to hear opinions around resilience, cultural values and the general opinion of mental health that were distinct to each community. However, it was difficult to bring people together at the initial stages of the research and following a few attempts to host a focus group, the decision was taken to hold individual interviews, all of which were ethically approved (**Appendix** 3: Pg 376). These semi-structured interviews gave participants the chance to gain a fair understanding of the scope of the study, establish trust, understand their role as co-researchers and offer their opinions on the subject matter in a more private setting than the one offered by a focus group.

Twenty-two (23) participants between the ages of 18-65 and over were interviewed during this stage, all of whom were from Black African, African- Caribbean and Mixed heritage backgrounds. Each online interview lasted an average of 55 minutes, even though the stipulated time was 30-60 minutes.

Thematic analysis was conducted to identify themes which were generated initially by manual coding of the transcripts, and the codes generated were included in a codebook, facilitated by the NVivo analysis software. The interview schedule was focused on addressing key topics relevant to mental health, resilience, community support, stigma as well as service delivery. Broken down into three sections, the first part of the study explored participants' views on the definition of mental health, mental health promotion and resilience, and encouraged participants to share stories of resilience and reflections on the qualities that enabled them

to adapt during difficult times. They were also asked to reflect on the role their families, community leaders and healthcare professionals played in encouraging resilience in a bid to identify the social capital that existed within these settings to support wellbeing. Discussions about values, cultural assets such as music, arts and sports were also explored to further ascertain the influence of cultural capital on mental health and wellbeing. The next two sections fostered discussions around mental illness stigma, the reasons surrounding late access to mental health services, as well as the negative and positive experiences of mental health services, to explore participants ideas around cultural competence in services. These discussions facilitated the implementation of the critical appreciative inquiry process, which led to many profound insights. The results generated from this Discovery stage (Phase 1) are discussed in the next section.

4.3 RESULTS

Following the online interviews, the thematic analysis conducted utilised both inductive and deductive methods to extract codes from the various narratives, which were then grouped into themes and sub-themes. The implementation of the Discovery stage in this phase set the foundation for the generative process of AI. Thus, the insights shared draw attention to participants' views about resilience and the assets available to support its development, the significance of cultural values to health and wellbeing as well as the scope of mental health promotion and service delivery within the community. The similarities and differences in cultural values as presented by the distinct cultures represented among the participants are all discussed in this section.

4.3.1 DISCOVERY 1- EVOLUTION OF MENTAL HEALTH IN THE BLACK COMMUNITY

Gaining insights into participants' understanding of mental health, mental health promotion and resilience were essential to establishing a baseline on their knowledge of these concepts, in comparison with standardised definitions. The responses received led to the development of the theme on the evolution of mental health in the Black community, highlighting the

changes that had taken place over the years in people's understanding of mental health. The sub-themes presented provide more insights into the nature of the responses provided.

4.3.1.1 Sub-theme 1: Defining Mental health and Mental health promotion

An understanding of respondents' views on the meaning of mental health and mental health promotion was important for evaluating their knowledge of the issue. To propose ideas and suggestions for improvement of mental health services, it was important to determine the scope of mental health promotion within the Black community and how widespread the awareness was. Both male and female participants had similar views on the connection between the psychological, emotional, physical, and social factors that contributed to mental health. They defined mental health as the ability to control one's emotions without relying too much on others as well as being able to regulate and balance emotions. Others also described mental health as holistic health and wellbeing that could be on a continuum and depended on how one's mood affects their behaviour. One interviewee stated:

P8- Your mental state. How you process things in life. Yeah, how your brain processes things in life and how you cope with emotions and feelings yeah. I think that, yeah, that probably involves certain thought patterns and how you deal with things, certain ways. How you deal with different situations and things like that, that's what mental health means.

For others, mental health was influenced by emotions and how one felt inside, stating that these emotions could either be positive or negative, and understanding mental health meant being aware of how one felt and making efforts to take care of oneself. Openness to these feelings and considering them as normal were necessary considerations for how one went about their daily life. Also, being conscious of who to discuss these feelings and emotions with played a big part in how one viewed their mental health. The right environment, therefore, was noted as essential for fostering good mental and emotional health.

P23- I say mental health, it's kind of just being open to listening to your own thoughts and being able to talk to other people about your thoughts and make sure that there isn't anything that you're particularly going through that is crippling your day-to-day life. And just being open to talk about it, whether that's positive or negative 'cause, it could be something that's positive that you're really dealing with and you wanna tell people, but you don't feel comfortable telling them. So yeah, I think that's kind of my gist of mental health, just being mentally stable within what you are doing within life and not potentially happy, but fine.

Some participants commented on the transformation in the way people within the Black African and African Community perceived mental health and mental illness, stating that it no longer meant someone was 'crazy' or 'out of their minds' but that we are all capable of having good or bad mental health.

P18- So growing up if I were to see somebody that wasn't, you know let's say in their right mind, perhaps acting crazy or you can tell that there was, not to offend anyone, but there was a screw loose, you would say oh they've got mental health. Yeah, it's only as I grew up, I started to realise well, everyone's got mental health.

One participant of African-Caribbean origin highlighted some of the words that are commonly used to denote mental health within this community.

P1- In Caribbean, we don't use the term mental health, we say 'off his or her head', that's something you will hear, or 'off her rockers'. We speak about hearing voices, yeah, we speak about deranged, that person is deranged.

The diverse contributions made demonstrated adequate knowledge of mental health across the board, with participants highlighting the influence of emotions, psychological, sociocultural, and environmental factors on mental health and wellbeing. Much emphasis was also placed on the fact that mental health or illness was not limited to schizophrenia or psychosis, as it encompassed a wider range of conditions that anyone could experience.

Subsequent discussions engaged participants' views on the meaning of mental health promotion and the availability of such interventions within the community, specifically those targeted at Black African and Caribbean communities. Majority of the participants had adequate knowledge on what mental health promotion comprised of, and even though it was often confused with mental illness treatment, the definition presented after responses were gathered (Jane-Llopis et al, 2007 definition of Mental health promotion) helped to offer clarification. Participants described mental health promotion as the action of shining light on support that is available for everyone rather than focusing on those who are ill. Definitions like this, centred around education and raising awareness within the community. They suggested that mental health promotion meant educating everyone on mental health so they could have capacity to support those that are struggling. To others, mental health promotion encompassed helping people become more aware of their thoughts and feelings and teaching them how to respond honestly to these feelings.

P3- It's trying to promote people's understanding of mental health, you know what I mean that's what it's all about. And they started it in a positive form, I think, uhm. I think it's good that it is done. I think it is done in communities as well as nationally.

P8- Just making sure people are aware that, well, for now, nowadays it's more like anybody, you know their mental health can be affected… I say, about promotion, like advertisements like on social media, TV, news, things like that really. Probably going into schools, public centres, probably in gyms as well.

For others, mental health promotion was expressed through ensuring that one's own wellbeing was in a good state, by doing things that supported wellness, such as identifying like-minded people who value their mental health and staying in those circles. This also included being able to access alternative avenues for improving wellbeing outside of mainstream healthcare systems.

P4 – kind of not just like counselling services, but also things that just promote like general wellbeing like having access to kind of like exercise or like yoga or like, art. And those kinds of resources, I'd say that that's kind of like what mental health promotion means to me, not just helping, like when it comes to a breaking point. It's kind of supporting people like before it gets there.

Opinions varied widely on the issue of if mental health promotion was taking place within the Black community. Many participants admitted that efforts to raise awareness on mental health within the Black community had increased. Some commented that social media had made information on mental health more accessible to the community and this had in turn helped to reduce stigma. One respondent highlighted the presence of organisations such as African Healing Circle, which was based within the Birmingham and Solihull Mental health Trust, that specifically focused on promoting black mental health. In their opinion, there were more initiatives within the community that created safe spaces to discuss mental health.

P10 – there are some different services, so I know within Living Well consortium which is quite a big mental health service in Birmingham and Solihull. There's a subgroup called African healing Circles, which is specifically for Black individuals. They kind of speak about the difficulties it can be being an ethnic minority and how to kind of promote your wellbeing.

A small number of participants suggested that the pandemic had highlighted the gravity of mental illness within the community and had necessitated an increase in awareness creation and education on the issues.

P11 – And I would say social media because of course at the moment with all the isolation as well… And I have seen some initiatives in the community that are speaking to the need for us to look at

this as a community, as people, and prioritise it. And you know, in efforts to create safe spaces and lift the stigma, I think we are doing amazingly well. All things, all things considered.

Yet some expressed the belief that not enough was being done to promote mental health within Black African and African-Caribbean communities. Racism was highlighted as one of the major factors for the lack of mental health promotion and the gap in service delivery within these communities. One participant commented that historically, black people have been left out of conversations surrounding their health and wellbeing and have been told to 'just get on with it', without being offered the necessary support to meet their specific mental health needs. In their opinion, many mental health promotion initiatives were designed without involving the Black community and consequently, the mode of promotion did not take into consideration the reality of the people the promotion was targeted at. Many times, these initiatives did not align with the culture and the values of the community and consequently led to a lack of engagement.

P6- it's still a very big issue and like I said, uhm, I, I think for what we all know it's like there's still a very wide gap between how the black is being treated and how the white is being treated and you know this cuts across every aspect of the black life. I think things are getting better but if you should ask me before now, I will say those who put together these kind of initiatives, they did not consult the black people to find out what is good for them. You understand me, in putting down what they have to do, how to treat them, how to deal with them, they did not involve those that are really concerned, so they did what they wanted and put on whatever program was in place.

A participant expressed that many times, mental health promotion within marginalised communities was just a tick box process for mainstream mental health services to demonstrate that they were culturally competent, even though no actual work was being done. Many times, this was done at crisis point when reports of cases had drawn the attention of policy makers and needed to be addressed urgently.

P10- So like different trusts are doing more education on BAME individuals and trying to promote mental health. So, think there is an awareness starting to come up, but I think sometimes it can feel like a bit of a checkbox as well like, tick diversity, yeah, we're doing that and stuff for like a hot topic. So, I think sometimes it can be hard to know if there's an actual initiative that's gonna stay or is this just a tick?

This lack of promotion led to conversations on mental illness stigma and the culture of silence that existed around mental health, that some participants said, could be implicated in the low uptake in mental health promotion programmes that were present within the community.

4.3.1.2 Sub-theme 2: Mental illness stigma and the Culture of Silence

The presence of stigma around mental illness still stood as a huge barrier in the uptake of mental health promotion initiatives and was said to be the cause of low help-seeking behaviour when it came to accessing mental health services within the community. One major concern was around the interplay between faith and mental health, where the nuanced views in differentiating spirituality, religion and mental health/illness affected people's ability to engage with mental health services, particularly in the African community. In one participant's opinion, many people's views on the causes of mental illness were still tied to religious and spiritual beliefs, such as demon/jinn possession which heightened stigma and discrimination. In some cases, a few participants indicated that even though the church, for example, was a great asset for the Black community, there were instances where the mental health of congregants was ignored, because of a lack of awareness on how to provide the needed support.

P22- We're not (providing support), as mental health is not as openly minded in the African community, not accepted as it is in you know, Western communities. I think people are still silent about it, because of like religion and spirituality, it's like a clash in their minds.

Some participants commented that owing to the lack of education on the causes of mental illness, many, especially, within the African community, still perceived mental illness as something that was made up and was also seen as a 'white man's problem'.

P23- But I feel that sometimes people don't want to talk about it just because some Black people might just be like yo, Mental health isn't a thing, you'll get on with it, init. You breathe in, you've gotta beat, yo, keep it pushing.

Some participants (65+) drew attention to the fear and stigma surrounding illiteracy also that fed into the culture of silence among some Black African Caribbean elders, who would rather shy away from any form of mental health literacy because of their inability to read and write rather than engage with the content. This further perpetuated the stigma around mental health and mental illness as some lacked the depth of knowledge to explain or be vocal about mental health.

P2 – We don't normally express that openly to other people. Yeah, yeah and so when you know when whatever yeah, we will try to hide certain things... for instance we will get people say, for instance someone can't read and write yeah within the community. Yeah, when you present them with any sort of a document or something like that, they will find an excuse for instance, 'Oh, I forgot

my glasses at home. And so, we tend to cover up a lot of things like that. Yeah, so we don't actually openly express, you know, our feelings.

This culture of silence also resulted in people only seeking treatment at crisis points, when they had severe breakdowns, which many times resulted in police involvement. The fear of being institutionalised also contributed to people refusing to speak up about their mental health.

P10- Like when I go to services, I go because I want help and I realise that there's a problem. But I think lots of people are maybe forced into it, so they don't really want to be there. I know of a girl who talks about having a mental breakdown and someone calling the police and she getting taken away in handcuffs.

P6- when anything happens to a black guy and the police is invited you find out that in many cases just like someone told us that day you find out a black person is sectioned immediately. Whereas it's not a mental health problem. You know, maybe the guy is angry maybe then reacts you know more than he should, and he is sectioned.

Another participant also shed light on some views around mental health that were specific to African culture. In their narrative, the participant highlighted the popularity of the belief that people with mental illnesses were dangerous and contagious and could be transferred by marrying someone with a family history. Even though this belief was based on some truth (biological explanation for mental illness), social stigma and self-stigma kept many from being open about their mental state as disclosing such problems could bring disgrace to them and their families.

P16- the stigma is that people think, and I used to think this that, 'cause that's the way I was brought up, that people who have mental health problems are seriously unwell and need some treatment. Uhm, and you know, uhm? I remember my grandmother, being of the view that you shouldn't get too close if you have mental health problems, because you can catch it.

One particularly interesting finding was the connection made between racism and discrimination and the issue of mental illness stigma. Some respondents proposed that Black people had a culture of silence that was necessary to protect our identity, which discouraged open dialogue and help-seeking behaviour. In their opinion, past experiences of discrimination had perpetuated feelings of shame and self-stigma, and the assumption that other races already held a negative view of them necessitated this secrecy. Thus, sharing mental health problems only tainted their image further and signified weakness.

P11 – because we're not supposed to talk about our feelings, not supposed to talk about our business. I think we're scared as well. If we let people know, that judgment, because we've been considered subhuman or whatever in the past, it's you carrying all of that inferiority…

P21- I think as black people, we've gone through a lot of trauma. I feel like we also seem like oh, we're strong. We're supposed to be these strong people, so we're not supposed to kind of show our emotion kind of thing. We've been given the stereotype that we're supposed to be strong so we kind of try and hold that up. So, I think that would probably be a big problem when it comes to the black community.

P3 – historically, we were told that we had to get on with stuff. Get on with it, had no, they never had support from services from day one being in Britain. So, the fact to get out and they weren't trusting of services either and not people understanding them. They were stigmatised and labelled. I mean all of that stuff has gone on before. One day you know you can feel people wouldn't have accessed services.

Finally, some participants shed light on the lack of trust and solidarity which existed within the Black community, that prevented others from speaking about their mental health problems. Some commented that there was a growing lack of sense of community that had led to more individualistic behaviours which varied greatly from the collectivist culture many had known. In their view, there was an illusion of support within the Black community and even though many claimed to support each other, their actions said otherwise and did not encourage a sense of trust or mutual support. One participant stated:

P8 – I don't blame some people. There are people in the black community that will spread it. Yeah, there is always that one person that gossips at any rate and I think black people do have a habit of dragging other black people down. Yeah, so I can understand that. You know, if another person doesn't wanna share it's just because they are concerned that the other person might run with it, just, you know, spread it to other people who would probably use it against them.

P12- I'm struggling with this one because you know I feel passionate about that but at the same time I know it doesn't always happen within unity. Yeah, and you know I feel sad about that you know what it is. And sometimes you know our own community is our own enemy and if we could just pull together, we could just be stronger and more effective in everything that we do.

As observed in the narratives above, there were many conjectures surrounding the reasons why mental illness stigma was prevalent within the Black African and Caribbean communities. Cultural taboos, religious and spiritual beliefs as well as generational attitudes were a major barrier to help seeking behaviour. Other experiences of discrimination as a result of racism perpetuated internalised stigma, which resulted in the reluctance to access support, many times, until crisis points and consequently, the distrust of mental health services. The supposed decline in trust and unity that formerly existed within these communities was also alluded to as the reason for the lack of open dialogue around mental health. All these factors

indicate the careful considerations required to address concerns around mental illness stigma.

4.3.2 DISCOVERY 2- RESILIENCE: AN IDENTITY RATHER THAN A CHOICE IN THE BLACK COMMUNITY

Discussions at this stage were focused on resilience as a protective factor for mental health in Black African and African Caribbean communities and participants delved deeper into the meaning of resilience, the resources, and networks around them that encouraged such resilience and shared stories on how they had applied such resilience to overcome difficult situations. The results presented several thought-provoking insights, the most significant of which was that within the Black African and Caribbean community, resilience was more than a skill, but rather was instrument in the formation of one's identity as a member of a minority ethnic community in the UK. The stories shared of resilience, the reflections on the qualities and resources that enabled coping in the face of difficulties as well as the influence the resilience identity has on mental health and help-seeking behaviour are discussed in further details.

4.3.2.1 Sub- theme 1: What resilience means to us.

In seeking to understand what resilience meant to participants, different definitions were shared, many of which centred around bouncing back in the face of adversity and trials. Resilience meant adapting to difficult situations and learning to cope properly even in the face of crisis. Phrases such as *'bouncing back'*, '*not giving up'* and *'finding a way around or fighting a difficult situation'* were used to describe resilience. For some, being resilient meant carrying on as normal in the face of hardship. One participant described it in these words:

P9- Resilience is resisting some sort of pressure, or whether that be peer pressure, physical pressure, like resilience, is just not being able to break basically and just being a bit more steady than anything else, and not wavering from the original structure of whatever it is basically. So, it's like if you got a shatter resistant ruler, it's not gonna shatter, it's gonna bend, isn't it?

Another alluded to the inherent trait of resilience Black people possessed as a result of the conditions they had endured over the centuries, stating that resilience was a result of what they referred to as *'a forced natural selection':*

P13- Our background means that we've had to grow up resilient and tough. It's a kind of background where only the toughest survive. There was no room for weakness. Yeah, in a way we kind of went through, what would you call it? They call it, I think in science they call it natural selection. Going through a natural, a forced natural selection, we didn't choose it. But the backgrounds that we have as a people have made us go through natural selection. No weak people could survive what we have gone through, and so the people that have now survived have now raised these really strong people too.

For others, resilience was defined within the context of rising above any form of racial discrimination and stereotyping, which also meant having to keep going despite the unfavourable conditions. Some participants highlighted that being cognisant of subtle racism and resisting any form of racial or ethnocentric discrimination were all encompassed in resilience.

P1- And you know, yeah, and you get kicked down to the ground by whoever, whether it be the racism or the oppression or the suppression, you think I'm gonna dust my feet off and I'm going to get up and I'm going to still keep on going because that's part of who I am and so on, that's resilience.

Others on the other hand, described resilience as being able to stomach the discrimination and racism, in order to avoid trouble or being singled out.

P12- It's about understanding as a black woman, the fight is going to be harder for me. And you know, but not to give up at that first hurdle because you know. But it's easier sometimes to just say I don't need this yeah and to walk away.

Resilience also meant coping and keeping the momentum in life without showing emotions or complaining. One shared opinion among participants of different ages and background was that survival in an environment where skin colour determined how one was treated required that one had a tough skin and unconsciously kept a stiff upper lip. Some participants referred to this as 'toxic resilience', which in their view, was a negative yet efficient way of coping and adapting to unhealthy environments as an alternative to dealing with poor treatment and racial discrimination.

P13 – It means just being very, very strong. It means really standing up for yourself. It means being rude. Even if you have to be rude, be rude; be rude and right rather than be submissive and have someone walk over you. You just have to be very very strong. It means being really strong and it

means we end up taking on way more than we ever designed to. You're either a resilient doormat or resilient fighter, it's one or the other.

P3 -there's one that I grew up with right, in terms of keeping the stiff upper lip, almost OK. You don't show things, it's unconscious. Yeah, you don't show sort of any feelings you get on with things.

P10 – When I was growing up, I understood resilience to mean you just keep going like you get knocked down, but you just keep going. Like I think I always remember when I was about 8 my older brother sat me down and looked at me and I will never forget this conversation. But he said you are a black person, you are an underdog, you're a second-class citizen. If the white child gets 40, you need to get 80, you will always be looked down upon, you need to work hard and that was really instilled in me like at a really young age. So resilience like what I thought was that you keep pushing you, keep pushing and you keep going and you keep going and if you're tired, you just keep going and you keep going.

One participant highlighted the difference in views on cultural resilience, comparing how white people dealt with difficult situations to people of African and African- Caribbean ethnic background:

P1- here's a difference between cultures, so white people and how they deal with trauma and disaster and that sort of thing, it is completely different. They freak out and we just think, hey? And they think, "How come you just so relaxed and calm about that? You've been through a terrible disaster or whatever and yet still you're managing to smile?" And look, you know we're still feeling it. We still have pain. We still have hurt. We still have discomfort, but the way how we then deal with it, it is in a completely different way.

Yet, another interesting narrative shared on the meaning of resilience was in relation to vulnerability. For some, being resilient required knowing it was acceptable to show weakness and accept one's negative emotions. This meant being able to ask for help and being open to receiving support, especially when it came to improving mental health and wellbeing. Some participants stated that though stigma and shame around mental illness were still prevalent within the community, there was much more open dialogue around the subject of mental health, which had helped transform their mindsets around viewing emotional distress as a sign of weakness or a lack of resilience. For one participant, being and staying resilient meant that they could finally accept that mental health was on a continuum and that it was normal to have difficult days.

P7- the word vulnerable tends to be around people who aren't able to manage. But I look at is as if you open yourself up, then you're vulnerable. You're either gonna activate self-change or somebody could come in and say, oh, actually, I know somebody who could help you with this or some person or an organisation. So I think the vulnerability allows you to become resilient.

Resilience was also described as allowing oneself to *'be human and feel emotions'.*

P22- Resilience means…to me it's not about being strong, it's OK to be weak, but then get back up, that's what resilience means to me yeah. Being able, allowing yourself to like, yeah, be in your emotion and feeling and accept them and then you know applying them and seeing how you can grow from it and be a better person or stronger person from it. You see when you say resilient like a lot of the time, we think is to block it out, you need to pull like a shield. But we're human, we can't live like that. But you have to feel like, it's your right to feel but just remember that it was just a moment and like things will go on.

The diverse perspectives shared led to discussions the value of human relations and other resources that had facilitated individuals' resilience during difficult times.

4.3.2.2 Sub-theme 2: The Relationships, Assets and Support Networks that help us stay resilient.

When it came to identifying and appreciating the resources within the community that nurtured resilience, some unique personal qualities, and characteristics as well as the value of relationships within the community were discussed. Faith and spirituality were often cited as one of the things that supported resilience. Participants cited that their belief in a higher power, as well as connections within their faith groups were essential for supporting their resilience in dealing with difficult experiences and traumas.

P8- I think in faith would be one. I rely on God I think the main one, though it's faith, that's what I've known. I don't know anything about the others though.

P10- So there are other people, like other communities, my faith community was a big one and other friendships I picked up from university and secondary school were really supportive in that. And in my church, like they said, 'we're here for you no matter what you do and stuff so that was really good.

Another spoke of the bravery and survival of ancestors who had suffered during the slave trade, and how the knowledge of this history nurtured this resilience.

P7- I go back to the 1st experience … where it seemed to me, I thought, gosh, this is over. I then felt a little bit of guilt for the way I was feeling. I was thinking, you know, you haven't actually gone through nowhere near what they must have gone through and that kind of perked me up. And I'm, you know, guilt maybe not the right word to use because everybody's situation is different and everybody's situation is important no matter what level of mental health. I actually then thought more about what my ancestors went through in the sick slave trade. Then I thought to myself; those guys survived all that brutalization. Had they jumped off the ship, I wouldn't be here. They survived the plantation, the brutality, and I thought to myself, you know something, they did that for you so that you could thrive.

Family, friends, work colleagues, community connections were noted as essential for building resilience in the face of adversity. Sisterhood and other networks within the community were highlighted as indispensable support systems during difficult seasons.

P23 – Probably the people around me for sure, my family, my friends. Even because for me, personally, I don't really talk about my feelings. If I do talk about my feelings, I need time to process it then I might come back a week later and then talk about my feelings. But also identifying that person that I know that they're supporting me. So, the same kind of way that people always say like it takes a village to raise a child and all that sort of stuff, it still takes a village to kind of raise and help an adult human being.

P11- Sister hood. Friends, I have uhm, dysfunctional family relationships. So, my family, the chosen people are my, they're my friends. If I'm being honest, not the same but I can't begin to explain how powerful this inner sisterhood with other women who can hold space for you, you know, is I'm all about that.

Community centres and other functional spaces such as sports groups and after school clubs where people could congregate and connect with one another were also highlighted as important resources.

P2- Our community centre… people come even though they don't play dominoes, they come down to the club as a social wellbeing centre OK and they will travel with the club because it's a feeling of togetherness. Yeah, at least they feel safe and secure that if something were to go wrong. For instance, they lose it they will know that several people around them are their friends and will support and defend them there.

Mental health professionals, were also highlighted as an invaluable resource for enhancing resilience:

P4- during high school I had a, like a counsellor, they didn't call them counsellors, but it was like a counsellor, and she was black as well. Yeah, so that was nice because when I was telling her about my experiences she could understand and kind of like relate to that. So, I feel like that really helped. Uhm, I also did a self-esteem like workshop kind of thing that was cool kind of like uhm, the school sent us, like a bunch of girls like from school and that was kind of like helpful as well.

The narratives shared on the circles of support, community resources and other networks captured ideas around the various assets and resources that strengthened resilience.

4.3.2.3- Sub-theme 2: Gender and Intergenerational Perspectives on Resilience

Following on, even though there were shared ideas on the meaning of resilience and the resources at hand to enhance it, there were a number of unique perspectives shared regarding the evolution of resilience, where participants drew attention to some gender and generational differences in the definition of the term. For one there was a consensus among

female participants on how their views of resilience had changed over time, especially in relation to wearing the 'Strong, black woman' badge, and what that meant for their wellbeing. Some participants even preferred avoiding the term resilience and requested that alternative terms be used to address the concept. In their view, playing the role of strong Black women had led to the development of dysfunctional behavioural patterns that were a barrier to seeking mental health support.

P3- I saw how my mother lived to me she's a survivor, you know, worked hard, just get on with things, you know. Get on with things, and I think to a large degree, you know there's this, there's this stereotype about black women being strong.

P11 -My definition has changed recently because I always saw myself as being resilient. Yeah? When so many people say that to me, they use that word, but then I'd rather be, and I forgot the other word I've replaced it with now, but I'd rather be that. Because things are going to happen, so resilience is like so rigid. It's like you can't melt and you can't interact, if they aren't, what is going on for you? You can't see it almost; you just have to be this iron rod sort of strength. So, I think resilience is a bit of a, it's one of those words at the moment I don't think, I don't want to be resilient. I'm fed up of being resilient.

The difference in opinions shared across generations surrounding the meaning of resilience was also a significant finding. While the older participants commented on the lack of resilience among the younger generation, the younger participants were of the view that the shift in mentality was necessary to maintain good mental health. One older respondent stated:

P1 -These over here especially those born here, they've been born with more almost like a silver spoon in their mouth. So, it's that they don't know hard times, and that is why I feel the difference in that British way of life and the British culture, you can identify it more in young people and they do not have that resilience to fight back and bounce back.

One younger participant alluded to fact that the intergenerational differences in views on resilience led to guilt and self-stigma, which could be detrimental to one's mental health.

P4- Like an example of that is like when my grandparents would just be like, ' just snap out of it' yeah, like in regards to like depression or anxiety. And so, I think, kind of, I think maybe there's a little bit of kind of like a feeling of like weakness, especially 'cause like when I think about like what my grandparents have kind of done, like what they went through when they were like 18 years old versus like me like at, well I'm 21 now. But at 18 like, but what they went through was like so like possibly that traumatic and yet here I am like sad, yeah, I've got everything. So yeah, there's a bit of like kind of that stigma is kind of like wrapped with a little bit of like guilt as well within it.

Another younger participant, however, shared expressed a different perspective:

P10 – As a 3rd generation black British person, my generation is more accepting of mental health and seeking support. It used to mean you keep pushing even when you are tired. You just keep going. I saw my parents do it. They didn't have a choice. But now it means being able to ask for help.

These varying opinions on resilience in relation to culture and mental health indicated the multifaceted nature of the concept and provided fresh insight into the views held on the topic, within the Black African and African Caribbean community.

4.3.3. DISCOVERY 3: EXPERIENCES NAVIGATING MENTAL HEALTH SYSTEMS

Gaining insights into participants lived and vicarious experiences of mental health services, from both statutory and community led organisations was essential to identify the gaps and barriers to access as well as set a baseline to inform further recommendations that would be addressed in subsequent phases. At this stage, participants described their positive and negative experiences of mental health services, as well as that of others, and shared insights on how services were delivered in a culturally sensitive manner. Some respondents indicated that they had no issues when they accessed either statutory or voluntary mental health services and were quite satisfied with the level of support they received.

P10- But overall, I've had pretty positive experience like some, I've been in, been in and out of services since I was 18, so I've had lots of different therapeutic input. Some have been a lot better than others, but overall, I'd say it's been helpful just having that safe space and having that permission, and that nonjudgment and stuff.

P7- oh the GP was brilliant, absolutely brilliant because it was the same GP when my father passed away and then they recommended and got me through to the CBT. I know there was a waiting list, but it was good to go through the whole process and even though after three or four sessions I felt good, I completed my sessions.

Some services such as Birmingham MIND and Forward-Thinking Birmingham, were particularly praised for their culturally sensitive support.

P9- Forward thinking Birmingham have helped me as well. With Forward thinking Birmingham it's actually a community mental health support group that helps you.

Yet, some respondents spoke concerning the unreliability of NHS mental health services due to the long waiting lists and the gap in cultural sensitivity, which was still evident among white mental health professionals, whom they expressed, did not understand our backgrounds. In their view, one had to fight for support and a lack of knowledge on how the mental health system worked meant that you received no help.

P20- I got an Occupational Health discharge letter after six months of waiting and they said, you've been discharged from the support services. And I was like, oh, I've been discharged for what? So I

phoned them and I said, why have you discharged me and I'm a nurse as well, you shouldn't discharge me. Oh, someone said that you got discharged and it's done now. So, the books are closed then I got put back on the waiting list I think that's 2018 and now it's 2022 and I still haven't been seen. So that's my example and my experience of mainstream services.

Some participants also expressed their concerns surrounding the lack of Black therapists within the mental health system and how cultural barriers impacted the quality of treatment. Others voiced their frustrations on having to explain themselves, and the influence of their culture on their mental health, to therapists of other racial backgrounds.

P18- Ah, cos the truth is, it's one thing to have a professional, but it's another thing to have someone that understands you from a cultural perspective. And I think without that there's always going to be a disconnect unless you have a true appreciation for their skill set. There's always gonna be a gap anyway.

They referenced the 'BAME' term and how this classification lumped all minority ethnic groups, leading to a lack of appropriate support that catered to the specific needs of service users. Frustrations were also expressed by participants who had prior experience of working within the health and social care system, regarding the over-reliance on medication, especially for Black African and Caribbean patients, when other races were offered CBT and other forms of therapy.

P1- You have a black person and a white person come to you with the same mental issues. Straight away, you're putting the white person on cognitive behavioural therapy, counselling, and on the others, so why can't you do that with the black person? Why is it you have to go down the big Pharma route here straight away and have them drugged up to the eyeballs like a zombie?

One participant highlighted that though some professionals of other races could be said to lack cultural competence, they had also had negative experiences with Black therapists who were unable to provide the culturally sensitive support they would have hoped for:

P11- I don't know what the angle is for you, but it was a black therapist at the time. I've never wanted to, I don't like to say, as I said, the person that they first put me in touch with had no clue how to speak to a person who has experienced what I have experienced. Yeah so it was more taxing, as in I am doing emotional work for that person, and also trying to educate them because they have no experience of it.

On the other hand, many participants cited the lack of awareness that 3rd and voluntary mental health services existed, especially those that catered to the specific needs of Black African and African Caribbean people.

P6- I don't think there is enough awareness of the existence of these organisations that you are talking about. They might that I know they're there, you understand me, but yeah people don't really know. Yeah, they don't know about their existence, yeah.

Commenting on the availability of mental health support during COVID, interviewees shared their knowledge on publicity of help lines where people could call to receive support for their mental health. However, there was no mention of specialised services that catered to the needs of the Black African and African Caribbean population, who were reported to be at higher risk of death during the pandemic.

Nevertheless, there was a general awareness of the state of mental health service delivery, and even though there were mixed experiences shared, the consensus was that voluntary services were not doing enough to make their presence known within the community.

4.3.4 DISCOVERY 4- APPRECIATING OUR VALUES

Gathering information on the values, assets, and strengths within both the Black African and African Caribbean communities grounded the generative process of appreciative inquiry used in this study. The question of what works best within the community and cultural context was further explored at this stage. One of the most highlighted values was the sense of community and family, that existed within the Black community. Respondents noted that there was always the availability of community support in difficult times and shed light on how much value was placed on the relationships and connections within the community.

P14- most black communities are more collectivist and less individualist than at least the white communities and I think that's a good thing. So, there's more emphasis on everybody in the community pulling together. There's more of an idea that if you're doing well, you will support other people. If you're struggling, you get support from other people or you will expect to be able to get support from other people.

The discipline of hard work, personal empowerment and other achievements were sources of pride, which many agreed had been fostered from a young age.

P7- It always pleases me when I see the success stories of the young black people and we have to always remember. It's within the midst of adversity, it's adversity so nothing is given. Parents used to say you know you're gonna have to work twice as hard to get there.

The role of faith and spirituality also came up many times. Even though there were a few reservations made concerning the way the church and other religious bodies addressed mental health within the community, it was still acknowledged that where other institutions were absent, these faith groups were present to offer support in areas that were not directly

related to mental health. Therefore, religion and spirituality still had their place in fostering a sense of community.

P6- Church is one place that I found out that uhm people socialise. People make friends. People get connected, a lot of people do uhm, they get help from the church. The church is one big place that, you know where black people get support.

Discussions also centred around some other elements of culture that held value within the Black community, such as music, arts, sports and how these promoted health and wellbeing. Music and arts were said to be important because they helped regulate emotions, especially spiritual songs, and acted as an expressive tool for Black people, where music and arts provided an outlet for sharing stories of resilience and promoted coping. Therefore, music and arts were not simply sources of entertainment, but were life-giving properties within the community.

P12 -especially with the music and drama that in itself; because messages can be expressed through the music, through the drama, through art. So, you know, and I think for those who can't express themselves verbally, you know can use these artistic messages to express themselves. And get that message across to the wider community….

P7 -music is massive, very important, and I think the music I'm talking about is the music with the stories in it. In Jamaica, we'd call it the roots music which there were certain groups that in their songs were talked a lot about African history, our heritage, valuing ourselves.

For young black people, it was a means of escape from bad vices such as drugs and gangs. Men particularly, had used sports as medium to speak about their mental health.

P9 -So the drama and acting can get a lot of youth, young black people away from doing bad stuff. There's also music. It's getting a lot of people away, young black people away from bad stuff. You know I'm saying it's just helping the youth. So, in the community, what drama and music does is it gives a vessel like something to for young people to do rather than go out and get into trouble.

The essence of community, love, support, and connectedness, all encompassed in food was a recurrent theme within both communities. For some, food was a language of love and support within the community and helped them to stay connected to their culture and roots. This narrative was particularly common among the African-Caribbean, especially the younger generation, who learned about the history of their culture through food.

P21 – I feel like with the black Community with food this is something that we use to kind of bring everyone together… Cause with me, I love when my family like oh this person is cooking, that person is cooking. Let's all get together and that kind of that in itself; just makes me feel better as a person being around my family and having their company and eating good food. So, I would say, yeah, that would play a big part in mental health.

P6- there is an adage in Africa that says that if food comes out of your daily challenge, then your problem is halfway solved. So, I'm not going to rule out the possibility of food playing a huge role in mental health.

P13- It reminds you of your tradition. Yeah, it reminds you of your culture and your tradition. I was reminded of my great grandma. I was reminded of so many people that have since moved on. When you sit down and eat those foods, those memories come back.

The final question, centred on appreciating what being Black meant to participants. There was a general feeling of pride around the things Black people have been able to achieve despite the oppression they have faced over the centuries. Taking pride in the colour of their skin, hair, food, and creativity was also an important part of valuing their identity. The influence of black culture on other cultures in relation to food, music, fashion, and lifestyle in general was also highlighted as one of the privileges of being of Black African or African-Caribbean background. The sense of togetherness, rich family dynamics and rich heritage found in the history of black people were also mentioned. For some, particularly those of African-Caribbean origin, remembering the journey of black people all over the world was one of self-discovery. In spite of all the history of trauma associated with slavery and years of discrimination, black people were still considered resilient and that was emphasised as an admirable characteristic of this community.

P23- We maybe only the minority within this area of the world but we've been the minority with the biggest shift in culture and the biggest impact on culture. So it's just kind of embracing that and kind of progressing with that and using that as a platform for yourself.

P16 – Let's start with the colour. I love my skin colour. I love my hair. I like the black culture. I like our history and I like our sense of humour. I like our creativity and the fact that we're you know, smart, bright people. Yeah, I love everything about being black.

P7 -The rich, the rich heritage, the rich heritage. Yeah, the resilience. As I keep saying, the resilience. I mean you know sometimes it brings tears to my eye, but I think in a way it's tears of joy and I think wow, what you people went through for us. So, we, you know we can go back just to my parents, my grandparents, my great grandparents, and then into slavery. What those people sacrificed because they wanted to keep the trail going, you know.

Ultimately, there was a general sense of pride shared across board on the value of Black identity. The ethos of the discovery stage, which seeks to highlight the life-giving properties within a group, organisation or community was further explored through the discussions had in this phase. The application of a critical appreciative lens allowed for the acknowledgement of both the negative experiences within culture and mental health, in addition to the exploration on what works best within Black African and African Caribbean communities. A

further evaluation of the findings of this phase in relation to the literature will be discussed below.

4.4 DISCUSSION

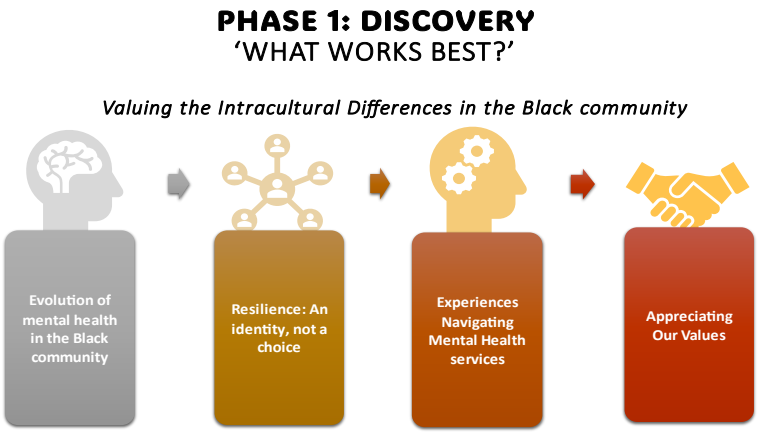

Figure 7: Summary of Discovery Themes

This first stage of the appreciative inquiry process, sought to identify cultural values in the demonstration of resilience, strength and coping abilities that foster mental health and wellbeing among Black African and Caribbean communities in Birmingham. Laying the groundwork for the rest of the appreciative process, the Discovery stage offered a starting point for the affirmative narratives that are at the core of the AI process. A critical appreciation of the life-giving properties intrinsic in the cultural values and beliefs represented within these communities was juxtaposed with discussions around the barriers and facilitators to accessing culturally sensitive mental health services. The significance of the Discovery stage is further discussed along with other key findings from this phase.

4.4.1 The Discovery and Appreciation of 'what works best'

Integral to the Appreciative inquiry process is the notion that every organisation or group has something that works and fuels the success and effectiveness of the systems at work (Cooperider, Whitney and Stravos, 2005). In identifying what these life-giving systems were

within the Black African and African Caribbean community, the Discovery phase was successful at bringing to light the affirmative narratives that existed around cultural values that fostered resilience and enhanced mental health and wellbeing. Sharing diverse perspectives on the meaning of resilience and the significance of the various resources and assets available to nurture these strengths and coping abilities, it was evident that the transformative power of the experiences discussed was grounded in a sense of cultural identity and pride. Similar findings are seen in a more recent study by Dey (2022) on the use of AI to understand resilience processes and identify cultural resources within refugee communities in India wellbeing, where the use of affirmative questions was instrumental for acknowledging the value of family support, faith, and spirituality, cultural traditions, and values as well as community networks in fostering resilience. One other noteworthy contribution of the discovery phase lies in the recognition of the evolution of mental health within the Black community in terms of the changes in mindset and acceptance of the realities surrounding mental illness. It was evident from discussions that there was an appreciation of the efforts being made to promote mental health and wellbeing through diverse initiatives implemented within the community, and even though there was still much work to be done, there was a sense of hope for the efforts being made.

The appreciative process also requires a conscious recognition of the participants' interactions with the multiple systems present within the research setting (Graham and Ridley-Duff, 2013). Thus, providing the space and opportunity for participants to present their multiple realities during this stage was key. In line with the constructionist principle, which states that words create and shape our perception of the world around us, this discovery stage shed light on insights such as those shared on the complexities around resilience within the Black community. By sharing both positive and negative narratives, the discovery phase drew attention to the impact of history, culture, socioeconomic as well as political factors in the shaping of participants' realities and unlocked new perspectives which facilitated the generative process (Bushe and Kassam, 2005). Connections such as those drawn between resilience and stigma, for instance were unexpected findings that may have been missed if a rigidly positive AI approach was taken. Nonetheless, in maintaining an appreciative line of questioning, the discovery phase facilitated an understanding of the cultural values, strengths and assets that facilitated resilience and coping abilities within the Black African and

Caribbean community. Collectively, these generative dialogues facilitated the process of co-construction of ideas and visions to be explored in subsequent phases of this study.

Gaining insights into the distinctiveness in narratives around cultural values between Black African and African Caribbean groups was of particular interest within this phase. The culturally sensitive nature of this study called for a strategic approach that shed light on the intracultural variations in lived experiences within the various ethnic groups, which according to Campinha-Bacote (2019) is essential for gaining a nuanced understanding of the cultural beliefs and values that are pertinent for promoting culturally sensitive healthcare. The Discovery stage of this critical AI framework thus encouraged a balanced appreciation of both negative and positive narratives around mental health promotion, resilience, and cultural values. This also offered a more holistic and constructive starting point for addressing the issues surrounding health inequalities and culturally sensitive mental health service delivery.

4.4.2 Defining Mental health and Mental health promotion.

One of the assumptions of Appreciative inquiry, as posited by Hammond (1998), is that the language we use creates our reality, and as the study progressed, the intersectionality within the various perspectives shed light on the similarities in the conceptualisation of mental health and mental health promotion. The ideas highlighted in the first theme on the evolution of mental health within the Black community offer new perspectives to the conversation on mental health promotion within this community. Public opinions and attitudes towards mental illness have significantly improved over the last decade, and with the advent of social media, there is even more widespread awareness on the support available (Time to Change 2023 National Attitudes to Mental Illness survey). Pointing out the influence of celebrities and public figures had had over the last decade in debunking mental illness stigma, participants shed light on how the openness of some Black celebrities had encouraged more dialogue around the subject. In studying the significance of Black Celebrity Twitter conversations on mental health promotion, Francis' (2021) analysis of an American Celebrity's (Cudi) public disclosure of mental illness brought to light the potential of celebrity disclosures via social media to reduce stigma and increase mental health advocacy. The author particularly highlights such media has been instrumental in the debunking of toxic masculine narratives

around willingness to discuss mental health as well-known celebrities such as Kanye West and Jay-Z have shared their experiences of mental health through their music. Gronholm and Thornicroft (2022) share similar insights and go ahead to provide recommendations on how the use of more culturally sensitive messages has facilitated the alleviation of mental illness stigma. Much of the research surrounding mental health in the Black community currently focuses on issues surrounding stigma and poor access to services, with very little evidence available on the wealth of knowledge that already exists (Bojang, 2021). Though the subject of stigma came up often even before the subject was broached, participants were quick to share how their own experiences of mental health problems had helped them tackle self-stigma and develop more empathy for others who lived with mental illnesses. Many went on to share how their experiences had helped them advocate more for open dialogues around mental health and these thoughts and ideas were carefully considered for further development in the dream stage (Phase 2) of this study.

Discussions around the awareness and impact of mental health promotion within the Black community showed that though participants believed that there was an increase in such initiatives within the community, many of these programmes were generic and lacked cultural sensitivity. The one size-fits-all approaches for racialised communities that had been frequently used lacked the depth needed to accommodate the diverse cultural needs represented as well as address the multiple socioeconomic and systemic issues that impacted mental health within the population (Fraser et al, 2002; Codjoe et al, 2021; Ellis et al, 2022). Participants were of the view that culturally adapted mental health promotion initiatives required the use of strategies that fostered inclusion of relevant stakeholders in the design and development of such projects. These findings corroborate those from other studies that have suggested that having sufficient knowledge of the lived experiences of the population of interest was essential for ensuring sustainability of such initiatives, and this could only be achieved through long-term partnerships with community members (Mantovani et al, 2017). Together, these results provided important insights into the various interpretations of mental health and mental health promotion within the Black African and African Caribbean community and painted a picture of the perceptions around the state of mental health promotion within these communities. The generative dialogues that were initiated at this

stage also set the foundation for further discussions on how culturally sensitive mental health promotion could be developed.

4.4.3 Black Culture and Resilience: Deconstructing Resilience

The theme around resilience as an identity rather than a choice proved to be quite significant in this study. In sharing their definitions of resilience and in telling stories of how they had showed resilience in adverse situations, the goal was to appreciate the strengths and capabilities inherent within these communities, who had historically, been marginalised. Even though this was achieved, particularly with the identification of resilience resources and assets within the community that nurtured such strength, the narrative had a different angle. Multiple perspectives were shared on the subconscious development of resilience as a survival skill, often motivated by experiences of racism and discrimination that came with being Black. Many times, this need to remain strong and act normal in the face of systemic inequalities was said to account for low help-seeking behaviour, late access to mental health services as well as the culture of silence around mental illness. Thus, despite resilience being a protective factor against mental illness, it may also be the reason behind some of the issues around mental health in the Black community.

A few erroneous theories and assumptions such as those propounded by Kessler, (1979) and Neff (1985) have been proposed around Black resilience as a buffer against mental illness, which state that Black people are less susceptible to risk factors of mental illness because they face more adversities. Others like Williams & Harris-Reid, (1999) intimated that as result of the presence of protective factors such as family support and faith, Black people had super-coping ability against various stressors. Such oversimplified theories have the potential to gloss over the external factors that necessitate such super-coping abilities and perpetuate the disparities that communities such as Black Africans and African Caribbeans face in accessing mental health support. Such conical views on the culture of specific ethnic groups turn a blind eye to the multifactorial influences and the social realities surrounding health and wellbeing within minority ethnic communities. They perpetuate negative stereotypes and promote

blanket explanations that gloss over the barriers that the very same culture may present to healthcare access and service delivery (Muaygil, 2018).

Scholars such as Franceschelli et al (2017) offered a different perspective on the development of resilience within Black communities, stating that resilience began from the home, where parents consciously nurtured their children to anticipate the challenges, they might encounter because of being black. This was evident in some of the responses shared, where participants highlighted that they were informed from a young age that they needed to fight to remain relevant in a system where Black people were not accepted. Many shared stories on how their forebears had fought racism and discrimination when they first migrated to the UK, and even though decades after, many had integrated within the system, they still found that they had to pass on these survival skills to their children.

Another layer of the narrative around resilience was in relation to the gender and intergenerational differences in opinions on resilience. The debunking of the 'strong, black woman' narrative for instance, was one narrative that was shared by all female participants, demonstrating a paradigm shift in attitudes towards resilience. According to participants, Black women were no longer interested in being addressed as 'strong black woman', because of the otherwise detrimental effect it had on their mental health and their ability to seek help. Donovan and West (2015) have shed light on how the strong, black woman narrative works to influence one's perception of self and others. In their study, they found that the endorsement of the strong black woman tag was positively correlated with stress, depressive symptoms, and mental distress, in line with findings from studies by other researchers (Lewis and Neville, 2015; Carter and Rossi, 2019; Graham and Clarke, 2021). Across the various age groups represented in the sample, there was a shared concern about the toxicity of such preconceived notions regarding women of Black ethnic origin, with some of the women sharing experiences on how such beliefs affected the quality of care they received during childbirth. They cited how notions around higher pain thresholds in Black women led to some receiving less attention, evidence of which has been documented in other studies (Knight, 2020; House of Commons Committee Report: Black Maternal Health, 2023). The need to address such microaggressions and racial stereotyping in the delivery of both physical and mental healthcare services cannot be emphasised enough. As evidenced from these findings,

tackling such implicit biases through cultural competence training, co-designed with the relevant stakeholders should be a priority for policy makers and practitioners.

On the other hand, among Black male participants, while discussions around resilience centred on strength and masculinity, the negative impact of this identity on mental health was addressed. In their opinion, having to be a mentally strong figure meant that any show of mental and emotional weakness was accompanied with notions of femininity and fragility, and thus the resultant hyper masculine identity limited openness around mental illness. Coping and 'keeping a stiff upper lip' in the face of difficulty was, therefore, a more socially acceptable approach to dealing with emotional difficulties rather than the display of vulnerability and weakness that is purported to accompany help seeking. This is in line with findings from various studies such as that conducted by scholars over the last (Sanders, Thompson, Bazile, & Akbar, 2004; Watkins & Neighbors, 2007; Meechan, John and Hanna 2021). These studies concluded that since society's expectations of masculinity did not fit within the constructs of mental health, many Black men failed to seek help for mental health problems, often leading to late access that many times, involved crisis teams and the police. Hammond (2012) additionally attributed poor help seeking behaviour among Black men to their past experiences of racism and cultural distrust. These are valid concerns also identified in various studies, and further obscure access to mental health and wellbeing support within this population (Memon et al., 2016; Mantovani et al, 2017; Public Health England, 2018). Seeking to re-examine the concept of resilient communities within a socio-political context where resilience is a natural response to systemic inequalities is key to responding to some of the long-standing queries around cultural competence in service delivery.

The differences in opinions on resilience between young and older participants was also a noteworthy finding, highlighting the presence of intergenerational tensions surrounding the subject. While elderly participants were of the view that the younger generation of Black African and African Caribbeans lacked the mental fortitude to endure hardships, younger participants (18-25) argued that the hardships faced by their grandparents had only paved the way for them to experience a better life, which allowed them to be more vulnerable about their mental health. A few scholars who have examined the influence of acculturation on intergenerational tensions in immigrant families (Choi et al, 2008; Albertini et al, 2019; Lui and Rollock, 2019) have mainly focused on the impact of these conflicts on antisocial

behaviour and mental health. However, there is not enough information on the intergenerational gap in resilience particularly among Black African and African Caribbean communities in the UK. Future research may benefit from investigating the influence of acculturation and Black British culture on resilience across generations.

4.4.4 Stigma, the culture of silence and its impact on service use

The culture of silence around mental health and mental illness influenced by a lack of knowledge on the aetiology of mental illness was frequently addressed. The stigma surrounding mental illness, which was said to be grounded in various cultural and religious beliefs also greatly impacted on help-seeking behaviour, as a result of the implications surrounding the disclosure of a mental health diagnosis. Mantovani, Pizzolati and Edge (2016) shed light on some negative implications of the disclosure of mental health diagnosis within Black African and African Caribbean communities. The first effect is the social stigma which is often based on cultural and religious beliefs that some spiritual underlying causes, such as obeah/witchdoctor (African-Caribbean) or juju (African) is the reason for such a diagnosis, which may lead to some form of religious intervention which could often end in abuse. The second implication is that this culminates in fear that drives the silence around any conversation around mental health, due to these misconceptions surrounding the modes of contracting mental illness. This eventually leads to an increase in prejudice and discrimination from family and the community and increases the associated risk of social exclusion that may come along following a person's diagnosis of mental illness (Corrigan et al, 2004; Ahmedani, 2011). All this, feeds into the vicious cycle of disempowerment and consequently, low help-seeking behaviour for mental health issues, among Black African and African Caribbean communities, as alluded to in this study. Mantovani et al (2016) referred to this maladaptive cycle of stigma within these communities as interconnected and mutually reinforcing, leading to poor outcomes and lower quality of life.

Racial and systemic discrimination were also said to be responsible for some of the stigma that still exists around mental health within the Black African and African Caribbean communities. Participants were of the view that owing to some preconceived notions held by

other races about Black people as an inferior race, openness about one's mental health would only validate such erroneous beliefs. In one respondent's opinion, encouraging Black people to talk about their mental health could cause more harm than good to the strength of the community, and their words, ***if it's not broken, don't fix it (P17)*** indicated that such disclosure only opened them up to more acts of systemic racism. Wallace, Nazroo and Becares (2016) and Spotforth et al (2021) demonstrated in their research that the fear of racial discrimination alone, was enough to have an accumulative effect on the mental health of people of minority ethnic background. Other stereotypes such as highlighted by Yorke et al (2016) in their review, showed that there was a high probability for Black African and African Caribbean mental health service users to be misunderstood, citing the use of gestures and animated speech, which is common among Black African and African Caribbeans as an action often easily misinterpreted for aggression. The probability for mental illnesses such as schizophrenia to amplify these already extroverted behaviours may also be heightened leading to the often-brutal nature of mental health crisis intervention experienced by Black people (Maclean, Campbell and Cornish, 2003). The consequence of this feeds into the cycle of fear that Keating speaks about, which continues to affect help-seeking behaviour when it comes to mental health and wellbeing among these communities (Keating 2002; 2021). Evidence that many services lack knowledge on how cultural values and beliefs differ from community to community, and how these influence expectations around resilience, coping, treatment, and recovery is demonstrated in the 'one size fits all' services and policies designed for racialised communities (Bhui and Rudell, 2002; Arday, 2018). The services made available to racialised communities are thus ill-fitted for their needs and a culmination of all these factors leads to poorer health outcomes (Dein & Napier, 2008; West Midlands Mental Health Commission Report, 2017). Until such concerns are effectively addressed, and services transformed to meet the needs of the Black African and Caribbean communities, policy makers may continue to go in circles trying to fix problems that are still deeply rooted in structurally discriminatory and racist socio-political systems (Keating, 2021). The complexities surrounding stigma and the culture of silence surrounding mental health in the Black community call for more comprehensive and culturally sensitive approaches to addressing this concern.

4.4.5 Appreciating culture, Valuing 'Blackness'

The poetic principle of appreciative inquiry alludes to the belief that organisations, or communities in this case, are a whirlpool of knowledge, and like open books, their stories of the past, present and future are sources of inspiration and transformation. Thus, the questions we ask and the things we choose to inquire into are fundamental to the generative process (Whitney and Trosten-Bloom, 2010). To this effect, an appreciation of the unique narratives shared on the cultural values, beliefs and life-giving systems that influenced health and wellbeing within Black African and African Caribbean communities was essential to the AI process. Hard work, family bonds and community, mutual empowerment, creativity and artistic expression, respect for elders, faith, and spirituality as well as cultural identity were all highlighted as some of the values that brought uniqueness to Black culture. Despite the dark history of oppression, discrimination and ongoing racism that has beset Black African and Caribbean communities, participants had many positive stories to share of how these values had spurred on hope and strength and led to many positive outcomes.

The indication of the church and other faith groups as both part of the problem as well as a solution is a topic that resonates throughout other research conducted on the influence of faith and spirituality on help-seeking behaviour among Black African and African Caribbean groups (Becares and Nazroo, 2013; Mantovani et al, 2016). Cowen (1991) also highlighted the role of community, society, and family in developing skills for competence and resilience that effectively foster positive mental health and wellbeing (Barry, 2001) and the AI process helped to identify these strengths and protective factors.

Reflections on ancestral connections, particularly by participants of African-Caribbean background, were shared with much pride as stories were told of how learning about their history had inspired much courage and perseverance. One participant put it like this "***I'm proud to hold my hand up and say yes, my ancestors were slaves but what they did for me so that I could be here today, you know is incomprehensible"- (P7).*** Others' stories on how their parents and grandparents had endured and survived various hardships have been theorised by some scholars as post-racial resilience and black resilience neoliberalism, elaborating on, and celebrating the exceptionalism and empowerment that is demonstrated by Black people both in the UK and the US (Joseph-Salisbury, 2018; Clay 2019).

The artistic creativity of Black communities was highlighted as some of the mediums through which stories of cultural heritage and traditions had been passed down. Pitt (2017) and Lordi (2020) shed light on the value of black arts and soul music and how they have shaped cultural sensibility and supported black pride and resilience and the global reach of Reggae and Afrobeat music for instance, are perfect examples. The positive correlation between food and health were also discussed extensively, especially in line with promoting family and community cohesion. The value of food was also linked to generational resilience, which aligns with evidence from research on the impact of black culinary history on fostering racial resilience and reducing inequalities (Theron, 2016; Navarro 2022).

The celebration of Black identity was explored within the context of self-discovery, and for many participants the journey of learning to love the rich heritage of their culture was one that birthed feelings of hope for the future. Despite the many negative experiences and adversities faced, there was an appreciation for the influence of acculturation, in the birthing of a Black British culture, which many felt had helped to foster a sense of belonging.

The findings unearthed in this Discovery phase drew attention to the power of positive narratives in shaping our understanding around how communities evolve in their interactions with the systems around them. These discoveries are crucial to transforming our knowledge on how people connect with each other and the society around them, particularly when it comes to evaluating the determinants of health among various populations.

4.5 CHAPTER SUMMARY

With the objective of exploring the cultural strengths, resilience narratives, and protective factors that contribute to the mental health and well-being of Black African and African-Caribbean communities , the Discovery stage was implemented in Phase one of this critical appreciative inquiry process. Using individual semi-structured interviews, this phase of the study engaged various participants across the West Birmingham area in sharing insights on the meaning of mental health and mental health promotion, resilience and knowledge on the cultural values that fostered mental health and wellbeing within these communities. In lieu of the regular deficit-focused approach, a critical, solution focused lens was applied to the

evaluation of mental health service delivery, with special interest in the barriers and facilitators in the delivery of culturally sensitive mental health care.

The overarching themes emphasised the process of evolution in the awareness and promotion of mental health within the community, the nuanced perspectives around resilience and its impact on help-seeking behaviour as well as the complexities of navigating mental health services. The appreciation of the rich cultural heritage present within the Black community juxtaposed against the negative impact of stigma and systemic discrimination encouraged critical and reflexive dialogues that facilitated the co-construction of knowledge around the realities of health inequalities in mental health. Even though some subtle differences were highlighted between the narratives shared by Black African and African Caribbean participants, for instance around the impact of faith and spirituality on mental illness stigma, many similarities were drawn in the narratives shared between both groups surrounding resilience, cultural values and experiences of mental health services. The findings from this Discovery Phase, laid the foundation for the design and development of Phase 2 (Dream stage) of this study. The affirmative dialogues generated within the Discovery phase initiated the process of change, which was developed in the Dream stage where participants were encouraged to share their vision, dreams, ideas and hopes for the future of mental health service delivery in the Black community. The generative, co-constructive process engaged in this phase was thus, pivotal in ascertaining the relevance of this critical appreciative inquiry framework as salutogenic approach to addressing health inequalities and promoting the delivery of culturally sensitive mental health services.

CHAPTER 5: METHODS AND RESULTS

PHASE 2: DREAM

"When it comes right down to it, the only way to face a crisis that makes any sense at all – is together. And the only direction to face – is up". – Phil Callaway

5.1 INTRODUCTION

The simultaneity principle of appreciative inquiry states that inquiry and change happen concurrently, thus, the questions we ask are fateful and have the propensity to initiate change from the onset of the AI process (Cooperider and Whitney, 1999). Phase 1 of this study, which aimed to explore the cultural strengths, resilience narratives, and protective factors that contribute to the mental health and well-being of Black African and African-Caribbean communities , therefore, set the course for this generative process. In implementing the Discovery stage of AI, the goal was to identify what works best and acknowledge the life-giving properties and systems present within these communities, which fostered mental health and wellbeing. In this regard, as participants were encouraged to share stories of resilience, strength and the connection to their cultural values and identity, their narratives also provided key insights into the different realities surrounding mental health, resilience, stigma, systemic racism, and its impact on help-seeking behaviour. The critical, yet affirmative approach adopted in this Phase fostered a generative, solution-focused process, where various ideas and resolutions were shared. Hence, the dialogues initiated in the discovery stage (Phase 1) of this critical appreciative process laid the foundation for further discussions in Phase 2, targeted at addressing health inequalities and developing ideas and visions aimed at improving cultural sensitivity in mental health services.

This 2nd phase of this study, therefore, addressed the Dream stage of Appreciative Inquiry, which facilitated the exploration of 'what might be', by encouraging those engaged in the AI process to share their hopes, dreams, visions and positive images and possibilities for the future of mental health in the Black African and African Caribbean community. Whitney and Trosten-Bloom (2003) were of the view that when people had the freedom to choose what they could contribute to the process of change, they were more committed to ensuring that

their contributions stimulated the growth they sought. This dream stage was, therefore, pivotal for positioning community members as equal partners and agents of change who could make meaningful contributions to the design and development of culturally sensitive mental health services. A number of studies have drawn attention to the lack of evidence on appropriate conceptual tools for evaluating the effectiveness of co-production models aimed at developing stakeholder engagement towards the alleviation of mental health inequalities, particularly in minority ethnic communities in the UK (Hatzidimitriadou et al, 2012; Lwembe et al, 2017). Even more apparent is the lack of evidence surrounding the use of salutogenic processes like AI in the development of culturally sensitive mental health service delivery, particularly in the Black African and African Caribbean community in the UK. The findings from Phase 1 highlighted the need for more holistic approaches to addressing the issues surrounding health inequalities. In view of AI's potential to offer this platform for further critical reflection on the possibilities for change, it was crucial to understand how the implementation of the dream phase could facilitate this process. In order to answer the research question aligned with Phase 2, the aim was , therefore:

To explore the process of engaging community members in the co-design of culturally sensitive mental health services that build upon the identified strengths and assets of Black African and African-Caribbean communities.

Guided by the anticipatory principle, which proposes that our present actions are shaped by our visions of the future (Cooperider and Whitney, 1999), participants from Phase 1 were brought together in focus groups and encouraged co-create positive images of the future of mental health as well as proposed actions and decisions that would guide the implementation of this vision. Grant and Humphries, (2006) and Ridley-Duff and Duncan, (2014) were of the view that the dream phase of a critical AI process ought to encourage participants to challenge the status quo by sharing ideas and innovative solutions which addressed systemic issues and other underlying inequalities in a bid to foster change. In view of the findings from Phase 1 which highlighted the pervasive influence of deeply entrenched systemic racism in shaping narratives around stigma, resilience and service delivery, the Dream phase sought to offer an empowering platform for participants to propose practical solutions to issues often highlighted as barriers to service delivery. In the sharing of stories that clearly resonated the lived experiences of the participants, there was already a sense of shared responsibility where

each person saw themselves playing an instrumental role in the change that was desired towards the transformation of mental health in the Black community. In bringing participants together, this Dream stage (Phase 2) fostered an environment for social interactions, leading to the creation of authentic connections towards the goal of co-production (Duncan and Ridley-Duff, 2015).

To gain a clearer perspective on how the AI framework was used to achieve the objective of this Phase, this chapter delves deeper into the methods of inquiry used to engage participants in this co-production phase. An overview is provided of the study design and justification for the use of online focus group discussions as the method of choice in this phase. Further details are also outlined on the recruitment process, particularly highlighting the importance of engaging the same participants from Phase 1 in facilitating the continuity of the AI process. Building on the themes from Phase 1 (Discovery), further insights are shared on how these findings facilitated the design and development of the interview schedule in this Dream Phase 2. Following an overview of the process of analysis and data synthesis, the findings of this phase are accompanied with a discussion on how best these outcomes addressed the objective of this Phase and the overall aim of this study.

5.2 METHOD

Following the gathering and analysis of data from Phase 1 of this study (Discovery) an interview schedule was developed from the themes generated from this 1st phase. Having made efforts in Phase 1 to establish trust with participants, which is fundamental to the success of any CBPR approach, (Becker et al, 2005; LaVeaux and Christopher, 2009), the next step was to engage participants in collaborative dialogues to generate creative insights as part of the co-production process. With prior information provided on how the proposals made at this stage would be fed back to service deliverers, participants were encouraged to partake in this imaginative yet critical exercise of envisioning the 3 top priorities that they would address if given all the power as well as full access to any resources needed to transform a mental health service. By capitalising on the strengths explored in Phase 1, the objective was to foster an environment for creativity and collective capacity, one that encouraged the

integration of cultural values and the leveraging of community assets in the co-construction of culturally sensitive mental health services. The priorities identified in this Phase were instrumental for evaluating how best service deliverers were currently meeting the needs outlined and identifying the gaps that service users felt needed to be addressed to foster the provision of equitable mental health delivery.

5.2.1 Sampling and recruitment

To facilitate the continuity of the AI process and further develop the ideas presented in the previous phase, participants from Phase 1 were invited to take part in online focus group discussions. Having been given prior notice of the full length of the AI process, participants were aware of the probability of being contacted for Phase 2 and had made commitments to attend, subject to their availability. Invitations were then sent via email to all participants who had agreed to be contacted during Phase 1, with details outlining date and time options and the mode of delivery which was the use of online focus groups via the MS Teams platform or Zoom. As a result of the noted preference for evening sessions during Phase 1, the online discussions were all scheduled for the evenings as well to accommodate the needs of participants. Participants were also reminded that their ideas and visions were going to be fed back to service deliverers and were therefore, encouraged to take part in this co-construction process to interact with, hear and respond to the ideas of others as well as have their own ideas discussed.

A total of twelve (12) participants eventually took parts in the four (4) distinct focus groups and though others showed interest, some last-minute dropouts affected the number of participants present in 2 of the sessions, where one group had only two (2) participants and another had (3) participants. These eventual changes did not, however diminish the wealth of information gathered during these sessions, and even though a larger turnout would have undoubtedly provided richer variety of perspectives, the insights shared were of great value to the overall study. The focus group discussions took place between the 11th- 24th of May 2022. A breakdown of the constituents of the various focus groups is provided below.

- Focus Group 1: 2 African, 1 Mixed (All Female)
- Focus Group 2: 1 Mixed (Female), 1 Caribbean (Male)
- Focus Group 3: 1 African (Female), 2 Caribbean (Female, Male), 1 Mixed (Female)
- Focus Group 4: 1 African, 2 Caribbean (All Male)

5.2.2 Data collection

The use of online focus groups was the most suitable choice for this stage of the study for various reasons. Whether conducted online or face-to-face, focus groups are a valuable qualitative data collection method that have been used to generate rich insights from research participants who come together to interact and share their various ideas in a collaborative environment (Morgan, 1997). Krueger (1994) states that focus groups yield the most favourable results when participants have similar ideas, and interests, making it more effortless to collaborate. They also provide rich data, generated from learning more about participants attitudes, opinions, and beliefs around the research topic, in a group setting where implicit social norms and cultural beliefs are exchanged (Hyden and Bulow, 2003; Massey, 2010). Over the last decade, there has been a substantial increase in the use of online platforms to conduct focus groups, and during and since the COVID-19 pandemic, it has become one of the preferred modes of conducting qualitative research (Flayelle, Brevers and Billieux, 2022).

As with face-to-face focus groups, there are a few advantages and disadvantages of online focus groups. Another noteworthy advantage of online focus groups is that it significantly reduces the time, energy and costs required as compared to operating face-to-face focus group discussions and this method of qualitative data collection also bridges the barrier of geographical disparity (Carter, 2011; Fielding et al., 2016; Flayell et al., 2022). On the other hand, one disadvantage is the challenge of observing body language during online discussions. Morgan (1996) drew attention to the need for the researcher to pay close attention to additional comments, body language and other forms of non-verbal communication that may occur within this setting in order to recognise any patterns or behaviour of interest. Though online focus groups may pose a disadvantage to the reading of body language such as

observing eye contact (Stewart and Shamdasani, 2017) there is still the option to go back and observe both video and audio recordings to identify some interactions that may offer new analytical insights which may not have been observed during the live sessions (Shelton and Jones, 2022).

Typically, face-to-face focus groups comprise of 4 to 12 participants particularly, with a moderator, often the researcher, who guides the discussion, and in some cases, an additional notetaker who supports the main researcher to record the exchanges (Krueger, 1994; Krueger and Cassey, 2009; Robinson, 2020). Lobe (2008) however, states that for online focus group discussion, the ideal number to maintain engagement of participants, allow in-depth discussions and reduce strain on the moderator/researcher is six (6). The proposed number was 4-6 participants for each focus group, with equal opportunities provided for all participants from Phase 1 to choose their group of choice. Allocation to the various groups was random and mainly based on availability, given the timing and context the study was taking place in. The choices were based on convenience but resulted in a good mix of participants in each group as different participants of different age groups, gender and profession were given equal opportunity to collaborate. Freeman (2006) was of the view that this heterogeneity promotes mutual understanding in groups and supports contributions from varying perspectives, all adding to the richness of data derived from focus groups.

As with face-to-face focus groups, the ideally proposed time is 60-90 minutes with the moderator responsible for managing the time and prompting discussions, while ensuring all participants have equal opportunity to share their thoughts and opinions (Stewart and Shamdasani, 2017). The posited time within this study was 90-120 minutes, with 2 hours being the limit to avoid the risk of participant fatigue and attrition (Gaiser, 2008). In-depth analysis of the conversational dynamics which occur within these settings give the researcher insight into delicate issues such as mental health, resilience, and cultural sensitivity, as discussed in this study, especially in research contexts that involve hardly reached groups.

The interview schedule for Phase 2, which was developed from the themes in Phase 1, utilised affirmative questioning in encouraging participants to share their ideas on the future they envisioned for mental health and service delivery in the Black African and African Caribbean community. A menu of priorities was presented to participants, drawing from the themes on

the evolution of mental health within the Black community, the nuances surrounding resilience and help-seeking behaviour, the value of cultural assets and identity to mental health as well as the impact of systemic racism on mental health and service delivery. With the added option to present ideas not already listed, participants collaboratively engaged in discussions around the potential avenues for integrating cultural values and assets into mental health services, the need to reconceptualise resilience narratives to foster help-seeking behaviour and the potential pathways for promoting mental health across generations. As part of the co-construction process, participants were also encouraged to reflect on their personal responsibility in fostering open dialogues and alleviating the stigma around mental health in the Black African and African Caribbean community.

5.2.3 Data Analysis

As in Phase 1, data from Phase 2 was analysed using both inductive and deductive thematic analysis, where a codebook was generated, and further analysis subsequently undertaken using NVivo. The initial codes generated were discussed with my supervisory team to further evaluate the significance of the data in line with the themes. Regarding data saturation in focus groups, Cron (2020) states that this occurs when no new data is gained from participants interactions or no new codes emerge from the repeated analysis of interviews. Following repeated analysis of data from all four focus groups, it was determined that saturation had been achieved when no new themes emerged. **Five (5)** overarching themes, classified under the title 'Priorities' to reflect the nature of discussions from the Dream stage (Phase 2), along with sub-themes were eventually derived following an in-depth thematic analysis. Excerpts and quotes are provided to offer insight into the nature of discussions and interactions generated at this stage. The results presented below provide further insights into the ideas and visions presented during this phase. They further emphasise the value of the AI process as an effective framework for engaging community members in the design and development of culturally sensitive mental health services for the Black African and African Caribbean communities in Birmingham.

5.3 RESULTS

The results from these four focus group discussions present insights into the rich creativity and co-constructive capacity that the Dream process of AI fostered among participants as they shared visions and aspirational ideas for addressing the concerns raised surrounding stigma, service delivery, resilience, and the place of cultural values in mental health service delivery. Following a short reflexive exercise at the beginning of the sessions to validate the themes from Phase 1, participants were presented with a hypothetical scenario, where they were given the opportunity to run a mental health service within the community for a day, with full access to all the power and resources needed to make significant and impactful changes. With the options to choose 3 top priorities from a menu of proposals generated from Phase one, as well as share any new perspectives, they presented their visions for community with a particular focus on transforming leadership, leveraging community assets, and alleviating stigma through increased mental health education. The collaborative co-creation of knowledge that this Dream phase fostered was evident in the enthusiasm with which participants developed each other's ideas, which led each focus group to pursue and discuss a range of practical solutions. In **Focus group 1**, there was an emphasis on ensuring that leadership and staff were representative of the Black community, especially with the inclusion of people with lived experience in the decision-making processes. **Focus group 2** emphasised a holistic, community asset-focused approach to health promotion towards removing the barriers around mental illness stigma, where support was brought directly to the community through the use of community spaces and mobile clinic. As one participant put it ***"if Mohammed can't go to the mountain, the mountain must go to Mohammed" (FG2.P1).*** **Focus group 3** took on a more 'professional' theme, where most of the conversations revolved around dealing with systemic racism at work and how service providers could support black professionals. **Focus group 4** is noteworthy because it took a socio-political tone, as the men discussed solutions to address struggles of black masculinity, having to live a defensive lifestyle in the face of racism and building a legacy for posterity. At the end of the discussion, one participant commented on how this brief discussion provided a safe space for him to relate with other likeminded men. He stated: ***FG4. P1- 'This, this was therapy. This was definitely therapy'.***

Perceptibly, the common tone adapted within each focus group could likely be linked to the effect of group influences and social desirability biases (Bergen and Labonte, 2020). However, one of the advantages of focus group discussions is the richness and depth of data obtained that comes because of the group's diversity and the nature of interactions. It was evident that these discussions brought about inter-subjective reflections of the social realities and lived experiences of participants, all encompassed within a generative presentation of ideas and dreams. A summary table is provided to give a general overview of the various priorities, visions and ideas shared towards the co-design of culturally sensitive mental health services.

5.3.1 PRIORITY 1: LEADERSHIP AND STAFF FOR AND FROM THE COMMUNITY

The first priority proposed was towards the transformation of the leadership and staffing structure of mental health services, with a special focus on including members of the community with lived experience of mental illness in the executive bodies of the various organisations. The suggestion to increase the representation of members of Black African and African Caribbean communities in managerial and decision-making structures of these services was prompted by the knowledge that the lack of diversity on leadership boards was linked to the lack of cultural sensitivity in services.

Further insights shared about cultural sensitivity were attributed to the lack of staff who effectively represented and respected the values of the communities they served. Though there was an honest appreciation of the measures being taken to increase mental health nurses and other staff from the Black community, one of the main concerns was that many of these staff still remained in entry and intermediate level positions, and still had no scope of influence in the decision-making process. There was, therefore, the need to re-evaluate the leadership structure of mainstream services, not simply as a tick box process to demonstrate equality and diversity, but to truly meet the needs of the communities being served. One participant described her point saying:

FG1. P3- …kind of how I describe the NHS and how other people describe it. It's kind of like, have you seen a like a pint of Guinness that's being poured. So you've got like all the black and Asian people kind of lower down and then like the white frothy layer of management of kind of like white people

and that's kinda like how lots of services are run, whereas it would be great to have leadership from the community as well and that management as well.

Participants drew attention to the need to do away with what one person referred to as **'the token black person'** mentality where only a few staff of Black ethnic origin were included in staffing structure to satisfy equality and diversity requirements. In their opinion, the intercultural diversity that exists within the Black community still needed to be recognised, where one person did not become the voice of all Black people. One participant shared their personal experience:

FG1. P1-it's important that the representation is on all levels because even sometimes in my service I feel like I'm talking for the whole of the black community and I don't think that's possible as well. So you know, I only represent my particular experience, but if you're like the authority on that part of the community, you know, if there was other people from, you know, the similar culture to myself, you know…. I can't, I can't represent everybody.

The inclusion of community members with lived experience of mental health services, either from a caregiver or service user perspective was particularly pointed out during the various discussions. One participant highlighted that this inclusion criteria was to begin right from the recruitment process for both executive and non-executive positions in both mainstream and voluntary sector organisations. They commented saying:

FG2.P1- And I was thinking about the idea that with the leadership to me, if you know, you're steering this ship so, so important that the Community kind of give you, the go ahead so that you can represent them because you're making these big decisions. So I think maybe some way where you can have people that have access to services in the past etcetera and they are involved in making the decision of who actually gets to be in the leadership position…. The real people who've got these mental health challenges, had these issues, used services in the past, got positive experiences, got negative experiences. You know that they kind of yeah, give them the thumbs up.

This led on to conversations on staff recruitment and the need to prioritise recruiting more staff from Black African and Caribbean backgrounds, especially in areas where the population of Black people is relatively higher. One participant highlighted that it was important that more considerations were made to match the ratio of Black mental health personnel to service users within these areas. His thoughts are shared in the following excerpt:

FG4. P1- So it will be good to just maybe have a ratio where depending in the area where the facility is just saying, you know, OK let's try and maybe aim for recruiting more, you know black, we could like you know, you can recruit agents these days if there are more black people, just recruit agents, staff to come and help out. I think that that does help in the long run. People open up.

Still on the topic of recruiting staff who represent the community, there was an emphasis on

the need to improve recruitment processes and the mode of publicity of advertisement. One respondent stated his opinion in these words:

FG2. P1- If all the money has been given, the starting point for me is the whole issue of recruiting the right people to assist, enable and empower. And that comes down to publicity that comes down to where are you going to put the adverts in order to recruit these people that are actually out there and could make a difference, that is not the Observer, not the Guardian, not the times, but going for what I see as the papers read more so by the black community, such as The Voice Newspaper, The Jamaica Gleaner, The Phoenix Newspaper, Carib Direct.

There were yet still, a few reservations expressed regarding the recruitment of staff of Black ethnic background as some respondents were of the view that even with the recruitment of mental health personnel from within the Black community, there was no guarantee that these staff would be culturally competent and sensitive to the needs of the communities they served. In summary, cultural matching did not always guarantee cultural competence. One participant expressed their thoughts saying:

FG1.P1- Just because people are from the community doesn't mean, 'Oh my God, you got the same skin colour so you're gonna, you know, you're the best fit for the role. It doesn't go like that'.

In view of this, participants advocated for selective recruitment of well-trained staff who are passionate about their roles and aim to assist and empower the people they serve. They emphasised that mental health service deliverers should scrutinise the attitudes of staff and that close monitoring and appraisal of services could be conducted periodically to ensure services were up to standard.

5.3.1.1 Enhancing Staff Cultural Competency through Training

The dialogue on recruitment and the representation of the community fed into the subtheme of developing cultural competence in service providers through effective training with suggestions made towards allowing professionals of other racial backgrounds to shadow black professionals who could provide better perspectives in various areas of service delivery. One participant was of the view that some of the 3rd and voluntary sector organisations were ill-equipped to deliver culturally sensitive mental health support to Black communities and that Black led organisations, who had knowledge of the community's cultural values and needs could facilitate such training. They stated:

FG4.P2-the non-black need to go on some culturally appropriate, not necessarily sensitive appropriate training be so that even if somebody who's black shadowed them when they were doing

the work. So, they could even relate and say well, you're actually mistaken his behaviour there. This is a pattern; this is a cultural thing.

Evidently, transforming leadership structures, promoting inclusive recruitment of staff, the inclusion of community members with lived experience of mental health and training in cultural competence were major priorities proposed towards the enhancement of culturally sensitive mental health services. Special emphasis was placed on the need to streamline recruitment to include more practitioners of Black African and African Caribbean backgrounds within various levels of healthcare organisational structure as well as provide efficient organisation wide training on cultural competence. Despite the nuanced perspectives on the risks of making assumptions that cultural matching translated to cultural sensitivity, there was a broad consensus that Black mental health professionals could play a pivotal role in advancing the agenda for increased cultural sensitivity in service delivery.

5.3.2 PRIORITY 2: HOLISTIC COMMUNITY-ORIENTED SUPPORT

Another priority that was proposed was the need to encourage the use of innovative techniques to promote more holistic approaches to the promotion of mental health and wellbeing, where both physical and mental health were advocated for with equal commitment. This meant advocating for initiatives that offered community members equal opportunities to access a range of non-traditional healthcare support, such as social prescribing, to encourage access to services. Bringing services to the doorsteps of communities was considered a sure way to break the barriers to access and promote inclusivity and community engagement.

Owing to the stigma attached to mental health and help- seeking behaviour within the Black African and African Caribbean community, participants proposed that novel tactics be employed in creatively introducing mental health initiatives into the community, alongside other health promotion for physical ailments like diabetes, hypertension, and cancer. Another suggestion made to better serve the Black community was to promote mental health in non-health related spaces, for example pubs, salons, barber shops, churches, where there was the likelihood for more engagement. These mobile clinics, as they were referred to, could

facilitate holistic community-based health support by transforming informal settings into safe spaces.

FG2. P1- And if even if you don't want to put it under the guise of mental health, it's you just gonna come look at your health in general. So you covering the physical, you're covering the mental, you're covering the social you're covering the loneliness all of this…. trying to convince these people in terms of their mindset, which is why I say OK, if Mohammed can't go to the mountain, the mountain must go to Mohammed. So I'm not, I'm not into clinics and surgeries and GP's and hospitals. I'm into the rum bar, the hairdressers, the barbers, the places where these people will congregate and go and see them on their terms and places where they feel safe…

FG1.P3- I know they like started, you know, doing medication distributions and like, you know, in like mosques and churches and stuff to kind of help with that. So really realising that that's a really big part of our culture, like really big part of our community. So you know, don't exclude that, doesn't have to be a traditional, you know, GP surgery, why can't we be more properly community based as well.

These proposals led to discussions on the need to foster sustainable and equitable partnerships with community assets.

5.3.2.1 Establishing and maintaining community-based partnerships.

One strategy recommended to initiate these onsite health promotion programmes was to establish collaborations between mental health service deliverers and other community-based organisations. Encouraging partnerships between religious bodies, community centres, schools, sports clubs was considered pivotal in supporting efforts to break the barriers to early help-seeking and facilitate effective promotion of mental health. As in Phase 1, there were divided opinions regarding the role of the Black church, as seen in previous conversations where faith and religion was discussed as both a protective and risk factor for mental health, with many highlighting its influence in encouraging mental illness stigma. Participants in this phase were still of the view that even though the church played a crucial role in bridging the gaps where other services had failed, there was still much mental health training and education that needed to occur within this institution, as with other religious institutions. Within their priorities, participants proposed that they would ensure that religious bodies who offered healthcare support went through basic training for supporting people with mental health needs. In one respondent's opinion, the training of faith groups and other

partner organisations to be more sensitive to the needs of community members contributed to the drive to break barriers of stigma and promote early access to services.

FG3. P3- So again, if we had again meetings with these third sector and culture organisations where they had meetings with church leaders and they could discuss how to, discuss these things… in a way that would fit in with faith narratives as well. Because I think it does work. I mean most churches are happy to accept people having medical treatment for whatever illness they've got, so they should be able to accept people having mental health support as well.

For all these changes to be incorporated effectively, services needed to be open to change and stay resilient in pursuing all angles towards reaching these communities who have often been tagged as 'hard to reach'.

FG1. P2- I'm just thinking about resilience in terms of the services and the staff not giving up to reaching the community. You know, their hard-to-reach business like. Which isn't the right way to put it anywhere in the 1st place, but do you get what I mean is don't give up like it's they're not unreachable.

One participant linked this to the term historically neglected/ignored/excluded communities.

FG2.P2- a lot of people will think that actually it's people at the grassroots that don't want to change. But in my experience, it's actually people at the top that don't say, you know what I mean, it's not people at the grassroots will usually go along with anything that you chose that they got. They'll just go along with it, you know? But it's people at the top, they don't like change.

The recommendations addressed the need to adopt creative strategies for mental health promotion within the Black African and African Caribbean communities where mental illness stigma still posed a major hindrance to help-seeking behaviour. Taking into account that health inequalities affect both physical and mental health, the need to adopt a holistic, bilateral approach to mental and physical health promotion was considered as crucial to also tackling stigma and discrimination. Additionally, community assets could not be overlooked when it came to the rolling out of these initiatives, and the importance of equitable partnerships between mental health service deliverers and religious institutions who provided compassionate healthcare services was particularly highlighted. The goal was that as services made efforts to establish trustworthy relationships between themselves and community members, the gap in the delivery of equitable mental healthcare would slowly be bridged.

5.3.3 PRIORITY 3: IMPROVING ACCESS TO STATUTORY AND VOLUNTARY MENTAL HEALTH SERVICES

In view of the realities surrounding access to equitable and culturally sensitive mental health services within the Black African and African Caribbean communities, the imperative to increase the visibility of trustworthy, culturally competent services within these settings was particularly emphasised. Considerations for expanding treatment options were also suggested, with special focus on recognising the importance of Black cultural values and exploring options for integrating these values in service delivery. Building on from the conversation on the various experiences of mental health services in Phase 1, the proposals made here provided an outlook on how both statutory and voluntary mental health services could enhance the scope of cultural sensitivity in their delivery. One of the main concerns was that services, particularly voluntary services that offered services specific to the needs of the Black community, were 'invisible'. Coupled with the history of mistrust of statutory services, participants highlighted how this lack of awareness of the presence of these organisations could significantly reduce the motivation to access services in when facing mental health challenges. The need to increase visibility and publicity for 3rd and voluntary services, particularly those whose services were tailored to meet the cultural needs of Black communities, was pertinent. One participant stated:

FG3.P2- I don't know a lot of mental health services within the Birmingham area anyway, there probably is some, but I don't think that they are advertised. And I think that that's worrying cause like obviously I know a lot of you know there's, a lot of charities that are like for cancer. You know what I mean? You see that everywhere, but you don't see a lot of mental health services like being promoted, really. And I think that's the main issue.

One participant, who had previously been in contact with some of these organisations suggested a possible reason for the lack of visibility:

FG3.P4- And you know, I think what it is, because you know, all those organisations that you've mentioned that I know of them and it's like they yeah, they're all involved in doing projects or whatever, but the only time you will hear about them is if they're doing an event or you know an activity. But I think what they all need to do more of is say, 'We are here for the community'. And I think something more needs to be done on that because what's happening in the background, ain't nobody gonna see what's happening in the background….

Be that as it may, participants were of the view that even if there was an increase in awareness of these voluntary services leading to increased access, the responsibility of statutory services

to tailor their services to meet the needs of these populations was not absolved. These led to further discussions on the importance of expanding options for treatment and mental health support.

5.3.3.1 Diversifying treatment options

Participants spoke about the need to diversify therapeutic approaches, where choices for more creative and non-traditional evidence-based pathways to person-centred care were particularly encouraged. The integration of innovative treatment options using arts, drama, music and other cultural artistic expressions into patient care plans in addition to medication and talking therapy, where necessary were considered one of the ways to promote cultural sensitivity in services. Social prescribing or community referrals, which allowed GPs to signpost patients to other non-medical treatment options, such as gyms, gardening allotments, among others, were also encouraged as an alternative approach to promoting mental health. Indisputably, there was no 'one size fits all' approach to providing treatment for mental illness, however, the options presented were said to be essential for breaking down the stigma around the use of medication only for treating mental illness. In their opinion, medication had to be the last resort, or only be introduced in critical conditions where necessary.

FG2.P1-If I'm in this position, I've had all this money, drugs would be at the last resort. I would be saying get all of these patients, whoever they are, into cognitive behaviour therapy, counselling, your drugs should be… Drugs are seen, especially by these people who are administering it because they want control, as the be all and end all. I am opposed to drugs just for the sake of pushing needles in people or telling them take this antidepressant or so on.

FG1.P3- Well it needs to be, something that people can feel is inviting to them so it would relate to their interests, you know. If you get someone that really likes, I don't know, music then there's a music sort of option where they can do some sort of therapy in that way so it's not just like the old traditional, uhm academic kind of those established Western ways of doing things to do mental health.

Also, recognising the role that music, arts and drama played in our culture was key to enhancing cultural sensitivity within services.

FG2. P1- Well for me, music, dance, music therapy, dance, I'm saying all those things that are part and parcel of what our culture is all about have to be embedded in whatever action plan or treatment plan one is wanting to do. In particular Black people music is part, is in our soul. It's in our DNA. OK, so the gospel songs, the traditional African American spirituals, the Sankey's, the hymns or how we were brought up in the in the church and so on. We need to embed that in whatever therapy we're wanting to do with anybody.

By engaging with such inclusive approaches to mental healthcare, services would be demonstrating their commitment to promoting equitable, culturally sensitive mental health care for these communities.

5.3.3.2 Integrating the Black community's cultural values in Service Delivery

The proposals for wider treatment options aligned with further suggestions towards respecting the value placed on Black cultural norms and beliefs and seeing how best to integrate these values in patient-centred care plans. In Phase 1, when asked to identify some of the values inherent in the Black community which acted as protective factors against mental illness, participants discussed the importance of perseverance, hard work, respect, spirituality and faith, cultural identity as well as mutual support from family and community. There was initial hesitation and some confusion regarding the applicability of this question to service delivery and the priorities stated, but the general idea was that Black cultural values were not effectively represented in service delivery. Including families in care plans for patients, for instance was highlighted as an essential consideration in delivering culturally sensitive services. Even though the role of the family and community in perpetuating stigma was acknowledged, their responsibility in supporting the treatment and care of a family member was still considered invaluable.

FG4.P2- I think if you're looking at how it will come into play, it's about then the service user and the service user's family and actually feeling comfortable that they're, whether it's their relative who's in the sort of mental health circle is actually receiving the kind of care and attention that they deserve.

FG1.P3- I think it could be more integrating things like I think systemic therapy and looking at how those family relationships would be really helpful, but you'd have to do it in a way that was appropriate to our culture and like kind of having… cause black families are very different to white families, let's not, you know, beat around the bush. And I think if you tried to put it that way, they would recommend white families doing things on a black family, it wouldn't work. But then not the way that black families do stuff because it isn't always the most helpful for mental health as well.

However, there were concerns raised on how some of these values such as perseverance and hard work still perpetuated the resilience narrative and needed to be carefully considered to understand mental health and attitudes to health seeking behaviour within the communities. One respondent voiced her opinion saying:

FG1.P1- That's not what they're getting because of, you know, the fact that they belong to the black community this is a reflection of their experience. That's what I was just sat here thinking. And I think hardwork and perseverance. Yeah. Because, you know, that's the whole thing of they can't have the breakdown, they can't be vulnerable. You know, they're strong. Keep going. And I'm just trying to see if I if I think these values that I think that could be it that's quite toxic anyway. So I don't

really think that that should be like perpetuated in the services or to encourage that even more.

The ideas shared here demonstrated that multiple strategies needed to be adopted by both statutory and voluntary sector organisations to encourage the use of mental health services. Expanding the reach of voluntary services, particularly those who specialised in culturally tailored support for people of Black ethnic background was particularly encouraged as one of the solutions to promote help-seeking for mental health support. The integration of non-traditional, therapeutic treatment options through the use of artistic forms and other cultural expressions was also deemed as relevant to fostering culturally sensitive care in a bid to alleviate health inequalities. Regarding the integration of cultural values and beliefs into service delivery, suggestions were made towards a delicately nuanced approach that was open to discussing and accommodating the complex relationships between some of these norms and beliefs and their influence in enabling stigma. The need to carefully deconstruct some of these ideas fed into further discussions on how to address the impact of resilience narratives on stigma and help-seeking behaviour within the Black African and African Caribbean community.

5.3.4 PRIORITY 4: DECONSTRUCTING RESILIENCE AND CONFRONTING STIGMA

In Phase 1, the conversation on resilience revealed some interesting insights into the influence of what some participants referred to as 'toxic resilience' had on perpetuating stigma and discouraging help-seeking behaviour in the community. In exploring this theme further, several suggestions were made towards the re-evaluation and deconstruction of resilience narratives within the Black African and African Caribbean community. Before discussing some of the solutions to the issue of toxic resilience, some participants shared how these notions of super-coping among Black people extended to other healthcare providers such as in maternal health services. One respondent shared her experience saying:

FG2.P2 - You know, I've been in pain, and I remember this white woman saying to me, well, you don't seem like somebody who's in pain. Because they're looking for a certain behaviour and they're not seeing it. So they think, Oh yeah you can't be in pain, you know. And I think the same thing happens mentally, almost like, I think we're very used to just getting on with it. You know, no matter what and so you know, nobody pays any attention until you're kind of like collapsing.

Another participant shared how Black resilience was often misinterpreted to mean Black Africans and African Caribbeans were not sensitive and could deal with any form of mistreatment.

FG4. P2 - But I also think that in the West, they confuse our resilience with us not being sensitive, they think we can't be hurt because we've been through so much, it's as if to say ohh they're tough, they're tough. You know, we're human, we cry, we bleed everything else. But I just think that the resilience has been confused. You know, they confuse resilience with us being tough and insensitive. But as you say it's either we resilient or we give up and giving up isn't an option.

This viewpoint was also shared in the discussion on workplace culture and resilience, with opposing views on how showing resilience both enabled systemic racism and yet, was necessary to maintain professional decorum. Nonetheless, the varying opinions were shared by a male and a female, thus the gender differences are worth noting. This quote also further highlights the impact of the 'Strong Black woman' narrative.

FG3. P3 -But I think that misunderstands fundamentally what resilience is. Showing that something hurts you is not a sign of weakness. It's taken me a very long time to accept that. Somebody saying nasty things to you or being racist to you will hurt you because that's wrong. It's a very demeaning and dehumanizing thing to do, and I think as a community, for too many centuries, we've taken on, and yes, we've thrived through all that but at a huge cost to all of us. And then for me, the one thing I would like as a black person, as a black woman is to be seen as a fully human person, not a machine at work, just churning out efforts. Just like my white and other colleagues, I have emotions too.

FG3.P2 - Yes, like certain people are ready to take advantage like in the workplace, for example. Like there's still this, there's still racism in the workplace where it's just presented differently. And if we don't show kind of a strength like, OK, you're being racist to me does not affect me. But I think if you show kinda like that kind of weakness that is getting to you, then I think they'll just pick on, like they'll do it a little bit more.

These discussions led to proposals regarding how best service deliverers could provide support for Black professionals, especially outside of the workplace. Speaking on dealing with microaggressions and racism towards professionals of Black African and African Caribbean background, some participants suggested that services could provide after-work safe spaces for black professionals (modelling after-school clubs). These safe spaces could provide an outlet to share their thoughts on dealing with such difficulties within the workplace and in turn promote their mental health.

FG3.P3- You raised a point about working people and I was thinking about that probably this obviously as a working person. I think it would, wouldn't it be nice to have places for working people to go and offload all the nonsense you've probably dealt with during the day. And then I do wonder if there is a role for, I don't know like a Saturday club or something where you can get together under the guise or something else and just the chance for you to just offload about what it means to be a black professional?

Notwithstanding, the stigma surrounding mental illness still stood as a major hindrance to mental health service delivery in the Black African and African Caribbean community and the need to re-educate the community on mental health was pertinent. Initiating and normalising conversations in churches, community groups, in schools, pubs, salons on the topic of mental health were said to be a good start to breaking the stigma.

FG4. P3- I personally think that we need to normalise, like not normalise it, but kind of normalise like the fact that people in general, in life, black or white, Hispanic, Asian, anything you like? People will have mental have disabilities. Like people have mental health problems issues all sorts. So I think to put things into play, we need to just make sure that people can feel comfortable enough to come out and speak to their doctors or speak to their whoever's or speak to their families.

One respondent shared on how this could be achieved:

FG3. P4- So it's how could we do something like that in regards to starting the conversation around mental illness and, you know, they start to share and how they have done and how they may have worked things out. So, you know, not to trick them, but how to introduce it into the conversation. And so you get even the unlikely contributors start contributing because it's like, ohh, what's going on over there kind of thing. So yeah, maybe food is the way and over lunch and tea. OK, let's do this before you go back to your Dominoes, let's do this before you go back to your whatever, knitting, whatever it is, let's do this. So it breaks up the activity and it just builds that in.

This sparked conversations on personal responsibility and the role each participant could play or was already playing within their communities to break the stigma around mental illness as well as encourage others to seek early access to mental health services.

5.3.4.2 What do I bring to the table?

As members of these communities, participants acknowledged that accepting their responsibility to promote mental health and alleviate stigma was an essential aspect of the co-design process. Some participants shared examples of how they were already contributing their quota to improving mental health outcomes for others within their communities.

One participant shared on how a cycling group she had begun with a few friends had become an avenue for improving the mental health of other women.

FG2. P2- I've been running a cycling group for women for seven years now. So every Saturday morning at the Edgbaston Reservoir and unbeknownst when I started it, I started it because I just learned to ride a bike at the age of 50 and I wanted to practice. But unbeknownst to me, what it became was a place where people could talk about how they were feeling.

Another said:

FG1. P3- I'm a bit of a sign-poster in my network. There's lots of people that have been very reluctant to access counselling or various mental health support, but because in my personal life I have experienced the benefits of it and now working mental health. So I guess that is equipping them with the things that they didn't even know were out there and also being authentic and saying, you know, I've had my struggles. And this is how I dealt with it. And yeah, I'm resilient. Yeah, I'm this and that. But these things outside of myself have supported that.

Other participants discussed their need to be catalysts of the change they wanted to see, and pledged to be more empathetic, seek out services where they could signpost others for help as well as be open about their own mental health.

One respondent stated:

FG4. P1- I think making that as a personal kind of contract with yourself. I'll put it that way to say, OK, for me, I'm determined to change the course of things. If there are issues, I'll talk about it. If I'm not well, you know, I'll say, you know, just give me a few moments, I'll go to the park, run or something just to get things back in balance. Yeah, there's no need for bravado.

The vision was that if other people were more open to sharing their experiences either through conversations or other creative outlets, the shame that encompassed mental health would cease to exist and people would be more open to seeking help.

FG4. P2- We have to do it within our own communities because I think in the past and I've certainly experienced seeing it where it's made to feel like you're weak, it's, you're ashamed, for you to actually go out there and talk about it. And sometimes we, you know, we have to encourage people to be, expose their vulnerability in order to get help, you know.

FG1. P1- In terms of creative approaches to helping people with their mental health and you know, you just talking there about theatre, so the productions and things like that is getting people with the issues to be involved in it. Whether they're costume design, whether it's music, the writing, and you can have them in the projects where it's great to communicate to others that we can break down the stigma, highlight different challenges and etcetera. But I feel like a lot of people need something that they can be a part of as well and they can get a sense of purpose.

A discussion on providing and promoting safe spaces for men to share their struggles, discuss mental health and seek mutual support was also delved into. The worry that Black men did not speak enough about their mental health required more innovative interventions to encourage them to open up.

FG4.P1- I think the men will play a big part in actually raising this awareness because we don't usually seek help. Umm, and I think having that vulnerability that if things are not OK, then they are not OK.

As earlier stated, one of the focus groups which comprised of only males was recognised as

one a good avenue for them to share their thoughts, as they realised, they were not alone in how they dealt with their emotions. They admitted that the online focus group made them feel safe enough to discuss their struggles and that this could be replicated in other areas of service delivery.

FG4. P2- I agree because, yeah, I've got lighter today, you know, listening to you guys, you know, I've got a lot out of it, you know, and it's really good to hear the different perspectives because sometimes you think you're so busy. Just me, that's thinking this way, you know, so yeah.

Shedding more light on the complexities surrounding resilience and its impact on early help-seeking behaviour and access to mental health support, participants addressed the need to re-evaluate the representations and expectations around unhealthy coping strategies. Interest was paid to the relationships between resilience and racial microaggressions in the workplace and in other healthcare services, where participants proposed that service deliverers could endeavour to promote workplace-based support for professionals of Black ethnic background. Discussions on the role and responsibility of participants as catalytic agents in the change they envisioned for the community also shed light on the efforts that were already being made by individuals to promote mental health and wellbeing. This initiated additional proposals on the strategies needed to promote mental health across all age groups, with a focus on prioritising school-based promotion.

5.3.5 PRIORITY 5: SCHOOL-BASED MENTAL HEALTH PROMOTION AND EMPOWERMENT

Participants proposed that to tackle mental illness stigma in the Black African and African Caribbean community, early education and promotion needed to start from schools and target young children. An early intervention approach to mental health education was considered invaluable to the improvement of mental health and help seeking behaviour among the Black community. Advocating for the inclusion of materials on mental health in the school curriculum as well as the need for pastoral care in after-school clubs and other spaces that supported students were some of the proposals made. This way, more avenues could be provided for free access to support students both in and out of the school environment.

FG3.P2- And it needs to start to normalise this, even in the schools, I think it needs to be in in the simplest form presented to parents that, you know young children through education, simplified education. So, so, you know, it starts to develop from very early on and across all age ranges that then becomes, it comes to culture of normality really to understand it and to know, and to be aware of it and deal with this stigma.

FG3.P4- And you know in regards to the schools because, if we get it into the schools, we need to get it on the curriculum and it's about having those discussions with the, Department of Education, the DFE to get them to agree.

In promoting school based mental health education, the vision was that this bottom-up approach could raise awareness among both children and parents or guardians, and then extend to the community, thus breaking the stigma around mental health. Additionally, the goal was that in undertaking more of such school-based education, it would potentially pave the way to mentor and guide the next generation of young Black people to embrace healthier attitudes and mindsets.

5.3.5.1 Inspiring the next generation.

One approach that was proposed to addressing health inequalities in the Black community was the need to empower young black people and guide them to seek additional opportunities for growth by encouraging them to aspire for higher and more influential professions in other fields where meaningful change could be executed. Especially in the wake of a lack of Black mental health professionals, some participants were of the view that encouraging young people, especially of Black African and African Caribbean background to pursue higher-level professions was one of the solutions to improving diversity in services. They proposed that organisations who had school mental health promotion within their mandate could also incorporate empowerment programmes that motivated young people to aim higher.

FG4.P1- Maybe come up with a drive to maybe advertise, maybe in a school, that this is actually a profession you can go into. Because some of these professions, when you're speaking to black people they just think nursing, so it seems like it's all you can aim for. If you miss nursing then you can do, maybe go into something else but it almost seems like it's a niche profession because it's not anything that is talked about in general life. So I think it's something, just to highlight it, advertise it to students in schools. Just actually say that this is something that you can do and in the future we preparing ourselves because you know whether we like it or not, we are here to stay and our kids they will need these services

FG4.P3- you don't see a lot of black people involved in them because there's not a lot of black academics that want to go into the medical field because it's so corrupt, you know, I'm saying. And

it's like we know that we can dance and that we can sing, but we just don't have enough young people like we've been killing dancing and singing on stages for how many years? We just don't have a lot of academics that want to go into the medical field.

The need to secure a better legacy and future for the next generations was emphasised, particularly in the last focus group, as respondents pointed out the reality surrounding racism and discrimination in current times. Their opinions illuminated that given the current political climate and the recency of some of the historical events surrounding race, they were doubtful that much would change during their time or in the next 20- 30 years.

FG4.P3- Personally, I don't think that we're gonna get a big change in the next 30 to 40 years because you know, I'm saying we're not even halfway on the journey there yet. They wanna accept us, but on their terms, so they love our food to a certain extent. They love the way we dress, the love the way we sing and we dance, but they don't like what else comes with us. They don't. They don't like to accept that we're just human too.

However, they were hopeful that if the suggested changes were put into effect sooner rather than later, there were better prospects for posterity. This required taking ownership of the change they wanted to see.

FG4.P1- we as black people we have to take ownership of where our destiny is heading. I think it's passed that point where we say ohh they're not doing this for us, they're not doing this for the... We need to really kind of just OK, we are part of this society, we have to just make, we have to do something that works for us.

The co-constructive approach implemented in this phase revealed the many positive recommendations that community members envisaged towards the promotion of culturally sensitive mental health services. Proposals were made on the need to promote representation of people of Black ethnic descent in leadership and staffing structures, where particular focus was placed on the imperative to engage people with lived experiences in decision making. Promoting cultural competency training, engaging community organisations in sustainable partnerships as well as enhancing access to a wider range of therapeutic options were especially highlighted as essential to encouraging help-seeking behaviour. The nuances surrounding resilience and the integration of some cultural values in services fostered discussions around the urgency for more spaces within the community where open dialogues on mental health could be facilitated. In view of the deleterious effects of systemic racism in the workplace and in other areas, the importance of fostering intergenerational mental health promotion and to empower others was also proposed. The multiple priorities propositioned during this Dream Phase 2 shed light on the need to amplify the voices of

community members in the design and implementation of services if progress in mental health service delivery is to be seen. From these findings, it is evident that engaging with these individuals as equal stakeholders towards the restructuring of mental health services through the use of this solution-focused framework is a feasible approach to addressing health inequalities.

5.4 DISCUSSION

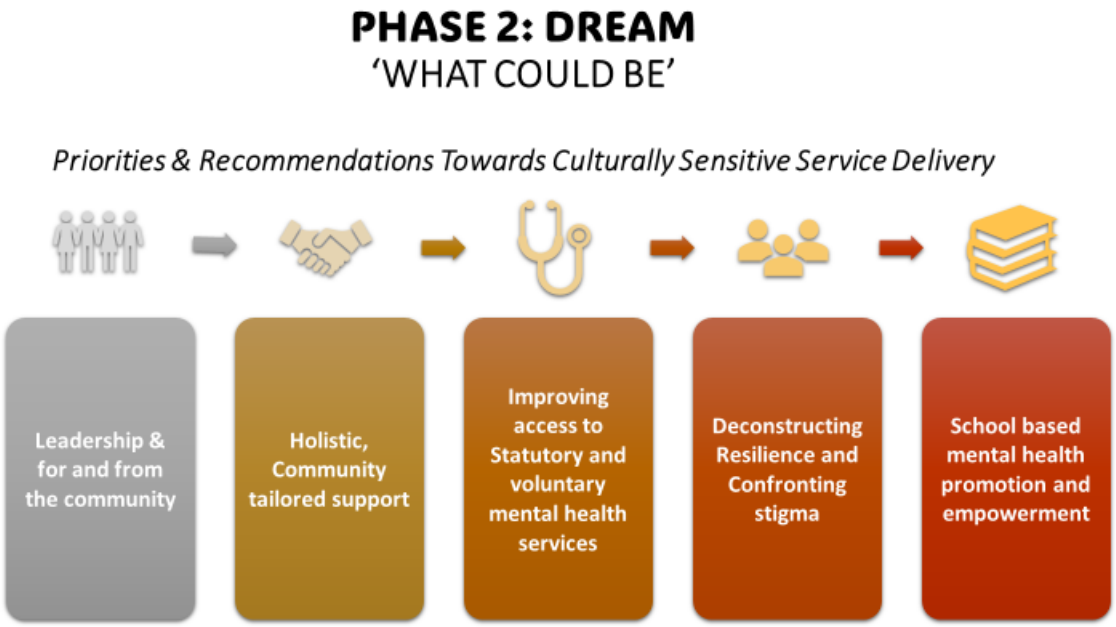

Figure 8: Summary of Dream Priorities

Phase 2 of this study, which addressed the Dream stage of the appreciative inquiry process, was aimed at exploring the process of engaging community members in the co-design of culturally sensitive mental health services that build upon the identified strengths and assets of Black African and African-Caribbean communities. Building on data gathered in Phase 1, participants were presented with the opportunity to engage in a solution-focused exercise of envisioning the changes they would prioritise if they were offered the chance to transform mental health service delivery within their respective communities. Having identified the strengths and values within the Black community, as well as barriers to service use, this phase

aimed to support the co-design of culturally sensitive mental health service delivery. The recommendations produced during these focus groups did indeed validate the use of appreciative inquiry as a viable framework for including community members in the co-construction of culturally sensitive mental health services that may be more suited to the needs of the Black African and African Caribbean community. The aspirational, collaborative process fostered during this phase is discussed further in this section, in addition to the other outcomes of this study, consistent with findings from existing literature.

5.4.1 Dreaming and Envisioning 'what could be'

The exploration of shared visions and hopes for the future of mental health and service delivery within the Black African and African Caribbean was effectively carried out during the Dream Phase of this study. Drawing upon shared narratives of the multiple realities surrounding mental health and resilience in the Black community, it was evident that this knowledge from past experiences coupled with the choice to apply it towards re-imagining the future stimulated the positive, generative solutions to addressing the issue of health inequalities (Cooperider and Whitney, 1999). This co-construction of future-oriented affirmative visions fostered an environment for mutual support and a recognition of the role each individual played in contributing to the transformation envisaged. Other scholars have highlighted the value of the dream phase for facilitating collaborative visioning and empowerment, developing aspirations as well as fostering social interactions that lead to knowledge generation (Lambdin-Pattavina et al, 2020; Merriel et al, 2022). The approach this inquiry took allowed participants to envision themselves in positions of power and influence where they could make a change. As participants made various proposals towards leadership, holistic community centred care and the fostering of sustainable partnerships, they envisaged themselves as agents of change who could make meaningful contributions towards the future of mental health in the community. In employing a critical appreciative lens to the dream stage, it was evident that encouraging introspective reflections around topics such as the deconstruction of resilience and the integration of cultural values in services led to the proposal of practical solutions that may not have been addressed if this study focused only on positive narratives. Ridley-Duff and Duncan (2015) were of the view that integrating

critiques that challenged the deficiencies within society often resulted in useful insights that focused on reframing negative narratives in a generative manner. The emancipatory nature of this Dream phase, where mutual respect and meaningful relationships were fostered was evident in the reflections shared during some of the focus groups, where participants felt a safe space had been created where they could exchange ideas and draw inspiration from other's experiences. The value of an effective salutogenic approach for engaging community members of the Black African and African Caribbean community in the co-production of culturally sensitive services is thus, evidenced in the innovative recommendations made during this Dream Phase 2.

5.4.2 Designing Culturally sensitive mental health services for the Black African and African Caribbean Community

The findings from this study contribute to bridging the knowledge gap in healthcare research that specifically addresses the needs of the Black African and African-Caribbean communities in the UK, yet they provide valuable insights on the areas requiring attention where the mental health of these communities is concerned. Much evidence already exists on how the combination of social, economic, cultural, and political influences contribute to the complexities surrounding mental health within the Black community (Keating 2007; 2009; Rabiee and Smith, 2013; Memon et al; 2016; Devonport et al, 2022). Evidence of the impact of systemic, institutional, and structural racism on perpetuating stigma and discouraging early access to mental health within these communities has also been addressed severally (Keating, 2004; Edge, 2013; Mantovani et al, 2017). Yet very few studies have addressed the positive effect of engaging the use of co-production models in understanding the nuances that surround mental health in the Black community with the aim of alleviating health inequalities and fostering equitable healthcare delivery (Sashidharan and Gul, 2020; Ezaydi et al, 2023). Deviating from the traditional, pathogenic-oriented top-down approach to service design and delivery, this implementation of the Dream phase of AI fostered a positive environment that positioned community members as experts whose views are critical for the co-construction of culturally sensitive services for the Black community.

Although other studies have investigated the feasibility of engaging communities in the design and evaluation of culturally sensitive services in the UK, these studies have addressed the issue from the perspective of the wider 'BAME' community (Vahdaninia et al, 2020), with very little focus on the experiences of specific ethnic groups. The need to engage a more ethnically specific lens to addressing the gaps in service delivery and health inequalities was, therefore, crucial towards adopting a multi-strategic approach to addressing the specific needs of the Black community, both in policy and practice. In view of the glaring evidence of health inequalities that the COVID-19 pandemic exposed, this study could not be timelier for engaging community members as key stakeholders in the design of culturally competent services. Beyond the stigma and low-help-seeking behaviour that are commonly discussed when conversations around mental health in the Black community arise, there is much more to be explored in the way of evaluating the influence of cultural values, cultural identity, and the appreciation of cultural assets on promoting mental health in this context. Miller (2004) for instance, highlighted the need to adopt more salutogenic approaches to understanding the social and cultural foundations of the phenomena of mental illness stigma within minority ethnic communities, highlighting the importance of following this up with asset-based interventions that fostered communal wellbeing. In summary, to be well informed on effective strategies for transforming mental health in Black African and African Caribbean communities, one must have adequate knowledge on how their lived experiences shape their views on how services can be transformed to meet their needs. This is precisely what this study achieved as the priorities addressed shed light on the wider systemic changes that are required to first, shift the power imbalance that has widened the inequality gap in service delivery, and then design and develop sustainable solutions to the issues concerning mental health in these communities.

Several studies have made suggestions on the factors to consider in the design of culturally adapted interventions for minority ethnic groups (Dowrick et al, 2009; Bassey and Melluish, 2013; Jordan et al, 2020). Some of these recommendations include modifying the content of materials or dialogue to include racial, ethnic, or cultural facts, values, imagery, or other cultural components as well as changing the way a service was delivered, including increasing the time and attention paid to recipients and encouraging cultural matching of providers to clients. The findings from this study offered deeper insights into the processes necessary to

implement these recommendations, and offered clearer perspectives into the considerations that needed to be made to ensure that proposed interventions were indeed relevant to the cultural needs of the community.

5.4.3 Better representation and diversity in leadership and staffing structure

The priority addressing the need to increase representation of people of Black ethnic background at different levels of influence in service delivery is highly relevant to the current conversations on enhancing cultural sensitivity. Discussions on increasing staff cultural competence through training as well as employing more staff of Black African and Caribbean background have been extensively discussed since the DRE policy in 2005 (National Institute for Mental Health in England (NIMHE), 2003). Yet it is a theme that is recurrent in studies of this nature where the underrepresentation of people of Black ethnic descent is particularly common especially in leadership and decision-making structures of healthcare services (Kalra, Abel and Esmail, 2009; Kline et al, 2014; Priest et al, 2015; Kapadia et al, 2022). Even though more efforts are being made to include experts by lived experience to engage community voices in the design and implementation of services, there is still much that needs to be done to bridge the gap in representation (BLACHIR Report, 2021). The inclusion of people with lived experience of mental health in the design of services, as proposed, is also key to stigma reduction and mental health promotion. In Australia for instance, consumer and carer participation is incorporated in policies on pertaining to the delivery of mental health services, where people with lived experience of mental health are even included in educating service providers (Happell and Roper, 2003, Owen and Reay, 2004; Happell and Roper, 2009). The replication of such initiatives in the UK may be essential in efforts to decrease mental illness stigma and foster cultural sensitivity in service delivery in Black communities (Codjoe et al, 2021).

Promoting diversity in the recruitment of staff and increasing the visibility of mental health professionals of Black African and African-Caribbean background signifies a willingness to improve cultural competence, especially in areas with a large population of service users of Black ethnic background (Lawrence et al, 2021; Devonport et al, 2022). Lawton, McRae, and Gordon, (2021) particularly suggest the need to educate and recruit more Black male

professionals who will help bridge the gap in mental health support for Black men, who are historically known to have negative experiences with mental health services. Research conducted on the effectiveness of racial matching in mental health service delivery has found that clients were more likely to consider therapists from similar racial backgrounds, with similar experiences as more credible and reliable (Meyer et al, 2011; Olayinan and Hayes, 2022). The propositions for more mental health professionals of Black ethnic background are, therefore, not far-fetched, and even though cultural matching may not always imply cultural competence (Bhui and Sashidharan, 2003), representation of healthcare professionals who are more akin to the needs of the communities they serve is essential for encouraging help-seeking behaviour.

5.4.4 Expanding treatment options beyond traditional one-size-fits-all approaches

The evaluation of which interventions are effective, for whom, and what sort of outcomes they influence is also particularly critical to enhancing cultural competence and promoting health and mental health in our diverse, multicultural societies (Healey et al, 2017). The information gathered from this study indicates that there is still a significant lack of varied therapeutic options offered to service users of Black African and African Caribbean background, outside of regular CBT and medication. Mckenzie-Mavinga (2003; 2015) and Prater (2016) write on the cathartic and effective use of creative writing as a tool for healing for Black women especially within group therapy settings, in a bid to promote intercultural counselling. The incorporation of poetry, drama, music, arts and even food in the design of mental health promotion programmes and treatment regimens was proposed as a critical aspect for ensuring cultural sensitivity in service delivery, yet these crucial factors are often ignored. The effectiveness of the use of expressive/creative art therapies is recorded mainly in research conducted in the USA among African American populations (Burrowes, 2019). Jacobs and Pentairs (2021) and Menon et al., (2023) propose a re-evaluation of certain Western therapeutic notions such as self-sufficiency and individualistic living that contradict certain cultural beliefs such as family relational dynamics, mutual support, and respect, which are typical of people of Black African and African-Caribbean background. Omylinska-Thurston et al, (2020) propose that owing to recent statistics from NHS Digital (2019) that state that there is a 64% drop out rate from IAPT programs, it is a crucial time for the NHS to promote

art-based psychotherapies that incorporate music, dance, drama, and art in mental health support, which is currently uncommon. Striving to reduce barriers to accessing mental health care and alleviating stigma necessitates the use of person-centred approaches that promote holistic health and wellbeing for improved treatment outcomes. The impact of social prescribing for improving mental health, particularly within this population needs to be explored further to gain a better perspective on how it improves access to mental health services. Social prescribing has been defined as short term, non-medicalised approaches to connecting patients in primary care to community-based services who help tailor support to effectively meet the health and wellbeing needs of patients (Bickerdike et al, 2017). Such considerations are key to ensuring that services are indeed accessible and relevant to the needs of these communities, especially where the impacts of austerity on mental health service delivery are concerned (Cummins, 2018). These considerations further emphasise the critical role voluntary sector and grassroots organisations play in addressing these gaps in service delivery towards reducing the burden of mental illness and alleviating health inequalities within the Black community.

5.4.4 Community Engagement that serves the Interest of the Communities being served

One important finding from this study was around the expectations community members had concerning the nature of community engagement and mode of service delivery within these communities. The recommendations made towards adopting a holistic, all-inclusive approach to mental health and wellbeing interventions further highlight the flaws in the one-size fits all approaches that have often been engaged in promoting mental health in minority ethnic communities. Targeting mental health as an isolated health concern within these communities without acknowledging the complex interactions between the multiple underlying socioeconomic determinants of health may not be the most effective approach especially where stigma around mental illness is already a barrier to help seeking behaviour. Alegria et al (2018) have argued that mental health initiatives, particularly in minority ethnic communities ought to expand beyond their narrow biomedical focus and incorporate programmes that address concerns such as housing, physical health, education, poverty, and discrimination, all of which significantly affect mental health and wellbeing. Sancho and Larkin

(2020) and Devonport et al (2022) advocate for the involvement of voluntary and grassroots community organisations in the design, implementation and evaluation of such holistic approaches to mental health service delivery.

These recommendations for equitable partnerships are particularly crucial for breaking the cycles of mistrust of statutory services that have often been implicated in the low levels of help-seeking behaviour within the Black community. A recent report by the NHS Race and Health observatory recommended that statutory mental health services strive to establish and sustain connections with minority ethnic 3rd and voluntary sector organisations (Kapadia et al, 2022). In their opinion, these partnerships were key to improving cultural competence in mental health service delivery and would validate the NHS mandate to decrease inequalities in mental health services. The evidence that exists on the invaluable contributions voluntary sector organisations make towards the promotion of mental health in minority ethnic communities, draws attention to the need to capitalise on such partnerships in an equitable manner, to facilitate the delivery of holistic culturally sensitive mental health services (Weich et al, 2004; Baskin et al, 2021).

It is, however, crucial that careful considerations are made where partnerships with various community institutions are concerned, especially with organisations whose primary services are outside the remit of mental health, such as faith-based organisations. In this study, the role of the Black church was extensively discussed, considering the position of the church as one of the greatest assets within Black African and African Caribbean communities (Davis, 2010). There is extensive history of the Black church being at the centre of many social revolutions that advocated for social and racial justice and has extended much support to the Black community in times of oppression and difficulty (Avent Harris & Wong, 2018). However, it was evident from the findings that even though the role of the church and other religious organisations was considered invaluable to the wellbeing of the Black community, their role in perpetuating mental illness stigma was of concern, especially considering the subtle interplay between faith and mental health. Mantovani et al (2016) who conducted a few studies in the Birmingham and South London areas among racialised populations found that the interplay between culture and ethnicity as well as faith and religion needed to be duly considered when seeking out solutions to improve mental health and wellbeing services and bridge the health inequality gap when working with these groups. Consequently, an

understanding of the dual role these institutions play within these contexts is essential to developing services that meet their specific needs. Ultimately, creative, and holistic approaches to community engagement which serve the best interests of these communities should be prioritised in order to achieve the goal of equitable mental health service delivery.

5.4.5 Black Mental health and the Resilience narrative

The present findings are also consistent with other studies that have investigated the impact of stigma, discrimination as well as systemic racism on mental health and help-seeking behaviour within the Black African and Caribbean communities (Bhui et al, 2015; Memon et al, 2016). Earlier observations made in Phase 1 concerning the implications of the resilience narrative within this community provided new insights into the connection to help-seeking behaviour and were further developed in Phase 2. Discussions around the influence of systemic racism and the history of slavery and oppression on perpetuating this super-coping, resilience narrative shed light on the deleterious effects of racism on mental health (Karlsen and Nazroo, 2004; Becares et al 2009). The fear of victimisation brought about by both overt and covert racism in schools, at workplaces and especially in the healthcare system were said to contribute to the development of this resilient identity within the Black community which further influenced perceptions around vulnerability and mental illness as signs of weakness (Carr et al, 2017). Hammond (2012) argue that one of the reasons behind the poor help seeking behaviour among Black men is their past experiences of racism and cultural distrust. These are valid concerns also identified in studies by Mantovani et al., (2016), Memon et al., (2016) and Public Health England, (2018), which further obscure access to mental health and wellbeing support within this population.

The ARISE project (Keating, 2021) aimed at raising mental health awareness among young Black men in a borough in London found that many black men were of the view that their identities were based on the expectations of society to stay resilient and keep a stiff upper lip, even in the face of racial injustice. Therefore, the lack of room to demonstrate vulnerability led to an instinctive portrayal of defensive lifestyle, which was often perceived as violent behaviour. The need to constantly look over their shoulder and heighten senses to pick up on any form of racial discrimination meant that mental health was put in the

background. In an evaluation of campaigns undertaken in various parts of the UK, such as Black Men on the Couch (Akinsete, 2011) and the Count Me In campaign by Mind (2019), Meechan et al (2021) address the need for more Black role models who help to break the barriers around the culture of silence around mental health. They cite that in other research conducted by Dillman et al, (2016) and Francis (2018) , participants highlighted the need to implement ideas that raise aspirations of young black people, encourage, and promote safe spaces for addressing mental health concerns and deconstructing the identity surrounding resilience. Proposals made in this study are similar to these findings, in that participants highlighted similar needs, emphasising the need for the promotion of safe spaces in workplaces, schools, community spaces and religious institutions, where open dialogues were encouraged towards the deconstruction of such beliefs to alleviate stigma and improve accessibility to mental health services.

5.4.6 School and Workplace Based Mental Health Promotion

The emphasis placed on the need to encourage early mental health promotion in schools to address stigma, improve knowledge around mental health and encourage help-seeking behaviour was also highlighted in this phase. Marks (2012) proposed that outside of healthcare settings, schools provide the ideal environment for promoting mental health and wellbeing. Having the right structures and the right audience in place, schools provide the optimal context for rolling out mental health interventions in the safest and most cost-effective manner. O'Connor et al (2018) adds that the benefits of school based mental health promotion can be seen both in the school and in communities, as students and staff are all involved in the process. Pinfold and Stuart (2015) justify the need for such early interventions, stating that as stigma and discrimination are rooted in ignorance and misinformation, the best approach to dealing with this issue is to target young people and provide basic education on mental health promotion and mental illness prevention. According to them, the school setting provides the right platforms to address emotional and behavioural issues and support emotional wellbeing of young people. Consequently, educating young people on the risk and protective factors surrounding mental health will promote early detection which leads to a better prognosis for treatment. In a review of empirical data of school based mental health

promotion in schools in Australia and England, Brown and Shay (2021) proposed that mental health promotion in schools should attempt to promote strategies aimed at building identity in view of cultural differences, in a manner that is congruent with the notions of society and community that the students find themselves in. In their view, this approach would spill over to the families and communities of the children who have received this education, given that the role of their societal beliefs surrounding character, resilience and wellbeing are acknowledged in the development of mental health interventions. In promoting mental health among Black young people and reducing stigma, Wittrup et al, (2019) found that natural mentoring relationships were beneficial to reducing racial discrimination and its effects on Black students. In their study, they found that including non-parental role models as mentors for Black students led to improvements in academic success and empowered students. Such evidence further increases the need for early mental health promotion targeted at stigma reduction, especially in school districts with a high population of students of minority ethnic background.

The pertinent need to address the impact of racial discrimination in the workplace was another priority outlined in this study, particularly in line with the narratives around deconstructing resilience and addressing the psychological distress resulting from racial microaggressions. Scholars such as Myrie and Gannon (2013) and Memon et al (2016) draw attention to the relationship that exists between continuous exposure to racial microaggressions in the workplace and the negative effects on both physical and mental health among minority ethnic staff. Yet very few interventions are provided for what Smith et al (2011) referred to as racial battle fatigue. In their opinion, the risk of continuously expending energy on race-related stressors in toxic work environments led to burnout and increased risk of mental health problems. The call for provision of safe spaces for Black professionals within the community was thus, of no surprise. Arday (2022), who evaluated the experiences of minority ethnic staff in higher education settings in the UK advocated for systemic changes that tackle foundational institutionally racist practices which have contributed to poorer mental health outcomes for ethnic minority staff. The need for safe spaces and psychological interventions that foster mental health and promote healthy work environments that foster organisational and professional growth cannot be emphasised enough. There is much value in creating an empowering environment that seeks to nurture

growth and encourage positive outcomes for the health and wellbeing of diverse populations, and schools and workplaces offer many prospects for accomplishing this goal.

5.5 CHAPTER SUMMARY

The findings from this Dream Phase (2) have provided much evidence that appreciative inquiry is an appropriate framework for engaging community members in the co-production of culturally sensitive mental health service delivery for Black African and African-Caribbean community. The Dream phase fostered a collaborative environment of mutual respect and dignity, where participants from Phase 1 (Discovery) were engaged as experts whose ideas, visions and proposals were vital to developing appropriate and equitable services that meet the needs of these communities. In envisaging the future of mental health in the Black community, a number of recommendations were made concerning the restructuring of leadership and staffing structures of healthcare services to be more representative of the populations served as well as the need to engage holistic, community-oriented approaches to mental health and service delivery. Prioritising the promotion of innovative alternatives to standard treatment options, facilitated by equitably engaged voluntary and community organisations was also proposed towards improving access to services which were better tailored to the needs of the community. In addressing the complexities within the interactions between Black cultural values and resilience, racism and mental illness stigma, proposals were made towards the promotion of mental health in schools and workplaces through culturally informed initiatives that foster an empowering environment for better health outcomes. Creating safe spaces to encourage open dialogues surrounding the beliefs and perceptions around mental health within the Black community was also regarded as crucial to breaking the stigma around mental health and consequently, promoting accessibility to mental health services. The emphasis on personal responsibility and the role of the community members in contributing to the change they wanted to see was essential to the generative AI process.

Much evidence supports the priorities and proposals shared in this study and given that many of these priorities have been repeatedly addressed in past research, the insights presented in

this study are reminiscent of the lack of implementation of these recommendations in policy and practice. In view of the increased recognition of the need for more asset-based approaches to the co-production of culturally sensitive mental healthcare delivery, the findings from this Dream phase provide sufficient evidence that AI is relevant for engaging members of the Black African and African Caribbean community in the co-construction of affirmative visions towards the promotion of equitable mental health care and alleviation of health inequalities. The objective to explore the process of engaging community members in the co-design of culturally sensitive mental health services that build upon the identified strengths and assets of Black African and African-Caribbean communities, was, therefore, achieved.

The recommendations made in this Dream Phase (2) were significant for sustaining the continuity of this AI process, as they built on the foundation laid in Phase 1 (Discovery) by creating momentum for further engagement with those concerned with the implementation of these priorities in their services. The next phase of this study, therefore engaged a range of statutory and voluntary sector organisations in the final Design and Destiny Phase (3) of this study. Utilising the recommendations addressed in Phase 2 as an evaluative tool for determining the extent to which these services were already implementing these priorities in their delivery of mental healthcare. Additionally, in critically reflecting on the priorities presented in Phase 2, the Design and Destiny Phase (3) sought to engage service providers in a collaborative process of deliberation where they determined how best to ensure that the proposed process of co-design and co-delivery of culturally sensitive mental health was efficiently carried out. The next chapter of this study, therefore, explores how the Design and Destiny stages of Appreciative inquiry were implemented towards promoting impactful and sustainable outcomes towards the alleviation of health inequalities in mental health service delivery for Black African and African-Caribbean populations in Birmingham, UK.

CHAPTER 6: METHODS AND RESULTS

PHASE 3: DESIGN AND DESTINY

"New understanding emerges when we begin our capacity building through welcoming the unknown as an opportunity for discovery and innovation". -Frank Barrett

6.1 INTRODUCTION

The community-defined priorities that emerged, following the implementation of the Dream Phase (2) of this critical appreciative inquiry study, generated valuable insights which articulated the needs and visions of members of the Black African and African Caribbean community in Birmingham, towards the delivery of equitable culturally sensitive mental healthcare. The recommendations focused on transforming various aspects of service delivery, such as the restructuring of leadership and staffing systems, diversity in the range of services provided, the scope and mode of engagement with community, as well as the promotion of safe spaces to support open dialogues around mental health. Having engaged these community members as equitable partners in the co-production process, the next step was to engage mental health service deliverers in an evaluative process to determine how their services aligned with the priorities outlined in the Dream Phase (2). Furthermore, to facilitate the generative momentum fostered since the Discovery Phase (1), it was important to ascertain how these community-defined priorities could be incorporated in services to support the sustainable delivery of equitable culturally sensitive mental healthcare for members of the Black community in Birmingham. The Design and Destiny stages of the Appreciative inquiry process were, thus, engaged in this Phase (3) to facilitate this co-production process.

The Design and Destiny stages of AI focus on fostering an environment for collaborative planning and strategising, by facilitating the practical stages of the generative process of AI, where action plans are drawn, and commitments are made to enact positive change from a solution-focused perspective (Keefe and Pesut, 2004; Cooperider et al., 2008). By asking the questions, '***What would that look like?'*** and ***'How will we get there?***', the Design and Destiny Phase (3) sought to engage service deliverers to evaluate the visions, dreams and priorities addressed in the previous phases against their current service provision and collaboratively

deliberate on how they could best commit to promoting innovative and sustainable solutions to the issues surrounding mental health and access to services within the Black community. In order to address the research question aligned with this Phase, the aim was, therefore:

To engage mental health service providers in collaborative design and implementation of sustainable solutions with for promoting equitable, culturally sensitive mental health service delivery for Black African and African-Caribbean communities in Birmingham.

Ridley-Duff and Duncan (2015) propose that, in the Design and Destiny stages, the appreciation of achievements and successes ought to be juxtaposed with a reflective process that encourages transparency and accountability to produce sustainable and transformative outcomes within a system, organisation or community. To further implement the first part of this critical appreciative approach, one of the goals in this phase was to identify and appreciate best practice in the current delivery of services, affording service providers the opportunity to highlight the efforts that were already being made to provide culturally sensitive mental healthcare. Subsequently, a critical reflection on the dialogues and priorities presented in Phase 2 was required to address the current gaps in service delivery and see how best these priorities could be effectively implemented in service delivery. Grounded in the needs of the community, the priorities shared with service providers in this phase served as a checklist by which mental health service deliverers could align their practices with the identified strengths and assets of the Black African and African-Caribbean communities.

Trajkovski et al. (2013) observed that one of the aims of this strategic planning phase was to facilitate the building of collaborations and partnerships between key stakeholders whose relationships play a crucial part in the change process. Much of the literature that surrounds partnerships between statutory and voluntary sector organisations presents a negative outlook on the nature of such relationships, mostly highlighting the issues of power imbalances that perpetuate systemic inequalities (Craig and Taylor, 2002; Reece et al., 2022). The decision to engage both statutory and voluntary sector organisations in these focus groups, therefore, helped focus on the potential positive outcomes of such collaborations for the future of mental health in the Black community. Special attention was also paid to highlighting the role voluntary sector organisations played in championing the delivery of equitable mental health service within the Black community.

Many community-based voluntary sector organisations have existed since the 1950s (Craig and Taylor, 2002) to serve the needs of their communities where statutory organisations have fallen short (Butt, 2001). Usually formed by community members, these grassroots organisations comprise of those who see the need to advocate against racial discrimination and exclusion in their communities in various areas of life (Williams and Johnson, 2010). Their shared experience of the difficulties their service users encounter in accessing health, employment, financial and educational support serve as their medium for influencing change towards racial equality (Race on the Agenda (ROTA), 2009; Murray, 2020). Netto et al. (2012) highlight the crucial role such organisations play in supporting the specific cultural, religious, and social needs of these minority ethnic communities. The report below, therefore, provides an in-depth analysis of the relevant themes derived from these discussions and their implications for advancing mental health policy and mental health service delivery in a manner that efficiently addresses the multi-factorial needs of Black people living in the UK.

This chapter provides insights into how this process of co-production engaged multiple service deliverers from both statutory and voluntary sectors in focus groups to discuss how the visions and dreams presented could be translated into workable and sustainable outcomes. The results of the focus groups are also discussed, considering the current literature on effectiveness of co-production on the delivery of equitable mental healthcare, and paying special attention to what this means for the future of mental health in the Black African and African Caribbean communities.

6.2 METHOD

To facilitate the generative, co-constructive process that had already begun in Phase 2, this Design and Destiny Phase (3) engaged a range of service deliverers in focus groups where their ideas and opinions could be exchanged in an environment that fostered mutual learning. The power of the critical reflections and dialogues engaged at this stage of the AI process is best ascertained in a setting that enables the sharing of multiple perspectives (Trajkovski et al., 2013). Dent (2019) proposed that when using appreciative inquiry as a framework for co-production among mental health service users and providers, the use of focus groups was

essential for fostering reciprocal learning, where the collective narratives shared promoted an understanding of the strengths and challenges present and facilitated the generative process. The qualitative data collection method of focus groups was, therefore, chosen once again to engage both statutory and voluntary sector mental health service deliverers in Phase 3.

6.2.1 Sampling and Recruitment

Purposive sampling, also known as judgement sampling, was utilised at this phase of the study to recruit participants. It can be defined as a method of selecting participants based on specific qualities they possess, as decided by the researcher (Bernard, 2002). The purposive sampling technique is commonly used in qualitative research to identify and make the best use of available resources, by including individuals who are proficient and well-informed about a particular phenomenon of interest (Patton, 2002; Creswell & Clark, 2011; Etikan et al., 2016)

Making use of networks established during my time with the Birmingham City Council, I was signposted to some potential organisations that already operated within similar services in the community, who were willing to take part in the research. I also took advantage of networks formed from my past collaborations with members of the community development team from the Birmingham and Solihull Mental Health Trust Foundation (BSMHTF) to reach out to a range of mental health service deliverers in Birmingham. Accessing their Waiting Room website, which houses a directory for a range of mental services that partner with the BSMHTF was also greatly beneficial in the recruitment process.

Email invitations were then sent to the various organisations operational within Birmingham, detailing a summary of the study thus far, and inviting service providers to share their thoughts and ideas on their roles in supporting the co-production process. A selection of dates and times was also included in the invitation and the focus groups were scheduled based on the availability of participants.

It is worth noting that, though third and voluntary sector mental health service providers were the main population of interest in this phase, because of their stronger community ties, being

more embedded within these communities, a few statutory service providers were included in the study. Due to their direct involvement and collaborative roles within the voluntary sector, these service providers had extensive connections within the local community voluntary services, had funded local initiatives and had developed sustainable partnerships, especially within the Black community. By including these statutory service providers, who were already involved in local community work, there was an opportunity to gather insights from both parties and critically assess the gaps within either service. This approach also helped paint a better picture of how the priorities shared in Phase 2 could be better integrated within both services towards increasing accessibility to culturally sensitive mental health services.

Statutory sector service deliverers, as indicated in this study, are those organisations that are government-mandated regulated public services, are public sector funded and established through mental health legislation. Third and voluntary sector services, on the other hand, are defined as non-governmental organisations whose services are value-based, non-profit and community-driven to promote advocacy, empowerment, and civic engagement. The term may be used interchangeably to encompass community organisations, charities, housing groups and social enterprises (The Law Insider Dictionary, 2023).

6.2.2 Data collection

As earlier stated, the feed-forward process adopted in this phase of the study saw the recommendations which were generated in Phase 2 relayed to service providers in the design and delivery stages. An interview schedule was developed from the five core themes derived from Phase 2, where participants were asked to highlight current service strategies, address gaps in service delivery, and share their visions and priorities for the delivery of culturally sensitive mental health services. In Phase 3, the method of online focus group discussions was once again utilised via the MS Teams platform. One advantage for the use of focus groups in research with healthcare workers is that it allows for a deeper exploration of the cultural and social dynamics of work culture within healthcare settings (Clavering and McLaughlin, 2007). An added benefit for focus groups conducted online is the increased accessibility and the potential to include a wider representation of service providers (Matthew et al., 2018;

Keemink et al., 2022). Other advantages and disadvantages of online focus groups are outlined in Phase 2 where the method was first used (Chapter 5: pp. 165-166). Data collection for Focus group 1 and 2 was conducted on the 1st and 30th of September 2022, respectively.

6.2.3 Data analysis

The qualitative method of thematic analysis was applied to the data collected within this phase, adopting a reflexive approach where the insights derived from previous phases provided additional context for examining and converging previous findings with the new data generated. According to Braun and Clarke (2019), understanding themes as creative and interpretive narratives of the data generated allows the researcher to explore intersections between theory and data, by organizing codes based on a central organising concept, or relative core commonality. This method of analysis thus supported the evaluation of how service providers' experiences and narratives aligned with the priorities proposed in Phase 2. The themes from this phase are referred to as **Strategies**, to emphasise the value of the approaches being taken by service deliverers to meet the needs of community members. The results of the data derived from these online focus groups are discussed in further detail below.

6.3 RESULTS

6.3.1 Introduction of Participating Organisations

A total of **eleven (11) participants** representing two **(2)** statutory and **six (6)** voluntary sector services took part in Phase 3 of this study, comprising **four participants (4)** in Focus Group 1 and **seven (7)** in Focus Group 2. There was the incidence of multiple representation of one statutory service (3) and one voluntary service (2) in Focus Group 2, which occurred due to uncertainties on availability expressed by some participants when invitations were sent out, who were later available to join. Even though this led to an over-representation of certain organisations, it was advantageous for gathering multiple perspectives from the different individuals as they each played distinct roles and shared different experiences that provided

better insights into their organisational culture and dynamics. This also fit well with AI's emphasis on collaborative discourse that is fostered within an environment where multiple realities and perspectives are encouraged.

Four (4) of the voluntary sector organisations considered themselves as 'Black-led' organisations, as they described their services as tailored to meet the specific needs of the Black African and African-Caribbean communities, even though their services were extended to other ethnicities. The other organisations represented serviced a more diverse range of service users. A further breakdown of the specific type of service offered and the service capacity are detailed below:

ORGANISATION	TYPES OF SERVICES OFFERED	SERVICE CAPACITY
Stat 1	Range of mental health services	25,000-500,000
Stat 2	Local council involved in community development with elders	25,000-500,000
Vol 1	Black Heritage based mental health and well-being services	250-500
Vol 2	Housing association for young people with mental health problems	250-500
Vol 3	Mental health counselling, advocacy, Volunteer training	250-500
Vol 4	Faith-based organisation that provides a wide range of mental and physical health, education, housing, and financial support	50,000-100,000
Vol 5	Black heritage and faith-based counselling and advocacy	500-1,000
Vol 6	Education and empowerment for children with learning disabilities	250-500

Table 2: Stat = Statutory services. Vol = 3rd sector and Voluntary services

As indicated above, participants represented a broad range of mental health and well-being services, encompassing specialised mental health and faith-based counselling services, general physical health and well-being, education-based support, welfare, and social care, as well as housing and employment support services. Their service capacities ranged from small scale (250-500 service users) to large scale (25,000-50,000 service users) annually.

As earlier stated, the one of the goals of this phase was to engage service providers to evaluate their existing services against the priorities and recommendations defined in Phase

2 (Dream); first, to identify how best their current services engaged with the needs addressed by community members and secondly, to address the gaps that needed to be filled. The goal was that in focusing on these priorities, service deliverers would collaboratively determine the best approach to sustainably implement the recommendations shared towards the co-design of culturally sensitive mental health services. Following the introductions on the background of the diverse services represented, discussions were held on the effectiveness of current strategies to promote representation in leadership, provide community-tailored support, promote diversity in the range of services provided, as well as encourage workplace and school-based mental health promotion. Further discussions explored some practical solutions to addressing the gaps highlighted, as well as the challenges service providers encountered in their efforts to bridge these gaps. The service providers then engaged in discussions on the best approach needed to mobilise the resources that stakeholders required to facilitate the co-design and implementation of sustainable, culturally sensitive services for the Black African and African Caribbean communities in Birmingham.

6.3.2 STRATEGY 1: ADVOCATING FOR INCLUSIVE LEADERSHIP

The first priority that service providers reflected on was the current strategies that their organisations had in place to support the inclusion of members of the communities they served in the leadership structure of their organisations. In Phase 2, participants had alluded that the poor representation of Black service users in higher leadership levels where their decisions could influence change was one of the reasons behind the lack of cultural sensitivity in mental healthcare, particularly within statutory services. One statutory service provider reported on how this priority had often come up in consultation with community members and was being taken more seriously. They highlighted their current approaches to engaging service users as 'experts by lived experience' on advisory boards to provide feedback on the quality of services delivered.

FG1. P4 - So we (the trust), demonstrate this inclusion not only in the consultation phase, but we are also now employing experts by experience in different areas within various departments and also, they are leading in certain departments as well …; my organisation is improving our access to, you know, those with expert lived experience and involving those people in what we're doing.

Another 3rd sector representative also highlighted how one of their services was birthed out of consultation with community members. They also shed light on how this had led to partnerships with one statutory service deliverer and had created opportunities for extending the community's inclusion in the co-design of services.

FG2. P6 -- The stuff that we're doing at the moment with *mentions NHS trust*, that was borne out of parents that had had their children shot, stabbed or lost to quite traumatic circumstances. So, we held an event or there was an event held in Aston Park, heard what parents said, asked parents, 'what would you like to do to move this forward?' The agreement that's in place was developed by parents, and by young people. And in terms of organisations, you have to buy in to provide services that parents and children are saying they need.

Another 3rd sector deliverer discussed their approach as a person-led approach, where the service user was allowed to take charge and dictate how they envisioned their support and have this tailored to meet their specific needs. In her opinion, this approach fostered a greater sense of self-awareness and was the key to sustaining community input in the delivery of culturally sensitive services.

FG2. P5 -- So in terms of us with the leadership skills and so forth, in our organisation, what we do is very person-centred, it's very person-led…. My aim and the company's aim is how we can lead this individual to a place of just absolute self-awareness and that independence and the achievement to know that they are going to be fully supported and to know that who they are as an individual is enough.

One representative of a larger voluntary sector organisation, however, admitted their limited inclusion of some members of the community in leadership, as much of the engagement with such service users was still at a surface level. Nevertheless, they did highlight the progress that had been made over the years to overcome this barrier.

FG1. P3 -- I'll be completely honest and say that you know historically there hasn't been leadership that reflects the demographics of the communities we serve and that's because you know we haven't necessarily done that in a way that's been very good. But there is an increased level of kind of representation across communities in a local area, especially compared to like 6-7 years ago or something. And but you know, these things take time to develop, just as we know within the context of statutory services, these kinds of culture changes do take time to develop.

Another statutory representative stated that though efforts were being made to foster such inclusion and promote representation of people of minority ethnic background within their leadership structure, there were several systemic barriers that had hampered such progress.

FG2. P1- So leadership, there are several levels. So myself and *mentions others* we work in an organisation. And there are issues within the organisations in terms of who gets to certain leadership, influential roles to be able to adapt, if you like services, and to be the voice of people that don't necessarily have a voice and there's something in that within itself. You know, and we've kind of come through the system and we're quite conscious in terms of trying to give people, organisations and services a voice and we have had influence and we have made changes, but it's very, very difficult.

These responses shed light on the various levels of collaboration and inclusion of community members in leadership structure, with some differences noted between how either voluntary or statutory sector services went about such processes.

6.3.2.1 Playing dual roles in the co-production process

Some voluntary sector deliverers also shared their experiences of playing dual roles in the co-production process, where they assumed the role of experts by lived experience, where necessary. Their input in the co-design and co-delivery of other services, particularly statutory mental health services, encouraged accountability from other service deliverers, particularly in meeting the needs of other service users outside of their reach.

FG1. P2 -- In terms of co-designing and co-delivering services you know, as a local provider and as an active activist, I always join any co-designing initiative within Birmingham and share my experience and you know, become an active member.

FG2. P6 -- I'm trained to deliver mental health support to the adults, the youth, I have suicide first aid and one of my unique selling points is that I apply a cultural lens to the training for our communities. I also make a point of attending like the internal groups with MHFA England, giving feedback. I'm linked to the West Midlands Police on certain scrutiny panels, from the uhm, street triage, which was actually… when they were revamping the course, I was able to get on it, to provide some feedback.

Overall, it was evident that there was incremental progress being made to integrate the input of service users and community members in leadership and decision-making structures. The value of peer input was also highlighted, particularly with voluntary sector providers, who took on the responsibility of ensuring that statutory services were making more efforts to increase the standards of care. Their role as community advocates and champions was deemed crucial to tackling the barriers that service users experienced in accessing equitable and culturally sensitive care. The transparency of the organisations surrounding their lack of more comprehensive engagement of service users in leadership showed that the process of implementing organisational change was still slow and needed to be addressed more skilfully.

6.3.3 STRATEGY 2: FOSTERING SUSTAINABLE INTER-AGENCY COLLABORATIONS

Leading on from the discussion on including the community in leadership and the decision-making processes within services, the need to improve current approaches to engaging service users and other community assets in sustainable partnerships was discussed. One of the priorities in Phase 2 had addressed the importance of promoting involvement of more community stakeholders in facilitating co-design and co-delivery of culturally sensitive services. The role of faith groups was specifically highlighted as invaluable to the expansion of culturally sensitive services, given that these groups were long-standing institutions within the community and had an extensive reach, making them capable of facilitating this change.

FG1. P4 -- I think for me, the community is invaluable and I think we've talked about the importance of places of worship. And to be fair, they have been resolving issues within community for years with or without help, you know that has to be said. But going forward, certainly from a trust point of view like it (our long-term plan) says we're moving from engagement to involvement. And it's how we (statutory services) develop sustainable partnerships and dependable, sustainable partnerships with community organisations to improve outcomes for mental health patients on both the preventative side and at the point of transition and discharge back into communities.

One respondent was, however, of the view that though faith-based organisations were a valuable community asset, much of their support was still limited to meeting the needs of their congregants and many times, did not extend to outsiders.

FG1.P2 -- So I think the faith communities are leading the way; however, that's with a certain demographic and their own congregation, and that learning and that leadership that they're doing is not visible in the actual community on the streets by the, you know, the actual communities. And so, they have no idea of that entry point or other than obviously that the faith institutions.

They further suggested that a more holistic, innovative approach needed to be taken to engage multiple stakeholders to address the multifaceted issues surrounding the mental health of Black and other racialised communities. Citing an example of a current project being undertaken in the West Birmingham area, they shared suggestions on how these partnerships could tackle these problems more efficiently.

FG1. P2 -- We have in the Handsworth area and the Soho BID, so it's a Business Improvement District which has a small amount of funding in terms of improving the local area. But improving the local area and we have to be honest and accept the fact that if you walk down Soho Rd, you're going to see lots of people who are probably drinking, on drugs, prostitution and you know and all of these are the results of mental health issues that they've been experiencing. So, if you're gonna have an initiative that's about improving the business district, you can't ignore the fact that there's a mental health problem in the area. And so, you know, those wider initiatives should you know, explore this

and work with faith leaders, local community leaders, with providers, with activists and work together so that we can improve the local area and tackle some of those issues.

The urgent need to promote and sustain inter-organisational collaborations, was further emphasised, especially considering how the recent COVID-19 pandemic had brought to the forefront the harsh realities surrounding health inequalities within Black communities. Some participants highlighted their joint involvement with other voluntary organisations in various capacities, especially during COVID, when the nationwide lockdown necessitated a re-assessment of the priorities and needs of the community. In a bid to protect the vulnerable and provide food and shelter for many during this health crisis, many organisations galvanised their resources and manpower to support each other.

FG2. P1 -- So if I tell you that during the pandemic, an area of my work was about emergency support and emergency assistance. So, you know, lots of people were suffering in terms of their mental health, you know, getting out, getting shopping resources and things like that and basically, the council couldn't do it. So, we had to go to stakeholders, organisations, neighbours and what have you, so we had to change up how we allocated resources to enable people to just help people. Do you know what I'm trying to say? So, I mean it can be done and that was right across from, you know neighbours, you know, right the way up to large organisations had to change the way they did things.

The imperative to cultivate more of such partnerships was, thus, acknowledged as crucial to the development of holistic, culturally sensitive services.

6.3.3.1 Barriers to fostering and maintaining community partnerships

Despite the acknowledgement of efforts that were being made to nurture such partnerships, especially between statutory and voluntary sector services, participants raised concern about a few obstacles that hampered progress in this area. Some participants noted that post-pandemic, many of the collaborations that had been fostered did not pan out because of ineffective communication between mental health service deliverers. One participant referred to the lack of inter-organisational communication as a crisis, stating:

FG2.P1 -- What we have as well is a communication crisis; never mind the mental health crisis. Communication is absolutely key and that is the foundation of what, what we do, the workshops, the activity days, is about communication. Cause I think we've got a massive crisis; we've got organisations that don't talk to other organisations. A lot of the things that I'm seeing, it's the communication. I'm like, I don't understand how we've even got this far, how we're even achieved, what we've got so far with the way that some of the communication is. There isn't any emails if they're not responded to or conversations, or you'll go to a meeting and then it's absolutely puff the magic dragon for the next year.

This communication crisis and lack of collaboration also led to the perpetuating of what one respondent referred to as the revolving door phenomenon in statutory services. This also resulted in a lack of coordination across providers and community organisations, particularly at the point of discharge, leading to a fragmented system of care:

FG1. P4 -- It's called revolving door. People who come in at a particular point of entry and then they move on at the point of discharge, but we're starting to see them come back. And what we're seeing at the point of discharge is the gap where there isn't the link to communities that we would hope for and this is why we're driven in terms of we need to start to talk to communities about the challenges at the point of transition and discharge, and how do we get those communities (individuals and organisations) involved to support those individuals. And I think there's a kind of breakdown in the referral processes when people are, you know, discharged. And I think that's when they need the support the most. So it's really again improving the partnerships and networks that we have.

This lack of communication was also linked to the poor visibility of black-led organisations within the Black African and African-Caribbean communities. This concern was also highlighted by participants both in Phase 1 and 2, where community members were of the view that they were unaware of the existence of some of these organisations. One respondent spoke on how the COVID-19 pandemic had affected many grassroots organisations, causing them to shut down and further worsening the already existing problem around low awareness of the existence of these services within the community.

FG1.P2 -- …I think prior to the pandemic, there has always been a lack of black institutions within Birmingham who were leading on this subject and I think now after the pandemic it's even more fragile and I find it difficult to kind of find those who were, you know, championing this outside of the faith community …; there isn't enough Black-led or culturally sensitive initiatives or organisations that are visible on the streets to those people and they probably exist. And I think some of the things we're talking about … is how we communicate, how we work together, how we promote what we're doing and how we provide that pathway for somebody who's experiencing mental health.

6.3.3.2 Solutions to bridging this gap

The identification of these barriers was followed up with various suggestions on how to resolve this issue. One participant proposed that organisations represented in this study should take the first steps towards championing the cause for nurturing and sustaining such inter-organisational collaborations.

FG1. P2 -- I think there is a real need to especially now for everybody to galvanize together and work more in terms of leadership. And leadership, you know, it doesn't have to be anything big at first. It could be just like, you know, sharing what we already know and doing a bit of a mapping exercise

and then taking it forward from there and then working with myself who I would consider myself to be a bit of an activist. So, working with activists like myself like, you know, to kind of make it happen.

Another participant further proposed that to sustain such partnerships, there was the need for the diverse services, especially those represented, to be honest about their limitations and plan towards establishing connections with other services that possessed strengths in certain areas, to better support service users. This further emphasised the need for a mapping exercise to identify the current resources and knowledge base available to support the delivery of culturally sensitive services.

FG1. P3 -- And so I think there is something there about how can we be honest and open about our limitations and then how we can recognise actually, we've got these limitations but if we work alongside and connect with people in this area or other folks in this space, that actually we have group strength. We have strength together and so that's my ask to folks in the meeting who might be working in and around Handsworth. I'd love to connect with you in person and thinking about how we take those steps forward as a collaborative.

They further expressed that one of their visions for improving awareness/visibility of services operating within Handsworth and surrounding areas was to make efforts towards providing a shared space where service providers could come together regularly and promote their services to the various communities.

FG1. P3 -- And you know, for the folks who kind of work in and around Handsworth, you know, one of the things I'm trying to kind of pull together is even just a once every couple months, some of the different service providers from voluntary organisations in Handsworth are able to kind of come together physically in the area and just share practice. And like, you know, we're talking about promotion of different services, promotion of different activities and, ultimately, you know we can't just assume because we run a service that people know that we're running a service. And the main way we're gonna be able to take steps forward together is actually thinking about how we can fit together as pieces of a jigsaw, because we're all really important pieces.

Another suggested the need for capacity building of grassroots organisations, especially through the support of other statutory or voluntary sector organisations that were well-established and had been successfully operating within these communities for a longer period.

FG1. P4 -- …also helping them in terms of, and this is the other side about sustainability, their governance. So, when communities set themselves up as organisations, they're great at delivery, fantastic on the operational side. But once they become an organisation, there's other things that they need to think about in terms of running the business, in terms of the administration, in terms of funding applications and sometimes we naturally almost deskill them from the operational bit. We should be doing more about supporting them from a capacity point of view. And then also building their governance around areas that support them so that they can maintain their very necessary operational stuff.

Another participant proposed that grassroots could be supported to build sustainable business models that ensured that funding, which was one of the biggest concerns around voluntary sector service delivery, was accessible.

FG1. P2 -- I agree that I think funding is an issue. I mean, at *mentions organisation*, we get very, very little funding and we deliver quite a lot. And we're able to deliver that, it's because I think we've developed a sustainable business model for the work that we're doing. Obviously, we're in a position where we don't employ anybody, but we do know higher sessional people who do particular areas of work.

Also, emphasising the lack of understanding between service deliverers and funding bodies due to the lack of governance structures within some grassroots organisations, one participant highlighted the need to promote evidence-based research and data-generation techniques among these organisations. Based on their experience of facilitating partnerships between funders and voluntary organisations, such data and evidence facilitated the continuous flow of funding to maintain services within the community.

FG2. P1 -- There are resources out there, whether you believe me or not. But with organisations and fundholders, you have to be able to demonstrate the need and you have to be able to demonstrate that positive impact it's going to have by doing this piece of work. What I think is that some of these organisations need to be approached and lobbied, using data. If you just go with anecdotal information, it's gonna fall on deaf ears. So, the data, health profiles and what have you, it speaks for itself. So, in a co-ordinated way, somebody needs to take the mantle to go to these organisations to flag what needs to happen.

As evidenced in the responses above, encouraging the building of sustainable partnerships was a recommendation which service deliverers also saw as an essential necessity for improving service delivery across both statutory and voluntary sectors. The lack of communication, poor visibility of services within the community and the lack of collaboration were highlighted as some of the barriers to nurturing such partnerships, which had also resulted in fragmented systems of care. Of particular concern was the neglect of partnerships that had been forged during the COVID-19 pandemic to meet the needs of diverse populations, as many organisations went back to normal service delivery when the crisis was over. Noting all these gaps, service deliverers proposed that some innovative approaches needed to be adopted to better engage multiple stakeholders within the community, as well as provide capacity-building support for grassroots organisations that could benefit from such

partnerships. These efforts were considered imperative to attaining the goal of improving accessibility of services.

6.3.4 STRATEGY 3: PROMOTING HOLISTIC, COMMUNITY-TAILORED SUPPORT

Another key priority proposed in Phase 2 was the need for service providers to adopt holistic and innovative approaches to nurturing community interest and engagement with services. Participants in Phase 2 had identified that some service deliverers were still out of touch with the communities and needed to do more to tailor their services to support the needs of the Black communities they served. One prominent strategy service provider said they had engaged with empowering community members through education and offering volunteering opportunities. One participant shared their approach saying:

FG1. P2 -- Learning is the next component of five ways to well-being. So we do focus on learning new skills and we're not talking about, you know, putting them under pressure and setting them up to fail by doing qualifications, but just learning new skills in general, doing gardening or, you know, learning how to become a committee member or, you know, stretching, you know, their capabilities is what we do. And then, obviously, to give back, so we encourage volunteering as part of the work we do. And that also helps people on their road back to employment and improve their well-being as well just, you know, being out in the Community doing stuff, you know, volunteering and seeing things from a new perspective.

Another participant stated:

FG2. P6 -- On our non-executive board, what we've done is we've encouraged people that have used our services, that are maybe at the other end of their journey to maybe start supporting in a way that they find beneficial to them but can inform our services. And we will at the end of every… closing of service that we've provided someone, ask for feedback. And from a lot of that feedback we have, well, those are the opportunities when we say to them, 'Come and support us'. This enhances the equity in the Community and that's what we need. And I always say, even with our volunteers, they will get all the training that we deliver as products for free. We will support them to either use our space for free as long as they're willing to put back into our community.

Others also highlighted their current efforts to bring mental health services to the doorsteps of the community in a bid to foster community engagement (Dream Priority 2):

FG1. P2 -- … we deliver a tailor-made programme of support for the local community, which is a mixture of many different elements. It's not one major thing. So that's our vision, that's how we intend to do it. We've got, at the moment, we've got our main hub, which is in Handsworth and I think we're quite well known within the Handsworth area in terms of the support that we give. We've developed our support in the Edgbaston area, which has become very successful and also in

the Lady Wood area at the *mentions venue*. So, we're kind of branching our wings and we're getting out there. We wanna take that model onto a bus and go right into the heart of neighbourhoods and you know, and bring our partners, our networks and our, you know, practitioners along with us on the way.

6.3.4.1 Barriers to sustaining community interest and engagement

Yet still, despite these efforts to nurture interests within these communities, there was still a lack of engagement and community involvement in mental health services. One barrier was around the issue of services not Speaking the language of the community, where the information shared regarding the services was either inaccessible or incomprehensible. This concern was also discussed in the previous phase, where participants spoke of the gap in communication between service providers and service users, notable among other organisations, particularly statutory mental health services. One respondent stated:

FG2. P4 -- There's lots of good research and data out there, but it's how do communities access that information in a way that they can understand it and then use that to inform their approaches, but also use that as their evidence base to go and have those conversations about how to make changes**. **And that's where I think, you know, sometimes you can read a report and you know just the language** (all agree) **or just the, you know, it's really difficult to interpret and then use that to move forward.

FG1. P2 -- Most organisations wouldn't understand this, but you know you have to understand the communities that you're working with and how you approach. It's such a sensitive and important subject with them, and sometimes the tools that the mainstream services use to identify and support well-being may not be effective.

6.3.4.2 Solutions to fostering community interests

Even though this communication gap was a significant barrier, participants agreed that the community also had a shared responsibility in fostering the collaboration, co-design and co-delivery they envisaged by taking certain steps to meet service deliverers halfway and engage with them. One suggestion made was that communities needed to make use of the resources that were already available and capitalise on them to support each other:

FG2. P1 -- We don't want to perpetuate the dependency culture whereby people are coming thinking, you know, I need help. It's about looking inside of them, you know, understanding what makes them the person and what their aspirations are and giving them the tools to do that, but also finding the unique nuggets that they have within them, that can also be a benefit to themselves and others**. **So, there's lots of things within it, I think, but sometimes, you get caught up in all the negative and that without actually appreciating that there's quite a lot of, you know, positives and good things out there.

Other propositions made on how the community could enhance engagement with mental health service deliverers were again redirected to the subject of communication. Service deliverers were of the view that community members had access to many information outlets and needed to be proactive in connecting with the services around them. Some service providers were of the view that community members needed to be more open and honest about their specific needs, especially around mental health, especially in a bid to destigmatise the topic of mental health in the community. They emphasised that community members needed to be committed to attending workshops and open forums where they could provide effective feedback and input into the delivery of culturally sensitive services. This honest engagement would further foster a positive partnership between service users, other community members and service providers, and thus, facilitate a continuous process of co-design and co-delivery of services. In summary, in the same way community members in the previous phase needed service deliverers to be persistent in finding out the needs of the community, service deliverers expected the same level of persistence.

FG1. P1 -- I think with communities to, you know, speak to organisations about what support that they need, what things they think is gonna work, what things they don't think is gonna work, and also as well expectations of organisations. Going to see them once is not gonna resolve what their barrier is, you know, stick with it. Carry on coming. Carry on finding out about the organisations and how they can help them.

FG2. P4 -- Do organisations, groups, communities have a responsibility to kind of raise awareness, so that you can develop that understanding or is it for those decision makers to come out and actually learn more? Now I think that it's a bit of both, isn't it really, in reality that I think it's that communities have to keep pushing…

6.3.4.3 Tackling mental illness stigma in the Black community

Even so, the reality of grappling with mental illness stigma and discrimination could not be glossed over in discussions around fostering community engagement. Being a long-standing issue within the Black African and African-Caribbean communities, mental illness stigma, compounded by racism and generational trauma still stood as a significant barrier to service delivery and access within these communities. Grassroot voluntary and third sector organisations within the community have been at the helm of affairs, providing support and advocacy for individuals with mental illnesses, while championing the cause against stigma. Yet still, these organisations are significantly impacted by the reluctance of community members to seek help because of the lack of trust for these services. The need to destigmatise

mental health was, therefore, continually raised as a priority in bridging the gap in access and delivery of culturally sensitive mental health services. Participants shared some of their views, saying:

FG1. P4 -- I think our biggest challenge is how we continue to serve a diverse community. And again, I and I think there's also a big issue around stigma. Mental health stigma is probably one of the biggest challenges that we still have and also improving mental health literacy is a big issue. So, we need to do a lot more work around preventative work.

Another was of the view that mainstream organisations also had a role to play in re-evaluating their approaches to service delivery within these communities, given the mistrust and circles of fear that existed, which further perpetuated the stigma.

FG1. P2 – So, it's that destigmatising mental health is not just about the community destigmatising mental health; it's about, you know, mainstream services destigmatising their approach to mental health and the way they react to mental health within black communities.

This dialogue on destigmatisation of mental health led to the discussion on the strategies that could be adopted to promote mental health education within schools and among young people in the community. The need to encourage intergenerational discourses was one that was highlighted as a step to first, bridging the gap in understanding of mental health between the younger and older generation and, consequently, reducing the cultural stigma surrounding mental illness.

***FG1. P4 -- And I noticed also that we're not having this intergenerational discourse. You know, we do things for young people over here and those of us who are slightly older, we have it over here. Where are the spaces for this intergenerational conversation, which is really important because the experience of the elders, if we wanna call that, you know, it's a very sort of old African style of, you know, the village mentality. But I think it's a really important core value and a principle of how we develop as communities, that is clearly left. I don't think it's missing because there are some of us that are operating in that way still because it's important. So that intergenerational discourse and creating intergenerational spaces. So that richness of the conversation and dialogue can continue to happen, I think is quite attractive, certainly to me*.**

The need to pass down traditions, values and other elements of culture from one generation to another in order to build resilience and support young people within the community was also emphasised.

FG2. P1 -- And I think you can easily overlook the fact that a lot of what is needed to move forward already exists. So, if I think about, you know, my greatest role model, a.k.a. my mother, and what she instilled in me and my perception about myself and the system and wherever we're living, I'm completely resilient. But again, you know, how am I perpetuating that, how am I passing that on, you know, to my sons or what have you, because there's something that you need to do.

Lastly, the potential assistance that the Black community could extend to educational organisations to facilitate the promotion of mental health among students was also discussed. Making use of online resources as had become the norm post-pandemic was one avenue to ensure that accessibility to information on mental health was promoted.

FG1. P1 -- Technology has enabled us to bring mental health support to the younger people, you know, into the 21st Century. Because before there was a very traditional way of tackling it. But by using these online spaces, now it's made it a little bit more accessible so we're creating different types of spaces, which are recognised by younger people but also accessible to the older people who are in isolation or, you know, not able to physically get to spaces. So, I do feel the online activity is a way forward in terms of bridging the gap, building safe spaces and increasing accessibility.

One participant spoke about the use of podcasts to discuss relevant topics that community members could engage with.

FG1. P2 -- … a really, really good intervention that we put in place was working with *mentions name* to put together a podcast. And that kind of started that conversation around topics and building online spaces for people to engage with. And the beauty of those online spaces is even if you only have, you know, three people around the table have any discussion, that discussion continues with the comments, and everything else that comes with online activity.

The responses revealed that service providers were taking steps to adopt more community-centric approaches to their service delivery, where efforts were being made to empower and build capacity within the community to promote mental health education and encourage accessibility to services. The success of some of the creative approaches through which services had been brought to the doorstep of the community were also highlighted. However, there were still low levels of engagement, which were attributed to the issue of stigma and a lack of trust of services that still existed within these communities. Service providers were of the view that they and community members needed to find a middle ground where they could both support each other to ensure that services were delivered in an equitable and culturally sensitive manner.

6.3.5 STRATEGY 4: CONFRONTING SYSTEMIC AND INSTITUTIONAL RACISM

The impact of systemic and institutional racism on access to mental health services was one area that was addressed both in Phase 1 and 2 of this study, especially in line with how this impacted on resilience and help-seeking behaviour. Unfortunately, service deliverers were not exempted from this experience and representatives of both statutory and voluntary services highlighted how racism was a major barrier to promoting cultural sensitivity in service delivery. Voluntary sector service providers particularly highlighted the impact of racism and discrimination on access to funding, lack of support from some statutory services, as well as the limited access to resources needed to reduce health inequalities in mental health services within the Black community. Reference was also made to statistics and research evidence that implicated systemic racism in the high rates of hospitalisation of Black Africans and African Caribbeans in secure mental health services, particularly men.

FG1. P4 -- From a statutory organisation point of view in relation to Black patients, and that's male and female, even though it's weighted more on the male, there's a huge over-representation. And it's a historic over-representation. So, if we're talking about cultural sensitivity from that point of view in terms of how that affects and impacts and how some of our own practices impact on the people that we're trying to serve, I think there's also some issues around systemic and institutional issues that we need to consider within our leadership roles.

The lack of cultural sensitivity and cultural competence in service delivery was further emphasised due to entrenched Western systemic and institutional practices.

FG2. P6 -- And when it comes down to it, it's because of the lack of cultural competence. When people are going out and getting these academic courses and to give you an example, I am qualified as a counsellor too and had be on a BACP-accredited course. When I took my course, everyone that was teaching was a white professional. You know, historically, counselling is like a white male type of role and the most that that course at degree level had to say about people of colour in terms of a typical presentation was that black people have a high uptake in mental services and there's a strong link to cannabis. There's a lot more to black people and their experience.

However, another participant cautioned that the term cultural sensitivity needed to be reassessed and redefined to gain clarity on what specific needs were encompassed within these terms which, in their opinion, were being overused.

FG1. P4 -- I think, for me, it's about access and when we talk about culturally sensitive services, what are we actually talking about? Because there are some other mainstream services that can support people, you know, in culturally sensitive way. It's not necessarily about black. And I think when we constantly talk about culturally sensitive, we have to really start describing what that is because just because you may be culturally sensitive doesn't mean you're able to meet a need. So, when I'm

talking about cultural sensitivity, we really probably need to start defining what that is, because that's the buzz term at the moment, culturally sensitive services. So, everybody is starting to put that in their briefing and in their policy. But if you actually break down what, if you start to ask them what that is you start talking about equality and diversity, which is very different to what I think is being discussed here.

Nonetheless, to effect long-lasting change in the communities they served, it was crucial that organisations developed strategies to counteract the effects of these systemic issues, as well as advocate for equity in healthcare delivery. In their opinion, the system was specifically built in a manner that placed Black Africans and African Caribbeans, as well as other minority ethnicities in disadvantaged positions within the society. One participant voiced her opinion, saying:

FG2. P6 -- You know, the system isn't broken. It works exactly how it's supposed to work to keep certain people where they want to keep them. And we've got to do things differently, you know; we have got to get ourselves out of this, 'cause no one, it's not in anyone else's interest.

One more respondent stated that because the system was designed to put some groups at a disadvantage, it was necessary to develop strategies to work within these systems, doing what he referred to as 'playing the white man's game'.

FG2. P1 -- I remember my mother saying, 'Son, you have to learn how to play the white man's game. That was something that resonated with me all the way through. So, what I'm trying to say is that there is a system that we operate in and in order to progress, we have to understand that system and work within that system. And if you don't know how to operate and work within the system, you're never ever going to solve anything.

However, it was evident that, as service providers from Black African and African Caribbean backgrounds, these participants had an in-depth understanding of dealing with racism and discrimination both on a personal and organisational level. Given that one of the areas highlighted during the dream phase was dealing with institutional racism at work, and this led to discussions on an issue highlighted in Phase 2, on how the organisations present could provide support and promote safe spaces for Black workers to deal with microaggressions and discrimination at work. Some service providers spoke on how they already had plans in place to provide such support:

FG2. P7 -- In terms of the staff, coming out in October, it should be advertising quite soon, we call it emotional healing; emotional lunch breaks. So, an online safe space for black people staff at lunchtime, that kind of thing, 45 minutes to an hour, every day, to be able to come online and engage

with blackfulness, soulfulness not mindfulness, blackfulness, soulfulness. A space to share, to be heard, to be held, to be nurtured, and to breathe.

One participant also highlighted that slowly, leadership of statutory organisations were embracing diversity and inclusion, and was confident that, as more individuals from racialised backgrounds rose to occupy positions of influence, there was hope that they had the capacity to bring some lasting changes.

FG2. P1 – So, in terms of that influence, I'm confident that, in the future, things could get decidedly better for, you know, kind of black, Asian minority background, staff going forward. I think you know there is room for improvement big time in a number of areas. But I'm confident that it will get better just because of that individual and even at a high cabinet level, there are key people that are really pressing the agenda.

As indicated in the contributions from service providers, the pervasive nature of institutional and systemic racism was, indeed, a major barrier to providing equitable and culturally sensitive mental health services. For voluntary sector organisations, the difficulty in accessing funding and other resources needed to carry out their projects was a major hindrance to service delivery. It was suggested that clever strategies needed to be employed to beat the systems that were designed to put such services, particularly Black-led services, at a disadvantage, especially if culturally sensitive service delivery was to be attained. One participant, however, encouraged that more consideration be made in addressing the nuances surrounding the term, 'cultural sensitivity', so as not to trivialise the gravity of the multiple needs that had to be addressed in providing culturally sensitive care. Despite these obstacles, there were notable efforts being made to promote empowerment and capacity building among service deliverers to enable them advocate for their rights.

6.3.6 STRATEGY 5: TAKING OWNERSHIP AND TAKING THE LEAD

Notwithstanding the limitations that systemic and societal influences caused in ensuring equality in access to healthcare within minority communities, participants discussed the need for Black service deliverers and users to finally take the reins and champion the change they hoped for. Service deliverers, frustrated by the lack of cultural sensitivity and competence in

statutory services, asserted that the time was right for Black-led organisations to mobilise themselves and work towards a common goal of self-reliance and resourcefulness. Some participants voiced that it was time to be unapologetic about Black identity and take ownership of services that cater specifically to the needs of people of Black African and African Caribbean backgrounds.

One participant, who had been championing the cause for Black-led mental health services for a few decades, recounted an experience of having made the effort to build a facility for Black people who had mental health issues, but had to close down the business for failure to receive government support, even though initially promised. Her view on how to circumvent the systemic barriers in place were stated in these words:

FG2. P7 -- So yeah, I hear we do have to have the evidence, but I think we've spent 50 years actually, you know, giving them what to do, what they say we need to do in order to be able to do that. It makes no odds in the longer run. I think that's kind of why I've turned away from trying to do that and just doing what we can do. What do we need to do for ourselves, for our communities that you know that that's self-sustaining, you know. And really having to, we can't be waiting for them. We know it's unjust, it's unfair and they (government) should be financing, and they should be supporting, but it's not in their interest. So, we have to take responsibility for ourselves, and we have to engage in a way that's meaningful and actually can begin to change it.

The need to empower service users was again highlighted as critical to influencing this drive to take ownership of and champion culturally sensitive mental health services. Offering resources for capacity building was one suggestion made towards helping community members to take control of and advocate for themselves and others when it came to accessing services.

FG2. P5 – A lot of our service users are not heard elsewhere and they're not heard because it is difficult for them to express themselves in a way that, you know, bigger organisations want to hear or are willing to hear. So, when they leave us with that little bit of education and empowerment, it means that they are able to fight their own fight. And then we feedback and they come back into our leadership…. We try and hold onto people who come through our door in order to build the resources in our community. So yeah, that's what our organisation does.

A respondent drew attention to some of the resources currently available within their organisation to facilitate the empowerment of service users.

FG2. P7 -- We're also developing African-centred courses for Level 3. So it's for people who have got no previous experience of counselling or therapeutic interventions; how to work with our community in a culturally appropriate way; how to do the work on yourself so you're not damaged by the work that you do. And then, we're getting this, in the process of getting that course accredited. So, you can actually get a certificate that shows that you have done the work and that you are skilled up

sufficiently to be able to go and do therapeutic interventions with others that's not going to damage yourself.

The need to empower grassroots organisations emerged once more, with an emphasis on tailoring services to better meet the needs of the communities they served, while remaining unapologetic.

FG2. P6 -- When there's no money, the public health approach goes out of the window. So, if we aren't educating our local organisations, our grassroots organisations to be compliant and able to actually go and tender, we will never get the services properly to the communities. It's about our local grassroots communities getting into these panels, having a voice and changing the strategy. We've got to train our own because no one's gonna do it for us. We know that because we're all sat here, frustrated because we're having the same conversation from 20 years ago, 30 years ago. We'll be having the same conversation in another 20 years if we aren't prepared to do something, what are you prepared to do is the question we need to be asking. Why do we have to be apologetic to say that we are considering black people or people of colour when statutory services don't? You know we've got to create our own. And it's that simple.

Participants came to a consensus that the envisaged change in service delivery for the Black community needed to start with themselves, as they all had a part to play and were in a position to influence change.

FG2. P1 -- There are people a lot on this call and that do have the tools to kind of move this leadership journey forward. So how is that being captured and how is that being passed on? So, there is that element. Also, there are people in quite influential leadership positions, albeit that some of them like myself and are bashing heads on glass ceilings. Nevertheless, we still have a degree of influence and we still have the ability to kind of, you know, move an agenda forward

FG1. P4 -- I think we're all leaders in our own right. But it's how we are innovative and creative about how we get that information out and we can look at the systemic issues, which is part of the strategy to be fair….

Having a mutual shared vision for ownership and empowerment, participants were able to identify and strategise towards utilising the opportunities available for the improvement of mental health services within the Black community, through mobilising resources and fostering sustainable collaborations.

The outcomes of this inquiry suggest that service providers were making significant progress in addressing the priorities that were proposed by community members in Phase 2 of this study. Having presented these recommendations to service deliverers, their responses

suggest that much effort was being made towards improving community representation in leadership and decision-making, fostering sustainable community partnerships, and encouraging community involvement using innovative, community-centred approaches. Although efforts were being made to promote the delivery of equitable and culturally-sensitive mental healthcare, there were many barriers that hindered progress, including the lack of inter-organisational communication, the lack of access to funding, low uptake of services, as well as the influence of systemic and institutional racism. Notwithstanding, there were several solutions proposed to overcome these hindrances, prominent of which was the need for Black-led mental health service deliverers to be at the forefront of championing the campaign for more equitable and culturally sensitive service delivery. Participants saw the current focus groups as viable opportunities to initiate the strategies they had collaboratively formulated towards reducing health inequalities within the Black African and African Caribbean communities. The Design and Destiny implemented in Phase 3, therefore, efficiently facilitated the co-production process.

6.4 DISCUSSION

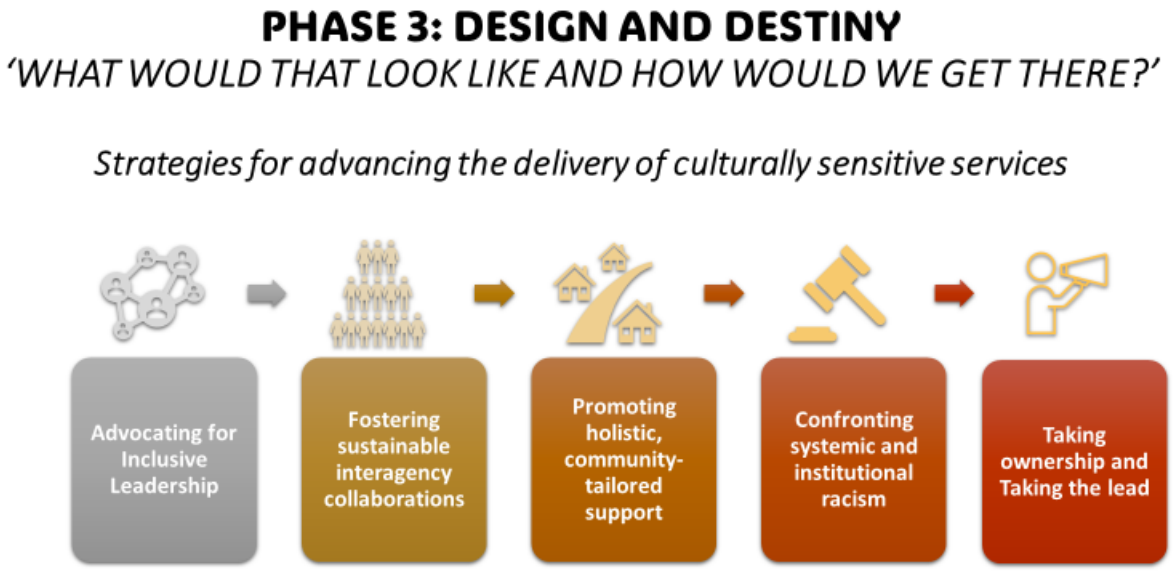

Figure 9: Summary of Design and Destiny Strategies

The final phase of this study implemented the Design and Destiny stages of Appreciative inquiry in discussions with statutory and voluntary sector organisations who delivered mental health and well-being services within Birmingham. With the objective to collaboratively design and implement sustainable solutions with mental health service providers for promoting equitable, culturally sensitive mental health service delivery, this Phase engaged 11 service deliverers (representing 2 statutory and 6 voluntary sector organisations) in addressing the recommendations and priorities proposed by community members in Phase 2 (Dream). Participants, who represented the voluntary sector, delivered a wide range of services within West Birmingham and other areas in the city, including counselling and advocacy, faith-based mental health support, Black-heritage mental health and well-being support, as well as supported housing assistance. One statutory service provider offered a wide range of in and outpatient secure mental health support, while the other worked with several local organisations to support the health and well-being of elderly people and promote community development. Gaining insights into the effective strategies currently in

place to improve culturally sensitive mental health service delivery was key to evaluating how well these services were executing their mission and vision for improving access to mental health for the communities they served.

The narratives shared in this Phase give account of the different angles at which either service providers or service users approached the realities surrounding the delivery of and accessibility to culturally sensitive mental health services, respectively. By evaluating the priorities and recommendations proposed by community members in Phase 2 against their current services, it was apparent that many efforts needed to be made by service providers to promote inclusion and representation of people of Black ethnic background in leadership and encourage the input of experts with lived experience in decision making. To ensure that participants were aware of their involvement in the co-production process, they were reminded at every stage of that their contributions were instrumental in positioning them as experts in the coproduction process. Thus, the priorities identified in Phase 2, where community members discussed specific areas of mental health that needed to be engaged to promote the improvement of cultural sensitivity contributed to what later developed into a checklist that helped ensure the research remained grounded in community needs. These priorities further facilitated the translation of community input into actionable strategies which service providers could compare with the current services they were delivering within the community.

Capitalising on community assets and fostering sustainable partnerships with the goal of reaching out and meeting the specific needs of the community was also extensively addressed along with the need to adopt holistic and creative approaches to tackling stigma and improving help-seeking behaviour. However, on presenting these priorities to service deliverers, the narratives shared revealed evidence that all these priorities were already being addressed at various levels and though there were still gaps to be filled, there was work being done to address the deficits highlighted. These contrasting narratives reflect that though these services are working towards the priorities of the community, there are still gaps, owing to a range of barriers faced by these organisations. There is therefore, the need for these services to establish more effective lines of communication to the community that would better inform them of the work being done to meet these goals, and the progress made in the face of the barriers encountered. Although there was an overlap in some of the

experiences shared, particularly around the impact of systemic and institutional racism on access to services and the delivery of equitable healthcare, the gap in knowledge transfer had resulted in a fragmented co-production process that had heightened the disconnectedness between both groups. Nonetheless, these results demonstrate that the critical appreciative inquiry process implemented here helped to gather comprehensive insights into nuances and complexities of the co-design and co-delivery process and fostered collaborative efforts among community members and service deliverers to address the gaps in healthcare delivery.

6.4.1 Design and Destiny: 'What would that look like' and 'How do we get there'

The positive principle of appreciative inquiry suggests that one of the means of keeping groups interested in the appreciative process is to value and acknowledge the differences in realities on what works best and what gives life to an organisation (Cooperider, Whitney and Stravos, 2005). Thus, in order to understand the realities of service deliverers and their efforts to deliver culturally sensitive mental health services, as well as effectively address the questions **'What should be?' and 'What will be?'**, it was important to understand the strategies these organisations currently had in place to support the needs of the Black African and African Caribbean communities they served. The poetic principle of AI posits that teams, groups and organisations hold an unlimited capacity to explore opportunities and initiate impactful change based on the perception of their strengths and how they apply these to the change they envision (Stavros, Godwin and Cooperider, 2015). In this regard, bringing relevant stakeholders together, as demonstrated in this Phase (3) of the AI process, was key to fostering creativity and enhancing collective capacity (Bushe, 2012).

One advantage of bringing these service providers together was that majority of them had never been in contact with each other and, thus, they were able to build a sense of connectedness, based on their shared vision for the future of mental health service delivery for the Black African and African Caribbean communities they served. Typically, the destiny Phase (3) of appreciative inquiry is where a tangible strategic plan is produced with mission and vision statements, as well as plans and objectives to be carried out within an agreed frame of time (Keefe et al., 2004). However, Bushe and Kassam (2005) suggested deviating from

traditional change management and problem-solving models that require a set of strategic plans and proposed a more dynamic approach to encouraging processes that permit improvised action (Cram, 2010). Their idea of the destiny stage also supported the view that collective agreement be birthed from a process of creative deliberation among groups, informed by the process of change that has already begun in previous stages (Bushe, 2007). Thus, providing an environment to foster networking among various service deliverers was the next step to initiating these strategic plans as is evidenced in some of the solutions and strategies outlined in this Phase , many of which had also been proposed in phase 2. Bushe (2007) further proposed that this process of initiating strategic plans helped leadership to leverage their strengths in a more generative manner that promoted sustainable, transformational change. Ridley-Duff and Duncan (2015) further suggested that when implemented well, the Design and Destiny stage encouraged participants to appreciate the power they had to act on the dreams, visions and priorities that had been developed in earlier stages of the AI process.

In this study, both community members and service deliverers identified the role they each played in fostering the changes they hoped to see towards alleviating health inequalities in the Black African and African Caribbean communities and promoting culturally sensitive services. The creation of what Cooperider et al. (2008) refer to as social architecture was also a key outcome of this phase. In their view, this social architecture consisted of practical solutions to ensuring the implementation of the systems of change addressed during these phases, where the information gathered led to continuous learning and improvement. Roddy et al., (2019) were of the view that the formation of this social architecture was a means of encouraging the mobilisation of resources, as well as improving training and communication aimed at anchoring and sustaining the generative process.

In this Phase, service providers' recognition of the need to communicate more, as well as provide mutual capacity building and empowerment support, was a significant outcome which the AI process had fostered. Roddy et al., (2019) added that the potential implications of these generative systems and processes could include changes to policies and practice, which emerged during this Design and Destiny Phase. The development of a checklist to support this continuous re-appreciation and reinforcing of generative change, primarily

facilitated by the input of both service deliverers and community members, is one of the outcomes of this study.

These findings, therefore, speak to the value of the appreciative inquiry process for engaging service providers in the co-production process, towards improving the delivery of culturally sensitive mental health services for the Black community in Birmingham. The other ideas shared during this phase are discussed considering the current literature on the process of co-production in mental health service delivery.

6.4.2 The role of the Voluntary sector in championing the delivery of culturally sensitive mental health services

The particular interest in third and voluntary sector organisations within this study was part of the appreciative process of highlighting evidence of good practice and contributing to the literature on the current role of these organisations in bridging the gap in health service delivery. Given the history of the voluntary sector in the UK, they have been known to play an invaluable role in the delivery of mental health and well-being services, especially among minority ethnic communities, in areas where statutory services have been unsuccessful. By developing innovative regimes of care, tailored to the needs of the communities they serve, they have provided extensive support in areas of healthcare, education, employment, and housing through their relational-based methods, which differ from that of mainstream organisations. Where there have been gaps in statutory service delivery due to mistrust and fear as a result of systemic racism and health inequalities, voluntary services have met the cultural, religious and social needs of these hardly reached communities (Care Quality Commission, 2012; Newbigging et al., 2017).

By fostering a sense of trust and understanding within communities, voluntary service providers have supported the nurturing of collaborative environments which empower service users and encourage their input and engagement in the advancement of services (Devonport et al., 2022). As demonstrated in this study, a few of the services present shared how many of the initiatives they had implemented had been designed through extensive engagement with the community that had provided feedback that helped address their specific needs in a more holistic, public health approach. The feed-forward process adopted

at this stage helped to draw parallels between the experiences and narratives presented in Phases 1 and 2 and those presented by service deliverers.

The presence of representatives of statutory organisations, was also pertinent to addressing concerns around leadership, interorganisational collaboration, as well as holistic community engagement, towards the promotion and delivery of culturally sensitive mental health support. Their views differed significantly from those shared by voluntary sector representatives, in that their efforts were still 'playing catch up' in their efforts to bridge the gap in service delivery. Although more efforts were being made to engage and involve community members in the co-production of services, there were still significant barriers to instituting organisation-wide change. The review of major policies, such as the Mental Health Act and the proposals set out in the recent White Paper (Department of Health and Social Care, 2022) are proof of the good intentions policymakers have towards improving representation of racialised communities in healthcare governance and leadership, among others. However, evidence is yet to be seen on how successful the implementation of these proposals will be towards alleviating the health inequalities that impact the delivery of culturally sensitive mental health services.

6.4.3 Promoting the sustainability of co-production initiatives

The need to foster sustainable community partnerships and encourage community involvement in the co-design and co-delivery of mental healthcare has become increasingly popular in public sector health service delivery (Boyle and Harris, 2009). Bolam et al. (2010) defined co-production or co-creation, within the context of healthcare settings, as the recognition of service users and community members as experts by lived experience and as assets in the promotion of equitable care. Several scholars have drawn attention to the effectiveness of co-production initiatives in mental health service delivery, both in the UK and internationally (Clark, 2015; Dent, 2019; Bester et al., 2022). Highlighting the positive impacts, they have shared evidence that these co-production efforts have led to transformations in power dynamics between service users and deliverers, changes in practitioner attitudes and fostered mutually beneficial relationships between service users and providers. On the other

hand, some arguments have been presented regarding the actual reality behind the implementation of such initiatives and the genuineness of the intentions behind such efforts, particularly when it comes to the inclusion of racialised communities in the co-production process. Scholars like Rose and Kalathil (2019) have addressed the failure of many co-production initiatives to efficiently challenge the existing power imbalances that essentially perpetuate the very inequalities being addressed. They criticised the tokenistic nature of such collaborative efforts, stating that the inclusion of experts with lived experience in the co-production process was simply a tick-box process to satisfy policies on equality and diversity. Similar concerns were addressed across all Phases in this study, and especially in Phase 3, where both statutory and voluntary sector organisations highlighted the risk of trivialising the efforts and input of service users and, subsequently, perpetuating the cycle of inequality. As suggested by one participant in Phase 3, it was time for Black-led organisations and other Black activists to be offered more executive positions, where they were remunerated for their input and not simply consulted on a one-off, volunteer basis. Cleveland et al. (2018) referred to this as cultural taxation which takes place when Black people volunteer their experience, expertise, and knowledge towards the improvement of services without being accorded the due recognition in return for their efforts.

Kirkegard and Andersen (2018) have also critiqued the transient, time-limited nature of such initiatives, stating that many of the outcomes of these projects are short-lived and do not lead to sustainably integrated reforms in policy and practice. According to Turnhout et al. (2020), true co-production is underscored by an environment that supports mutual learning between multiple stakeholders, challenges dominant systems, norms, and policies, and works towards embedding the change proposed in institutional frameworks to promote sustainable change. Having fostered a collaborative environment between these service providers, one notable outcome was the shared vision to challenge such performative systems of co-production to ensure that the change sought was not only aspirational, but resulted in concrete, sustainable outcomes that targeted the systemic barriers which often hampered progress. Similar sentiments were shared in Phase 2, where community members argued for institutional flexibility and encouraged service providers to be 'resilient' in their pursuits towards engaging community members in such co-production efforts, as often, their voices and input were merely gathered to comply with established protocols. Promoting equity in leadership

structures required promoting black health professionals to positions of influence and respecting them as valuable contributors to the transformation of policies that govern the healthcare needs of Black people.

One proposal elaborated on for advancing efforts towards an equitable co-production process was the need to efficiently engage various community assets as hubs where empowering environments could be fostered for engaging community members. Many of these organisations present stated that they already made use of various community assets, such as community hubs, faith-based institutions, and cultural centres and these had proved beneficial for bringing their services to the doorsteps of the communities they served. Frost et al. (2021) bring light to evidence of the effectiveness of the use of such safe spaces in the co-design process in their evaluation of the various projects under the Space to Connect initiative, in partnership with the Department for Digital, Culture, Media and Sport (DCMS) and the Co-op Foundation. They highlight a project in Stoke that supported progressing arts and cultural activities within various communities, by bringing together an advisory group constituting of local mothers, university staff and people with lived experience of mental health from diverse backgrounds. Their evaluation of this co-design and co-delivery initiative showed that community organisations saw better sustained engagement and the delivery of more innovation within these creative thinking and capacity building schemes when they promoted the use of these assets within the area.

Another strategy discussed was the integration of digital innovation in the co-production process by adopting a blended digital/physical approach to involving service users and community members. In a post-pandemic era, Fancourt et al. (2021) proposed the need for more innovative inclusion of digital technology in service user engagement as imperative to the improvement of service delivery. The use of Zoom and other video-based technology have become popular for providing a platform for service user engagement and should be encouraged in lieu of face-to-face methods of service delivery. Service providers highlighted some of the efforts they had made to narrow the digital divide that was apparent within these communities, and, in their view, the pandemic had revealed that the boundaries could be pushed in seeking innovative ways to engage the community to promote sustainable change.

6.4.4. Co-production as a means of addressing stigma in the Black community

Promoting the co-design and co-delivery process among community members was also an important consideration towards effort to destigmatise mental illness and access to mental health services within the Black community. Education and capacity building, as well as other prevention and promotion methods were repeatedly highlighted as a key aspect of service delivery. Edge and Grey (2018) emphasised the importance of the use of such community-partnered approaches in their study on the development of culturally adopted family interventions for Black African Caribbeans living with schizophrenia towards alleviating the stigma around this condition. They attributed their success to the application of a strength-based approach to partnering with service users, carers, stating that engaging seldom-heard-of communities in the co-production process of their family intervention service endorsed the service as acceptable and promoted accessibility to the service.

Jensen et al. (2021) also argued for the use of more asset-based approaches to engaging in the co-production process, stating that this collaborative approach encouraged contributions that challenged some of the assumptions, held by service deliverers, regarding racialised communities, such as those of Black ethnic background. Addressing the nuances behind the resilience narrative in the Black community, for instance, was an example of challenging some of the assumptions surrounding the barriers to help-seeking behaviour. Some of the service deliverers who were of Black ethnic background shed light on how their own experiences of tackling racism and discrimination had encouraged them to empower others to lend their voices towards shaping interventions that helped normalise and destigmatise help-seeking behaviour.

As both statutory and voluntary sector deliverers collaboratively deliberated on the strategies needed to alleviate stigma and promote accessibility to services in the Black community, it was evident that an appreciation of the lived experience of those represented in the room clearly resonated with that of community members. This further fostered a sense of solidarity as service providers recognised at this stage how their complementary experiences had shaped their approach to dismantling the barriers to access to mental health services within the Black community. Because of this, some proposals were made towards improving efforts to promote school and workplace-based mental health promotion, as well as engaging

communities through initiatives that foster intergenerational dialogues, all aimed at reducing stigma and encouraging open dialogues around mental health. Garlock et al. (2023), for instance, share evidence on how their use of a community-based arts initiative facilitated intergenerational dialogues around empathy, trauma, resilience, and cultural traditions that act as protective factors to support well-being. This fostered an environment for reciprocal learning and helped address cultural perspectives around mental health in the African American community. Such findings further validate the proposals made by both service providers and community members to engage innovative approaches that encouraged the use of creative arts in promoting mental health within Black African and African Caribbean communities.

6.4.4 Fostering sustainable partnerships

The imperative to promote sustainable partnerships between statutory and voluntary mental health service deliverers was another strategy discussed towards advancing cultural sensitivity in services. Even though the government and policy makers have prioritised partnerships between statutory and third voluntary sector organisations, there is much evidence on the many challenges voluntary and community organisations experience within these partnerships (Lester et al., 2008). The power imbalances, the lack of flexibility and unwillingness to engage with policy changes and innovation are frequently cited as deterrents against such inter-organisational partnerships. Lester et al. (2008) have suggested that these barriers strengthen the evidence and influence of systemic racism in the organisational culture of statutory services, that is extended in the delivery of services, especially within minority ethnic communities. In their view, a shared vision and agenda, mutual respect in interpersonal relationships, as well as better understanding of the social, political, and economic influences within both institutional contexts, are crucial. Bhattacharyya and Benbow (2013) also recommended that commissioners within statutory services provide funding, capacity building and sustainable organisational development training for voluntary sector partners, in a bid to promote person-centred services that meet the specific needs of minority ethnic service users. Yet, as evidenced in this study, issues pertaining to funding were still major barriers to the delivery of equitable care. Especially in the time of government-

sanctioned austerity measures, it is worth noting that the cuts in budgets to support long-term projects and the complexities surrounding training and supervision support have made community and voluntary sector organisations wary of partnerships with statutory healthcare institutions (Clifford, 2017; Pape et al., 2019; Lee et al., 2022). Even though austerity measures can be associated with the difficulties in access to funding, there is still disproportionate access to funds, where funding bodies and commissioners often favour white-led organisations over minority ethnic community-led organisations (Featherstone et al., 2012; Tilki et al., 2015). This may also account for the lack of inter-organisational communication among service deliverers, given that they must compete for access to the same limited streams of funding. Harries et al. (2020) have also brought to light the competition that exists between white-led and minority ethnic voluntary sector organisations, especially where white-led organisations are seen by funders as better equipped to roll out various initiatives than grassroots organisations, thus, the former being favoured over the latter. Manful and Willis (2022) further draw attention to a report conducted by the Ubele Initiative (2022) that showed that minority ethnic voluntary and third sector organisations still had to deal with institutional racism even within the voluntary sector, especially when it came to accessing funding.

To address these concerns, one of the proposals made by service providers at this stage was to improve alliances with other organisations to produce evidence-based research to support project proposals, that meet the expectations and criteria set out by funders and commissioning bodies. The need for capacity building and training workshops organised by funding bodies to equip grassroot and community organisations is one step towards building such sustainable partnerships and enhancing the efficacy of the voluntary sector. This aligns with participants' suggestions towards building sustainable business models for grassroot organisations that would equip them to strategically adjust their service delivery to meet the ever-changing needs of the diverse populations they serve.

Following the COVID-19 Pandemic, the significance of voluntary sector organisations in the health and social care sector has been amplified and there is marked interest from the public sector to engage more of these assets in promoting the delivery of equitable mental healthcare. Nonetheless, it is important to note that this enthusiasm surrounding inter-organisational partnerships can only be transformed into sustainable, long-term alliances

when all parties come to a mutual understanding that the delivery of equitable care can only be successful when the systems that perpetuate these power imbalances are challenged, and ownership and control of resources are given over to the community to ensure that these partnerships yield sustainable benefits for these communities.

6.4.5 Taking ownership of and Championing Culturally Sensitive services for the Black community

The discussion on the pressing need to take ownership of, and the lead in championing mental health services that best served the Black African and African Caribbean population in Birmingham was an interesting outcome of this Design and Destiny phase. In one participant's words, *'it was time to stop playing the white man's game and be unapologetic about meeting the needs of Black people'*. Ware (2013) had shared similar sentiments of frustration when addressing how various government policies, such as austerity measures, had contributed to silencing the influence and voice of minority ethnic voluntary organisations. In her book, *The Unapologetic Guide to Black Mental Health*, Walker (2020) also examined the trends in Black mental health in the USA and called for galvanised efforts within the Black American community to heal from racial traumas, fight mental illness stigma and encourage joint communal efforts to promote access to culturally appropriate mental health care.

Mhar (2020) have asserted that the need for tailored community-led approaches becomes even more pertinent when a group or community continuously advocates for changes to a failed system of service delivery which does not support the socio-economic needs of the community. In these instances, community-led approaches that foster leadership for and from the community and promote equal engagement of community members in the execution of strategies to provide holistic support are encouraged. In America, for instance, where the Black Lives Matter movement began, this initiative was borne out of a need to galvanise resources within the Black community to advocate for equality and encourage positive change (Attygalle, 2020). By advocating for a say in the decision-making process, especially in the areas of healthcare service delivery, community-led initiatives can share new perspectives with stakeholders who lack the cultural awareness to provide the needs best suited to the diverse communities they may serve. By building trust and facilitating capacity

building and empowerment of community members, organisations that promote community-led initiatives have the potential to ensure sustainable, positive change, even within unfavourable socio-political contexts (Attygalle, 2020).

Being unapologetic for prioritising the needs of the Black community was emphasised as a crucial step towards materialising the vision of Black-led organisations championing the campaign for cultural competence in both mainstream and voluntary mental health service delivery. Organisations, such as the Baobab Foundation (2023), have been known to champion the causes of Black-led mental health services in the UK. Douglas et al. (2022) outlines the details of a sustainable community-led partnership framework applied within the Canadian context to reduce health inequalities among Black service users. Their approach had within its mandate, the goal of applying critical race theory in the education of medical and public health professionals towards providing equitable and culturally competent support to people of Black African and African Caribbean backgrounds. Capitalising on the shared expertise within their community of Black physicians, they helped create mechanisms to foster dialogues with other organisations and facilitated their engagement in committing to promoting equity, inclusion, and reforms to promote cultural sensitivity in service delivery. Even though the recency of the study makes it difficult to ascertain the long-term impact and success of such initiatives, other scholars, such as Kumagai and Lypson (2009), who have conducted longitudinal studies of a similar nature have demonstrated the success of such approaches in promoting cultural competence among medical professionals. Such initiatives further validate the need to encourage a sense of ownership and an unapologetic approach to advocating for, and promoting anti-racist education and promoting culturally sensitive services that meet the health and well-being needs of the Black Community.

6.5 CHAPTER SUMMARY

This final phase (3) implemented the Design and Destiny stages of appreciative inquiry process in critically engaging mental health service providers in the co-production process to facilitate the delivery of sustainable and equitable culturally sensitive services for Black African and African Caribbean communities. This phase engaged both statutory and voluntary

sector mental health service deliverers in critically assessing the proposals made by community members in Phase 2 against their current strategies, in an attempt to appreciate and highlight best practice, while addressing the gaps that still exist in the delivery of equitable and culturally sensitive mental healthcare. Service providers shared evidence of the efforts being made to promote representation from the Black community and include experts by lived experience in leadership and decision-making structures, promote sustainable community partnerships and efficiently deliver community-tailored support within the Black community. While it was evident that some progress was being made, particularly on the part of statutory services to engage members of the Black community in more equitable co-production initiatives, there was still much to be accomplished in the way of re-establishing trust and nurturing sustainable and equitable collaborations.

Even though both service providers in this Phase (3) and community members in Phase 2 identified similar challenges around the impact of institutional and systemic racism, it was evident that a communication gap obscured the pervasive realities around the barriers service deliverers encountered in their efforts to promote equitable and culturally sensitive mental healthcare. This outcome further justified the need to engage strength-based approaches, such as appreciative inquiry, in the co-production process, as the feedback and feedforward process implemented in this phase offered a platform for bridging this communication gap, even though participants were engaged in separate phases.

Nonetheless, the proposals and strategies discussed towards taking ownership of and championing initiatives geared towards the improvement of culturally sensitive mental health service delivery for Black communities, both in the statutory and voluntary sector demonstrated the need to provide more opportunities for collaboration, partnerships and resource sharing. Enhancing visibility of services within communities by promoting mental health initiatives in accessible spaces, as well as facilitating mutually beneficial relationships with community stakeholders, were all recommendations made in response to encouraging the co-design and co-delivery process.

Among several noteworthy contributions made in this phase, was the view that the onus in engaging in collaboration, innovation, and inclusion of community members in organisational leadership also lay on the organisational heads, and not the community members. It is, therefore, critical that service providers hold themselves accountable for the impact of their

decisions within the communities they seek to bring change and strive to ensure that the sustainable change they envision start with them.

Ultimately, this Design and Destiny phase (3) presented an opportunity for statutory and voluntary sector organisations to engage in collaborative dialogues that helped them to understand the priorities they needed to address in their service delivery as proposed by community members in Phase 2. It also afforded them the chance to deliberate on solutions to address the challenges they themselves faced in their efforts to promote culturally sensitive mental health for the Black community. By building connections through the identification of mutual goals, this phase fostered the continuity of the co-production process and encouraged service providers to commit to engaging with more sustainable and adaptive practices towards achieving long-term outcomes for mental health service delivery in the Black African and African Caribbean community.

The next chapter explores the convergence of the narratives, proposals and strategies shared throughout all the phases of this study, providing further evidence into the significance of the salutogenic appreciative inquiry framework towards promoting sustainable solutions to alleviating health inequalities in the delivery of mental health services among the Black African and African Caribbean communities in Birmingham.

CHAPTER 7

DISCUSSION & LIMITATIONS

"A mindset of curiosity towards multiple perspectives is more likely to trigger insights and inspire innovation." - Frank Barrett

7.1 INTRODUCTION

Words create worlds and the narratives that shape our realities hold the potential to inspire innovation, especially when they are brought together within an environment that encourages an appreciation of the strengths and life-giving properties within a group, organisation, or community. This study thus far, has engaged various stakeholders from within the Black African and African Caribbean communities in West Birmingham in a salutogenic, co-constructive appreciative inquiry process, aimed at addressing health inequalities in the delivery of mental health services. To make sense of the multiple perspectives, proposals and strategies presented over the course of this study, this chapter extends the previous discussion sections by drawing key points from the various phases to increase the confidence of the findings and identify areas of agreement and divergence through the method of triangulation. To effectively engage community members and service providers as equal collaborators in addressing systemic issues and health inequities, through the design and development of culturally sensitive mental health services, a salutogenic, critical appreciative inquiry process was used. This co-production process applied the 4D stages of appreciative inquiry in 3 distinct phases, through a series of online interviews and focus group discussions.

The 4D stages of appreciative inquiry (Discovery, Dream, Design, Destiny), were useful for facilitating a salutogenic, yet critical reflection and appreciation of the multiple realities surrounding the influence of cultural values on mental health and help-seeking behaviour within the Black African and African and Caribbean communities. The implementation of these stages in this critical Appreciative inquiry process fostered an environment for both community members and service deliverers to share their visions and strategies on what works best in catering to the mental health needs of individuals in the Black African and

African Caribbean communities in Birmingham. The 4D stages of AI as applied in this study are, therefore, summarised as:

- **Discovery** -- appreciating best practice, strengths and skills of a group or community (Phase 1)

- **Dream** -- envisioning the necessary actions to be taken to effect changes to services in the future (Phase 2)

- **Design** -- working with service deliverers to collaboratively co-construct an ideal format or pattern of service provision that takes into consideration the visions and proposals that have been shared in the Dream stage (Phase 3)

- **Destiny** -- finding ways to sustain the evaluated process and working to constantly empower and adjust procedure to be aligned with the strengths and skills available (Phase 3).

The rigorous and thorough process of data collection utilised in this study over these three phases addressed the various objectives outlined at the beginning of this study. The overarching aim was to explore the factors identified by the Black African/African-Caribbean community and service providers as important in the design and development of culturally sensitive mental health services, using a salutogenic, critical appreciative inquiry process. Identifying and acknowledging any variations in cultural values between Black Africans and African Caribbeans, particularly pertaining to health and well-being, helped to capture the distinct intracultural qualities and experiences within these communities, which are often lost under the broad umbrella of the BAME term. Consequently, an understanding of how these values and beliefs fostered resilience and coping against mental illness, in view of the influences of systemic inequalities, was essential to setting the tone for further appraisal of how these aspects of culture either facilitated or obstructed early access to mental health services. Uncovering new perspectives on the priorities that community members hoped service users could address was also essential to the co-design and co-production process. The critical appreciative inquiry framework applied facilitated an in-depth exploration of how a salutogenic lens could be applied to understanding how resilience, empowerment, and an identification of the social and cultural capital present within these communities could promote a more generative, solution-focused approach to enhancing the delivery of culturally sensitive mental healthcare. Subsequent discussions with service deliverers helped shed light

on the relevance of the AI process to the development of culturally sensitive services. In this instance, the ideas shared by community members in Phase 2 served as an evaluative tool to assess the current scope and impact of both statutory and voluntary sector services in the delivery of culturally sensitive services.

To generate a more holistic overview of the diversity of thoughts shared throughout this study, the process of data triangulation applied within this section adequately outlines and summarises how the various phases come together to highlight the relevance of the AI framework as a viable model for co-construction. This, ultimately, contributes to the broader body of knowledge on the use of asset-based approaches for addressing health inequalities and promoting equitable co-design and co-delivery of mental health services in Black African and African Caribbean communities. Findings from the pilot study conducted at the beginning of this study (Chap 3: pg. 91-92) further elucidate the need for more spaces, where culturally appropriate services operating within Birmingham and community members could efficiently engage with each other and provide ideas towards the co-design of culturally sensitive services. As previously indicated, the data collection process was set out to align with the study objectives in line with the 4D stages of AI. Below is a summary of the results and key findings from each phase:

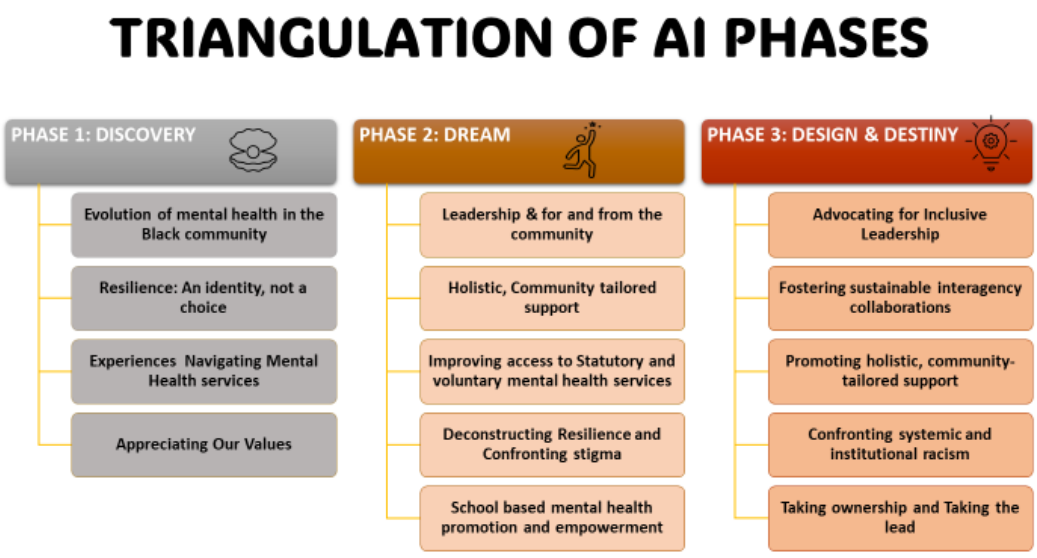

Figure 10: Triangulation of AI Phases 1-3

7.2 SUMMARY OF PHASE 1 (DISCOVERY: ONLINE INTERVIEWS)

The objective of this phase was to explore the cultural strengths, resilience narratives, and protective factors that contribute to the mental health and well-being of Black African and African-Caribbean communities. The Discovery stage of Appreciative inquiry was, therefore, implemented using the qualitative data collection method of individual interviews with twenty-three (23) participants from Black African, African Caribbean and mixed heritage backgrounds from various communities in West Birmingham. One goal was to understand participants' perspectives on protective and salutogenic factors, such as faith and spirituality, social support from family and friends, as well as pride in racial identity (Mushonga and Henneberger, 2020) embedded within Black culture that supported good mental health. The influence of other components of culture, such as food, music, arts, and dance, was also discussed. By identifying these protective factors, there was also scope to explore and challenge the aspects of culture and societal beliefs that hindered access to services, such as stigma, discrimination, mistrust of services and the effects of racism.

Four major themes emerged from the 1st phase. Firstly, there was a recognition of the transformation which had occurred over the years in the way the community viewed mental health. New perspectives emerged on how current mental health promotion initiatives had shifted from awareness creation to promoting overall well-being, influenced by factors like social media, education and a general change in mindset surrounding mental health. This paradigm shift was also possible due to the heightened promotion of health and well-being practices during the COVID-19 pandemic, which led to a significant alteration to people's approach to issues on mental health and, in turn, reduced some of the stigma around mental illness. Nonetheless, the culture of silence surrounding mental illness in these communities was identified as a major hindrance to early access to services. On exploring the subject of resilience as a protective factor for mental health, the theme on resilience as an identity rather than a choice, was quite a compelling and novel finding, with particularly unique gender and intergenerational differences in the narratives presented. In participants' opinion, being resilient as a Black person was an essential survival skill that one was born with and while resilience still acted as a protective factor, it also significantly contributed to the reluctance to seek help, and, consequently, affected mental health negatively. Following discussions on personal and vicarious experiences of mental health services, the third theme

centred on the experiences of navigating both statutory and voluntary services, with participants highlighting good practice in some services, while still emphasising the need to address the influence of racial and systemic discrimination in service provision. The lack of Black professionals, the disempowerment of Black people in services and the over-reliance on medication rather than alternative therapies were said to perpetuate the cycle of low help-seeking behaviour and led to poor mental health outcomes. Notwithstanding, the discourse on appreciating what works best within the community led to the fourth theme which homed in on the significance of cultural values, such as hard work, family support, social and cultural capital, faith and spirituality, in fostering mental health and well-being. Despite the history of oppression and ongoing racism that Black African and Caribbean communities have endured, the knowledge of ancestral connections was identified as a source of resilience and the massive influence of Black culture on contemporary society were evidence of the transformative power of the Black community. The study revealed similarities in narratives between Black African and African Caribbean communities, possibly following the emergence and influence of a shared Black British culture because of acculturation (Alexander, 1996; Donnell, 2002; Adi, 2019). Nonetheless, participants stressed that addressing stigma and transforming service delivery to meet the specific needs of these communities were vital towards alleviating health inequalities. Cultural sensitivity and consideration of the local context were highlighted as crucial elements in designing mental health promotion and intervention services. The overall objective of gaining a deeper understanding of the cultural components that promote resilience and mental well-being among Black African and Caribbean communities was, therefore, achieved. This set the tone for discussions on what the landscape of culturally sensitive services should encompass, which was addressed in the next phase of this study, the Dream stage.

7.3 SUMMARY OF PHASE 2 (DREAM: ONLINE FOCUS GROUPS)

Phase 2 (Dream) sought to explore the process of engaging community members in the co-design of culturally sensitive mental health services that build upon the identified strengths and assets of Black African and African-Caribbean communities. This phase's objective,

therefore, corresponded with the Dream stage of Appreciative Inquiry, with the aim of allowing participants to envision an ideal future and imagine the prospects for improving cultural sensitivity in mental health services (Trosten-Bloom & Whitney, 1999). During four (4) distinct online focus group discussions, some of the participants from the Discovery phase who took part were asked to imagine the top three priorities they would address if they were given the opportunity to run a mental health service for a day. The approach allowed participants to envision themselves in positions of power and influence where they could make a change, by focussing on the strengths identified in Phase 1 in response to the barriers highlighted. Discussions focused on addressing various concerns around resilience, the integration of black cultural values in mental health services, addressing stigma, effective engagement with community groups, and personal responsibility in mental health promotion. By encouraging contributions from participants, the generative, co-design process of AI was well underway, where participants were made aware that the ideas and visions shared would be relayed to service providers, thus, emphasising their role as key contributors in the co-production process. The purpose also of this phase was to foster a solution-focused outlook on addressing mental health concerns and promoting collective creativity to inspire visions of the ideal future of mental health in the Black community. The findings verify that hope and inspiration in an environment where social bonding is encouraged, are fundamental to the salutary, generative process of change that AI inspires (Gergen, Gergen and Barret, 2004; Bushe and Paranjay, 2015).

Five themes stemmed from the four focus groups, the first and second being the need for representation of the Black community in the leadership and staffing structure of mental health services, as well as the need for holistic community-oriented support that prioritised both physical and mental health promotion, respectively. Making use of the creative methods in engaging the community, using arts, music, and drama, was the third theme that emerged, with participants suggesting a re-evaluation of certain Western therapeutic notions and promoting art-based psychotherapies that incorporate music, dance, drama, and art in the treatment of mental illnesses both in the community context and in secure services. The fourth theme that resonated across all groups was the need for third and voluntary sector organisations present within the community, particularly, Black-led organisations, to increase the visibility of their services to enhance access, given that there was still a lack of awareness

of the existence of these services. Finally, the fifth theme highlighted the need to deconstruct narratives of resilience that impacted help-seeking behaviour, calling for the promotion of mental health in schools as a crucial step towards ensuring early education on mental health which could help alleviate mental illness stigma.

The results highlight the need for a multidimensional approach to policy and practice that promotes diversity in healthcare leadership structures, as well as incorporates holistic, alternative non-Western medical healthcare standards in treatment. Effective mental health promotion strategies, as proposed in this phase, are those that cut across various educational, workplace and community sectors and are steered towards empowering the communities being served. The themes presented in this phase led to the development of an evaluative checklist, which served as a guide on the areas to tackle in the next phase, where service providers were engaged.

7.4 SUMMARY OF PHASE 3 (DESIGN AND DESTINY: ONLINE FOCUS GROUPS)

The final phase was aimed at collaboratively engaging mental health service providers in the design and implementation of sustainable solutions for promoting equitable, culturally sensitive mental health service delivery for Black African and African-Caribbean communities in Birmingham. This was achieved by feeding forward information from previous phases (1 and 2) to statutory and voluntary sector organisations operating within Birmingham. Stavros and Torres (2005) highlight that the design phase continues the co-production process by determining the actions and strategies required to translate the dreams and hopes from Phase 2 into reality. Consequently, the destiny phase emphasises the need for sustainability of the actions and strategies birthed from the dream stage, embracing change, flexibility, and improvisation as crucial to aligning the plans developed with the strengths of the group in question. In their view, the relationships developed during these planning stages were particularly essential to the sustainability of the strategies proposed (Stavros and Torres, 2005). Thus, one aim of this phase was to foster collaboration among service providers to develop practical solutions for improving mental health services. Focusing on the themes generated from the previous phase, service providers were given the opportunity to share

how their services facilitated an inclusive leadership structure, encouraged creativity, empowerment and holistic care in their service delivery and collaborated with other community organisations. Acknowledging the current scope of service delivery was key to the planning process utilised in this phase, allowing service providers to celebrate their impact within the community, while recognising and responding to the gaps identified by service users.

Five major themes were derived from the two focus groups conducted within Phase 3, the first and second of which focused on the need for including leadership that represented the communities being served, as well as the need to foster sustainable inter-organisational partnerships, respectively. Promoting equity in leadership structures and sustainable partnerships within the mainstream and voluntary mental health sector were seen as crucial for meeting the needs of the target population. Another theme emphasised the need for embracing creative techniques to integrating tailor-made initiatives for the local communities which included taking advantage of the assets, such as the religious groups and grassroot cultural organisations, through the use blended digital/in-person approaches when it came to promoting community engagement. The fourth theme revolved around the need to confront systemic and institutional racism and address its effects on service delivery, particularly in the treatment of Black service users, as well as access to long-term funding for service continuity. Consequently, the primary focus of the fifth and final theme was on the potentially vital role service providers could play in taking ownership of and championing the drive for the promotion of culturally sensitive service delivery, particularly, as Black-led mental health service deliverers. Mental health education and promotion, as well as empowerment and capacity-building strategies, were also highlighted as important for developing service delivery at the grassroots level and improving mental health access within the Black community. Participants stressed the importance of sensitivity, respect, equality within the co-production process, with particular emphasis on the need to avoid tokenistic involvement of minority ethnic communities. The promotion of capacity-building workshops and training on how to develop evidence-based research were proposed to support grassroots organisations in understanding how to efficiently engage with funders to ensure sustainability of funding for service continuity.

The Design and Destiny stages facilitated the co-production process by gaining the perspectives and shared vision for culturally sensitive mental health services from service deliverers. The process helped to translate the visions and dreams generated from the Discovery and Dream stages into actionable outcomes, promoting a generative process that involved both statutory and voluntary sector mental health organisations. The appreciative inquiry framework applied throughout this study further supports findings on the value of promoting strength-based, solution-focused models for community engagement, especially towards facilitating an equitable co-production process aimed at improving access to culturally sensitive mental health services (Dent, 2019; Albert et al., 2023).

Overall, the critical appreciative inquiry engaged in this process supported a progressive and equitable method to implementing the process of co-production among multiple stakeholders within the Black African and African Caribbean communities in Birmingham. The 4D stages applied across the 3 Phases facilitated a process of critical reflection and constructive questions that challenged the various issues surrounding mental health in the Black community, while fostering an environment for co-constructive planning. Key insights derived from this study are discussed considering the current literature and evidence on health inequalities, culturally sensitive mental health service delivery and the relevance of processes like appreciative inquiry in facilitating the co-production process. The novel contributions from this study are also further outlined, along with the methodological implications and the perceived limitations.

7.5 KEY INSIGHTS AND CONTRIBUTIONS TO KNOWLEDGE

7.5.1 The relevance of Appreciative Inquiry to research on Black mental health in the UK

The application of the Appreciative inquiry framework to the alleviation of health inequalities and the improvement of culturally sensitive mental health service delivery, as addressed in this study, is novel, particularly towards shaping current perspectives around the value of salutogenic frameworks in the co-production process for Black African and African Caribbean communities. This study contributes to providing insights into the different perspectives

surrounding the multiple social realities of Black African and African Caribbean people living in the UK and the consequential impact on service delivery and help-seeking behaviour. As evidenced in earlier chapters, much research has been conducted on the poor treatment and inequalities people of Black African and African Caribbean backgrounds face in engaging mental health services (Bowl, 2007; Edge and Mackian, 2010; Rabiee and Smith, 2014; Devonport et al., 2020). Yet, much of this research discussing mental health inequalities has been situated within the BAME context, with many studies not effectively addressing the specific needs of Black African and African Caribbean communities because of the homogenising of minority ethnic groups under one umbrella term (Aspinall 2021). The advent of asset-based community development (ABCD) and engagement initiatives over the last decade, aimed at improving mental health among minority ethnic groups in the UK, is the closest indication of healthcare services working towards alleviating such inequalities (Marmot Review, 2010; 2020). Blickem et al. (2018) and Harrison et al. (2019), however, point out the lack of research evidence detailing the processes underlying successful asset-based community development, alluding to a disconnect in the translation of asset-based theories into practical, sustainable outcomes. In their opinion, a clear presentation of the mechanisms and theoretical background that permit the adoption and promotion of ABCD models will provide a good foundation for other institutions and stakeholders to adapt and replicate the process in different settings, although presumably, any evaluation undertaken would first need to show ABCD approaches to be effective. Empirical evidence of the outcomes of such initiatives would further enhance the feasibility of the application of such models in real-world contexts, especially in a bid to challenge traditional, Western, medicalised systems of care and promote positive and sustainable outcomes in the communities within which they are implemented.

This study's critical appreciative process addresses these critiques, as the framework provides insights into the systematic, reflexive, and co-constructive approach adapted to engage multiple stakeholders in translating their visions and dreams surrounding the future of mental health into practical and sustainable outcomes towards the improvement of services. Durose et al. (2017) emphasised the transformative potential of the AI framework towards providing greater clarity into the step-by-step processes essential for the implementation of the albeit equivocal process of co-production, particularly in the design and delivery of mental health

services. Beyond the predominantly positive ethos of the AI framework, this study's critical approach permits a balanced evaluation of both the barriers and facilitators to implementing sustainable change towards addressing health inequalities and improving access to culturally sensitive mental health services. By adopting a salutogenic approach which deviated from the traditional problem-solving model that is common within research on health inequalities, more light is shed on issues repeatedly reported in the literature around issues, such as stigma, poor access to services and a lack of trust of services. By sustaining a solution-focused ethos across all three Phases, the value of this co-construction process became more evident as a shared vision emerged within an environment where reciprocal learning, mutual respect and equitable partnerships were forged.

In Phase 1 (Discovery), the focus on various aspects of Black African and African Caribbean cultures and their potential to act as protective factors against mental illness fostered a generative process that encouraged community members to reflect on their various social realities and lived experiences of mental health. Exploring resilience as the affirmative or core positive topic, as is conventional of the AI process, helped to uncover some of the underlying thoughts around help-seeking behaviour and the culture of silence around mental health. In agreement with the simultaneity principle, the questions asked were fateful and had the potential to initiate the process of change even before any solutions were discussed.

In Phase 2 (Dream), critiquing the role of cultural norms, values, and beliefs in fostering resilience and promoting mental well-being prompted self-organised ideas around how the inclusion of these factors within services was significant towards fostering cultural competence in healthcare delivery. Delving into the value of social and cultural capital in the context of Black community also presented meaningful information, particularly pertaining to the dual role family and community play in either supporting or hampering mental health and well-being (DeSilva et al., 2005; Bamford et al., 2021). The critical AI approach used was, thus, instrumental in identifying and effectively evaluating the multiple perspectives that shaped ideas around mental health, resilience, and help-seeking behaviour within the Black community.

The methods and processes discussed in this study also provide a step-by-step outline of the generative AI process applied in Phase 3 towards sustainable change, which engaged service providers in making commitments towards taking initial actions to foster partnerships and

develop sustainable solutions as part of the co-production process. Bushe and Paranjey (2015), following an extensive review into the evidence presented on AI's generative properties in comparison with problem-solving models, shed light on AI's capacity to encourage creativity and foster an innovative environment for planning actions and designing sustainable pathways to change. In their view, throughout the process of trading stories and experiences, optimal social conditions are created for the generation of ideas, where participants can learn from each other and collectively explore new strategies of change towards addressing similar concerns. In Phase 3 (Design and Destiny), as the priorities from the previous phases were proposed to both statutory and voluntary service deliverers, there was a shared sense of urgency to address the gap in communication that disconnected service deliverers from the lived realities of community members and vice-versa.

Ultimately, the overlapping narratives shared across all Phases demonstrated that a consolidated approach needed to be taken by both community members and service deliverers in the Black community to address the pervasive systemic issues that affected service delivery and perpetuated health inequalities. It was more apparent that stakeholders had interconnected roles in engaging systemic change.

The priorities produced during this study, as stated earlier, served as a critical evaluative tool against which service providers could appraise the effectiveness and impact of their services towards addressing health inequalities in the Black community. Through consensus building around shared values and visions for the future of mental health for the Black community, members defined the parameters for what should be considered in the delivery of culturally sensitive mental health services, emphasising the need to understand the multiple realities surrounding culture and mental health in the design of culturally competent services. Having challenged some of the systemic assumptions surrounding resilience, stigma, cultural values and help-seeking behaviour, the focus was shifted to how the strengths identified in the Discovery Phase 1 could be capitalised on in the designing of culturally sensitive services. Subsequent engagement with service providers fostered collaborative dialogues that also focused on leveraging current strengths and capacities of both statutory and voluntary organisations and inspiring innovation on how to equitably integrate the priorities shared in earlier phases to improve the standards of their services. The collective knowledge produced during these deliberative dialogues demonstrated that adapting a flexible approach to

integrating changes in service delivery was possible when the process of co-production was embraced as a dynamic one that required continuous and adaptive learning. As service providers made commitments to fostering sustainable change, they also offered new perspectives towards the improvement of the evaluative tool/checklist produced through engagement with the priorities proposed by community members in the Dream Phase.

Effectively incorporating the principles of appreciative inquiry in lieu of the objectives explored in this study are also noteworthy in the application of the framework to the topic of health inequalities in mental health service delivery. The overarching constructivist principle of AI, which reflects acknowledging the subjective experiences and realities of participants, highlights the value of language and conversations in shaping the social realities of people within a specific context. The narratives around resilience and staying strong to survive the deleterious effects of racism are telling of a side of the conversation on stigma and the culture of silence that indicate the need for further inquiry. The simultaneity principle was embodied in many of the dialogues presented in this study, demonstrating that inquiry itself creates opportunities for change. Participants in Focus Group 4 of Phase 2, for instance, saw the discussion as a safe space for fostering intergenerational conversations among Black men on mental health and other issues. Also, drawing on the various strengths and capacities represented set the tone for participants to appreciate their personal responsibility in promoting change. Consequently, choosing to focus on Black mental health, resilience, and the relevance of cultural values to the co-production of culturally sensitive mental health services, specific to the Black African and African Caribbean communities in Birmingham, highlights the poetic principle which suggests that the topic of focus in the AI process is crucial to shaping the narratives presented. The inspiration for positive actions and change shared across board highlights the anticipatory principle, given that community members and service providers alike had shared views on their personal responsibility and role in destigmatising mental health and creating a safe space for fostering support. The positive visions shared around empowerment and capacity building were reminiscent of some of the present-day actions that were highlighted by some individuals and service deliverers, which might otherwise be lost if these stories were not shared. This further shed light on the application of the positive principle within this study which emphasised that positive questions lead to positive change. The social bonding and connections that were formed among both

community members and service providers set the pace for the collaborative work that many have desired to see in the community.

One of the concerns discussed within this study by participants was the lack of visibility of Black-led services. When this issue was presented to the service providers, one of the suggestions was to compile a list of the various, Black-led services operating within Birmingham, and promote this directory within the community to improve access to mental health services. This recommendation did not necessarily suggest that all Black-led services were demonstrating cultural humility; however, it was to include visibility of these services to improve access as well as foster a more inclusive and diverse mental health support landscape, acknowledging the importance of culturally sensitive care options for Black African and African-Caribbean communities. Ultimately, these principles were instrumental in providing guidance on the design of this study and provided direction on how to effectively incorporate the 4D stages of AI to promote collaboration and facilitate the co-production of mental health services suited to the needs of the Black community. The relational process that AI employs gives space for dialogues constituting varied local-cultural realities, where every participant is an expert with an open invitation to propose change.

7.5.2 The relevance of Appreciative Inquiry to research on the co-production within the wider context of mental health in the UK

As stated in earlier chapters, the use of the AI framework is gaining popularity as an evaluative co-production model within the healthcare sector in the UK (Watkin et al., 2016; Dent, 2019; Albert et al., 2023). As service providers become progressively aware of the need to engage community groups and relevant stakeholders in the design of health services to increase accessibility and alleviate health inequalities, strength-based frameworks, such as AI, offer a strong evidence base for the effectiveness of co-production (Durose et al., 2013; 2017; Filipe et al., 2017; Lwembe et al., 2017; Creary et al., 2021). Tricket et al. (2011) and South and Philips (2014) recommended that public health service providers adopted a context-centred approach to engaging and empowering communities, viewing them as capable agents in shaping the scope and outcomes of public health interventions. The evidence of the long-term impacts of empowering collaborations that allow community members to be at the

forefront of the co-production of services demonstrates that capacity building and empowerment are crucial to promoting sustainable outcomes for equitable service delivery. The process of AI has been known to challenge the conventional, problem-solving approaches that other studies take in conducting research on community cohesion and diversity, especially in minority groups, as it encourages participants to challenge established stereotypes by adapting an affirmative approach (Shuayb et al., 2009). Drawing on the principles of AI, Randall et al. (2022) pointed out that AI provided a sense of restoration of a power balance between the service users and service deliverers, as participants in their study noted, that being given the opportunity to share their ideas as experts with lived experience with service providers, service users felt safe and empowered. McCullin (2023), in evaluating the sustainability of co-production approaches, argued for the use of AI as a feasible approach for enacting long-term change in organisational culture. In their opinion, the system of reciprocity of respect and learning which AI forges, fosters an empowering environment that allows service users to challenge power imbalances from an empowered stance, where the value-based approach builds on the strengths and assets that are already available within the communities of interest. The power shift is, therefore, enacted when community-defined priorities become the benchmark for evaluating the quality of services through a continuous, adaptative process. Even though more research is needed to validate the potential of Appreciative Inquiry to ensure that co-production efforts have sustainable outcomes, the extensive evidence of its success over the years in facilitating organisational change and development shows promise for the capacity of this framework to drive long-term transformation in the healthcare system (Trajkovski et al., 2013; Watkins et al, 2016; Armstrong et al., 2020). Taking all this into consideration, it is essential to contextualise the following findings and emphasise their implications on the current conversations around reducing health inequalities and promoting cultural competence in service delivery.

7.5.3 Re-defining resilience: Appreciating what is and transforming the narratives surrounding Black Mental Health

One of the most significant yet novel findings from this study is the outcome of discussions around resilience as an identity rather than a choice, and the impact of this reality on the

culture of silence around mental health, in perpetuating stigma and, consequently, hindering help-seeking behaviour within the Black African and African Caribbean communities. Erikson and Lindstrom (2006; 2010) and Mittlemark (2021) define the concept of resilience within the context of salutogenesis as a process rather than a personal attribute of a person or a community, that acts as a resource or asset to facilitate coping in the face of adversity. Resilience, in this study, was initially identified as an asset and protective factor within the Black community which needed to be better understood, considering its role in supporting coping and safeguarding mental health within this population. However, the narratives presented within this study engaged a different point of view on the processes and systems that had shaped resilience within these communities. One consensus drawn from this study was that resilience was not always as glamorous as it sounded, and the 'strong black man/woman' tag, for instance, no longer benefitted the mental health of Black people. The prevailing viewpoint here was that, in the face of racial discrimination, putting up a defensive, resilient front impacted on the decision to seek help when experiencing any form of mental distress, unless the issue became life-threatening and called for crisis intervention. The implication of this resilient identity, as linked to the fear of loss of freedom and dignity, as evidenced by Keating and Robertson (2004), feeds into the circle of fear of services, which obstructs willingness to seek help in times of crisis. Clay (2019) consequently refers to this resilient identity as an illusion of empowerment, where the ideas around being a 'Strong Black man or woman' are the product of survival skills developed in the face of racial discrimination, which eventually feed into mental illness stigma, late help-seeking behaviour, and poor health outcomes. Taylor (1995; 1998), in exploring the relations between the 'strong black woman' tag and depression, highlighted the feelings of exhaustion and frustration that many women in her study described as a result of hiding behind the armour of strength. Beauboeuf-Lafontant (2007) further explicated how the strong black woman narrative normalised negative coping strategies among black women who tried to demonstrate selflessness in their relationships with others, which eventually adversely affected both their physical and mental health. In existing within a society that participants in this study referred to as *'elegantly racist'*, asking for help was the equivalent of showing weakness, and reinforced the culture of silence and stigma around mental health. Critically evaluating the impact of resilience as an identity within these communities is relevant to addressing other areas of healthcare delivery, such as maternal health where the mortality rates of Black women are recorded to be higher

than other ethnicities, as service providers buy into theories on super-coping and make assumptions that Black people have high pain thresholds (Golden, 2021; Onanuga et al., 2023). These findings on resilience also compliment Schomerus et al.'s (2013) study on personality-related factors as predictors of help-seeking behaviour, where they proposed the need to evaluate resilience as both a protective factor and a barrier to formal help-seeking behaviour from a population-focused perspective. Allan and Phillipson (2017) also identified the need for researchers to further evaluate the role of social capital in perpetuating harmful societal norms, such as illustrated in conversations in Phase 1 (Discovery) around toxic resilience, highlighting the need to unpick how such notions of *keeping a stiff upper lip* perpetuated within the Black community discourage help-seeking behaviour and access to mental health resources.

Fundamentally, the promotion of resilience is still crucial towards encouraging good mental health and coping in the face of adversity. Nevertheless, it is important to promote healthy resilience and coping mechanisms that reframe the narrative around resilience (Taylor et al., 2020) and encourage open dialogues beyond the idea of *'bounce-back-ability'*. Rather, the promotion of resilience should also encompass the need to see resilience as being vulnerable enough to ask for help in the face of a crisis. Reshaping mental health promotion initiatives to promote such ideas may prove to be instrumental in addressing mental illness stigma and late access to services within these communities.

Consequently, the call for alternative terms to address resilience and the recognition of such 'toxic resilience' narratives as barriers to seeking mental health support align with critical race theory's (CRT) emphasis on challenging dominant narratives and centring the voices and experiences of marginalised communities in shaping discourse and practice. As earlier discussed, CRT primarily emphasises the centrality of race and racism in shaping the lived experiences and social outcomes of people of minority ethnic background (Crenshaw et al, 1995), therefore, the notion of resilience as a means protecting oneself from the negative impacts of racial discrimination aligns with CRT's focus on the ways people of minority ethnic background resist and challenge oppressive systemic structures (Collins, 2022). These findings further elucidate the complex and multifaceted nature of resilience within Black African and African Caribbean communities in the UK, emphasising the need for further research that

applies a CRT lens to investigate the influence of acculturation, Black British culture, and intergenerational dynamics on resilience and mental health.

7.5.4 Empowering communities as a pathway to addressing health inequalities.

At the core of any mental health promotion initiative is the drive to empower various target populations to be able to manage their own health and well-being by efficiently utilising the resources at their disposal. Similarly, one theme that was predominant throughout all the phases of this study was the need for empowerment of both communities and grassroots and community service providers. The kind of inclusive empowerment proposed was geared more towards Black people taking advantage of every opportunity to empower and motivate one another to promote and sustain the resources and systems already in place to support mental health and well-being. There was a particular focus in Phase 2 on school-based education, mentoring and engagement, where the need to enrich and inspire young Black people to optimistically anticipate a future filled with better possibilities and prospects, beyond the stereotypes placed on young Black men and women, was repeatedly emphasised. Given the historical evidence of exclusion of children of Black African and African Caribbean backgrounds within the educational system (Bourne, Bridges and Searle, 1994; Christian, 2005; Graham et al., 2019), these recommendations are significant towards promoting inclusion and good mental health within this population. The need to promote the use of innovative and progressive initiatives as a means of education and engagement using the arts, music and sports were emphasised both within the school and community contexts. One service provider in Phase 3 shared on how their art-based education techniques using t-shirts and student-developed educational material had led to many positive outcomes, promoting self-esteem and self-identity. Several studies provide evidence on potential for school-based mental health promotion to reduce stigma and remove barriers to help-seeking behaviour, particularly in school settings with a high population of students of minority ethnic backgrounds (Barry et al., 2009; O' Reilly et al., 2018).

Creating safe spaces within the community, such as afterschool clubs, were also suggested as suitable environments for mentoring, particularly around encouraging Black youth to aim

higher when it came to career prospects, towards bridging the attainment gap evident and decolonising career guidance within this population (Haywood and Darko, 2021; Ranavaya, 2022). This adds on to Byfield and Talburt's (2020) advocacy for the development of targeted interventions aimed at promoting social, educational, and professional aspirations, as well as improving emotional well-being, particularly among Black boys. This vision was also shared in connection with the theme on transforming the leadership structure of healthcare providers and increasing the Black mental health workforce.

Empowering service users and those with lived experience of mental illness in contributing to the leadership structure and decision-making process of services was also suggested as one of the keys to improving cultural sensitivity in service delivery. Given the current NHS agenda (Working in partnership with people and communities, NHS England, 2021) to foster community engagement and promote patient involvement in service delivery, the timing is favourable for encouraging more of such discussions. Consequently, Public Health England's (2020) whole systems approach to community development seeks to promote bold leadership, collective bravery and a shift in mindset surrounding the co-design of services for communities. Fortuitously, Appreciative Inquiry fits well into this whole systems approach, and has the potential to facilitate effective evaluation of such initiatives as it offers the opportunity for community members to play the role of researchers and identify the impact of community engagement initiatives based on contextual parameters. The simplicity of the process of generativity that AI offers does not require extensive training and preparation and may allow people with no background in evaluative processes to engage service providers in critical appraisals whose outcomes would be beneficial for the expansion of the community engagement and co-production agenda.

The organisations represented in this study highlighted the positive impact of their current empowerment and capacity-building initiatives, demonstrating how the training and advice they had provided had helped people to stand up for their rights. Notwithstanding, Ocloo and Matthews (2016) caution that, in seeking to empower communities, other stakeholders must avoid being tokenistic in co-production initiatives by ensuring equity in the distribution of power and foster the creation of healthcare models that promote equitable decision-making. This issue of tokenism in community partnerships was also shared by participants, particularly service providers who voiced concerns that their expert opinions were often sought by other

policymakers and healthcare commissioners, yet on an unpaid, voluntary basis. In their view, their contributed time, knowledge, and experience ought to be recognised and adequately compensated, especially by including them in policy and decision-making processes that also granted them access to influence the allocation of resources towards the provision of equitable mental healthcare for their communities.

In addition to this, providing workplace support and prioritising the safety of Black workers against dealing with microaggressions in the workplace are also worth considering towards fostering culturally sensitive mental health promotion. Kenny and Briner (2010) shed light on the interactions between social class, ethnic identity and racial discrimination and their effects on professional identity for employees of Black African and African Caribbean backgrounds. Having to deal with microaggressions at work, while being treated as what one participant referred to as the '*token black person',* could impact on the mental health and well-being of Black workers. In their opinions, organisations and employers had the mandate of making their employees feel valued by ensuring equitable representation of workers of all ethnic or racial backgrounds at different organisational levels. Their recommendations for tackling these barriers included increasing ethnic minority representation in leadership, developing mentoring, networks, and support programmes, as well as providing staff training for improving cross-cultural communication. Some service providers in this study demonstrated that they were already making efforts to create a platform of supportive online networks that workers could engage with to support their mental health. One statutory service also shared privileged knowledge that more efforts were being made to include people of racialised minority backgrounds in leadership and was confident that the future held a lot of potential for including the voices of racialised communities in health policy formation and implementation. As demographic composition of Birmingham rapidly transforms, there is no better time for leaders of both statutory and voluntary sector organisations of Black African and African Caribbean backgrounds to advance the mission for the promotion of more equitable partnerships within the public and voluntary sector, as well as more inclusive workplace culture. As presented in this study, the time for Black professionals to take a united stance against systemic and institutional racism is long overdue, and platforms, such as the one this AI study permitted, are a first step to achieving success in the promotion of equitable and culturally sensitive mental health services.

7.5.5 Harnessing the full potential of strategic and sustainable partnerships

The findings from this study (Phases 2 and 3), in line with other scholarly works, indicate that inter-organisational collaborations are the key to presenting a united front in efforts to alleviate health inequalities. The COVID-19 Pandemic highlighted the value of grassroot communities that galvanised efforts during this difficult period to support vulnerable populations, despite limited access to resources (South et al., 2020; Woodward et al., 2022). The urgent need for the cultivation of collaborative partnerships within the Black community that address mental illness stigma and promote asset-based engagement cannot be over-emphasised in the drive towards reducing mental health inequalities. For instance, the dual role of faith and religion as both a facilitator and barrier to mental health access has been explored a bit more in-depth by other researchers (Knifton, 2012; Mantovani et al., 2017; Codjoe et al., 2019).

Within this study, the theme also came up on how faith groups could play a better role at addressing mental health stigma and provide a safe space for the Black community to receive care and support, devoid of discrimination. The role of the Black church, as well as other faith-based organisations, should, therefore, be explored further to determine their influence in the delivery of culturally sensitive mental health support (Whitley, 2012; Planey et al., 2019). Bhui et al. (2007), for instance, suggested that healthcare service providers be open to engaging religious leaders and traditional healers in understanding the cultural and spiritual context behind mental illness, as well as collaborating with them to promote mental health education given their considerable influence in shaping attitudes and perspectives around mental health and well-being. Mantovani et al. (2017) also stated that by providing mental health training for religious leaders, there was more scope to engage them in providing faith-based therapy that could serve as an alternative treatment option, one which community members could resonate more with. Codjoe et al. (2021) provide evidence on the success of such collaborations in their systematic review, demonstrating that by training clergy on mental health literacy, cultural competency and counselling skills, there was a significant improvement in knowledge of mental health and attitudes to help-seeking among congregants in Black faith communities. Though there was no representation of religious leaders among the service deliverers, the narratives shared by those who already provided

faith-based therapy and counselling, showed that efforts were being made to promote mental health in Black faith communities.

Capacity building for grassroots organisations should also be a priority for statutory mental health service providers. Given the significant role community organisations play in filling the gap in healthcare service delivery, particularly in the provision of mental health support, it is essential that statutory services help to equip these services through training and development aimed at enhancing service delivery. Recognition of the knowledge, skills and experiences of these services and seeking to develop their already established structures should be the goal of health policy makers and other public sector organisations who hold the mandate of supporting community engagement initiatives (NICE Community engagement guidelines, 2016). Providing training and guidance on developing leadership and governance structures, as well as sharing knowledge on how to professionally write bids and apply for funding, are some of the areas that public health services can support grassroots services with.

Findings from the pilot study (Chapter 3, pp. 96-99) also reiterated the need to provide extra support particularly around digital innovation and research knowledge to improve the impact of their services and contribute to evidence-based knowledge within the field. Furthermore, the need to ensure equality in partnerships is critical to the sustainability of these collaborations. There is evidence of unfair collaborations between statutory and voluntary sector organisations, where there was a clear power imbalance between both parties, which led to a breakdown in trust and interest for such partnerships (McGovern, 2016; Race Equality Foundation, 2021; El-Hoss et al., 2023). Issues with power-sharing, a lack of recognition and respect of the expertise of grassroots organisations and differences in work culture all stand in the way of developing long-lasting partnerships where services work together to implement strategies to tackle health inequalities. Douglas et al. (2022) draw attention to the risk of delayed improvements to service delivery if the input of community organisations and community members is undermined, which is often the case within such partnerships because of the power imbalances (Netto et al., 2012; Tilki, 2015; Manful and Willis, 2022). Nonetheless, they suggest that it is essential to ensure that the development of service strategies is informed by the vision of community members, by engaging people with lived experience as key stakeholders in the decision-making process, as well as guaranteeing

sustainability of partnerships by following through on the process of implementation and evaluation. This study, particularly Phase 3, was essential for bringing together service providers from both statutory and voluntary sectors to talk through the complexities of partnership and provide recommendations on how these organisations could work together to ensure equitable healthcare delivery.

7.5.6 Navigating the Intersection between Cultural Competence and Humility in mental health service delivery.

The findings from this study make significant contributions to the current literature on cultural sensitivity and competence in service delivery, providing key insights into the expectations of the Black community in this matter. As demonstrated in this study, many of the concerns are directed at tackling the systemic and institutional political and economic structures that perpetuate these inequalities. As highlighted in previous research by Rabiee and Smith (2014), one of the most common recommendations for improving equality in healthcare service delivery is about cultural/racial matching. A few studies, such as those conducted by Olayinan and Hayes (2022), have evaluated the effect of cultural matching in therapeutic relations on patient satisfaction and professional credibility. Their findings suggest that, in racially matched patient-therapist groups, participants were more likely to rate services as trustworthy as they felt that mental health professionals could understand and identify with their lived experience more. The results pertaining to cultural matching in the current study were, however, mixed, with some participants sharing negative experiences within therapy services where they were racially matched with a Black professional. Even though the sample represented was small, there is still a scope for further exploration into how racial/cultural compatibility is determined in therapeutic relations, particularly where there is an 'automatic assumption' that all Black professionals are culturally competent and can meet the needs of their service users (Bhui et al., 2007; Chu et al., 2016).

As efforts to improve and promote culturally competent services advance, Healey et al. (2017) suggest that it is pertinent that efforts are focused on the isolated study of cultural adaptations applied in promoting mental health within specific groups to identify which among them augment efficacy. The moderating role of acculturation could be explored to a

greater extent to yield a more complete understanding of the role of tailoring health services to the needs of the populations they support. Perhaps, this is where the conversation around cultural safety and cultural humility, which were highlighted in an earlier chapter (Chapter 2, pp. 47), come into play. Initially proposed by Papps and Ramsden (1996), cultural safety is defined as a component of healthcare practice that encourages reflections on the influence of a healthcare practitioner's cultural identity in relation to that of the patient, and how this affects power relations and the practitioner's ability to respect the patient's rights. Subsequent definitions, such as the one provided by Downing et al. (2011), include cultural safety being a means of addressing the impact of entrenched colonial systems and institutional racism on healthcare delivery, and how these systems perpetuate health inequalities.

In addition to the literature on cultural safety, over the last 3 decades, there have been more discussions around the need for cultural humility in replacement of cultural competence training. Proponents of this suggest approaching the concept of culture as a construct that cannot be fully analysed or learned, but can be accepted, respected and appreciated through a reflective process of self-awareness concept (Comas-Diaz et al., 1998; Tervalon and Murray-Garcia, 1998). They further propose that cultural humility requires consciously seeking to understand the power relations and socio-political structures that play a significant role in perpetuating health inequalities. Rather than seeking to fix culture, they propose a system of change that promotes mutually beneficial collaborations, that highlight and align with the values of the communities served, in a manner that demonstrates respect and dignity for cultural practices (Lee, Leung, & Kim, 2014). Abe (2020) corroborates these suggestions, proposing cultural humility as a social practice that has the potential to promote sustainable and impactful change in healthcare service delivery, where power imbalances, exacerbated by structural and systemic influences, are prominent in shaping policy and practice. Ranjbar et al. (2020), consequently, support the idea of cultural humility as an essential guiding principle, suitable for encouraging critical self-reflection and institutional accountability, particularly in instances where power imbalances exist in inter-organisational collaborations, as has been highlighted in this study, in the case of statutory-voluntary sector partnerships.

On the other hand, other scholars, such as Yancu and Farmer (2017), have suggested that cultural competence still holds a relevant place in healthcare service delivery and, thus,

should not be replaced, but should complement cultural humility. They describe cultural humility as the process required to attain the cultural competence needed to serve minority ethnic populations. Campinha-Bacote (2018) goes on to propose a combination of both concepts, coining the term *'cultural competemility'* (cultural competence + cultural humility). In her opinion, cultural awareness, knowledge, skill, desire, and encounters, which are the five components of cultural competence should align with the reflective process that cultural humility prescribes. Nonetheless, Curtis et al. (2019), after a review of the definitions of cultural competence, cultural humility, and cultural safety, from 59 studies, conclude that culturally, competent healthcare can be provided by a professional of any race, gender or religion, granted they take into consideration the impact of power dynamics and institutional practices on patient care. In their opinion, it is up to the patient to determine how culturally safe a service is, based on how much consideration is given to acknowledging the interaction between the background and diverse needs of the client, and how that translates into the delivery of holistic health service. Hui et al. (2020) further support these findings, suggesting that culturally, competent health interventions are those that actively address the impact of institutional injustice in a manner that reduces its impact on holistic, person-centred care. They further state that such services should seek to alleviate health inequalities by effectively evaluating the impact of biopsychosocial influences on a patient's health, respecting their views, while consistently reflecting on the interplay and effects of individual and institutional biases on patient care. They, subsequently, suggest co-production initiatives as critical to achieving this level of service delivery, proposing that service providers keep an open mind and accept the worldviews of others, particularly concerning issues around mental health and stigma. They are also of the view that this can effectively be addressed by encouraging open dialogue and authentic interest in the lived experiences of those involved.

As society continues to evolve, constant reflection on awareness of self and others is crucial to understanding those around us and fostering healthy relations, particularly within multicultural communities like those represented in Birmingham. Stavros & Torres (2005) proposed AI as a good starting point for initiating such self-reflective awareness, emphasising its relevance in helping one to examine the impact and possible outcomes of power and relational dynamics on others. This proposition aligns well with concepts of cultural safety and cultural humility which promote self and social awareness in healthcare service providers.

AI also has the potential to track change over time, because as the process evolves, a roadmap slowly begins to form that identifies the shared relationships between various resources and stakeholders, leading to a critical evaluation of outputs and impact in line with strengths identified along the way. This logic model that is generated is, thus, in itself an indication of what an evaluation plan should consider when revisiting the initial co-production process (Preskill and Tzavaras Catsambas, 2006).

The critical appreciative inquiry approach adopted in this study, thus, helped to emphasise the visions of emancipation and empowerment that are uncovered when investigating complex social phenomena, such as health inequalities, cultural sensitivity, and mental health service delivery within the UK context. By acknowledging the influence of power relations in dialogues, such as that developed in this study aimed at addressing change at a multi-system level, more scope is provided for open dialogues among participants, allowing them to construct narratives and share their realities within an empowering context.

The results of this study indicate the pertinent need to re-evaluate our understanding of what co-production entails in the design of culturally sensitive mental health services. Beyond cultural matching, there are a broad range of recommendations that are worth integrating in community engagement initiatives and Pinfold et al. (2015), for instance, point out the need for flexibility in the co-production process. These findings, therefore, hold potential for reshaping the perspectives of both service providers and users around the value of co-production towards addressing health inequalities, delivering culturally sensitive mental healthcare, and promoting positive outcomes for the health of racialised communities in the UK. The convergence of diverse perspectives gathered across all 3 phases provide a critical lens into the nuances surrounding culture, mental health and service delivery and the recommendations made have the potential to contribute to the development of an evaluative tool to inform standards of cultural safety, humility, and competence in service delivery.

7.6 METHODOLOGICAL CONTRIBUTION

The use of a critical appreciative inquiry process as a salutogenic framework for engaging multiple stakeholders in the co-production of culturally sensitive mental health service delivery to address issues on health inequality, offers some meaningful methodological contributions on the use of participatory action frameworks in healthcare research within racialised communities. Understanding the value of the strength-based framework that fostered a collaborative environment for both community members and service providers to address the limitations of traditional problem-solving models that neglect the influence of societal contexts on shaping mental health in the Black African and Caribbean community is thus, a relevant contribution of this study.

In applying the principles of appreciative inquiry at each phase, this study addressed these limitations by engaging a social constructionist standpoint that emphasised the significance of language in shaping social realities. Implementing the 4D cycle of AI in this study provided a structured process for facilitating this participatory inquiry, using a range of qualitative data collection methods, such as online interviews in the Discovery Phase (1) and online focus groups in the Dream, Design and Destiny stages (Phases 2-3). In a bid to effectively explore the potential for collaborative dialogues to inspire change (Gergen et al., 2004), the critical reflexive process employed at the various stages helped to identify the various priorities and strategies that needed to be engaged with to effectively produce sustainable outcomes in the delivery of equitable healthcare.

Some proponents of Appreciative Inquiry describe the framework as a method of looking at old problems through a new lens (Schon, 1993; Roberts, 2013). In their view, the system of inquiry which AI utilises encourages those involved to generate innovative ideas and discuss common problems from a new perspective. Bushe and Kassam (2005) suggested that AI practitioners needed to critically evaluate the effectiveness of the framework as applied within their research context by asking these crucial questions:

- Did AI produce new knowledge, when compared with traditional change management and problem-solving models?
- Did the process lead to new strategies of addressing the issues highlighted?

In the case of this study, the answers to both questions are yes. Although a more critical lens was applied to this predominantly positive framework, the focus on the life-giving properties and systems within the Black community encouraged participants to share positive stories of strength, courage and resilience that were forged through the influence of cultural values, norms and beliefs. Whiles discussions around the negative impact of racism, marginalisation and generational trauma were still addressed, the sense of hope and empowerment was drawn from the various expressions of strength and perseverance. This led to the production of new knowledge on the nuances surrounding the interactions between culture, resilience, and help-seeking behaviour, which may often be overlooked in research within Black communities. Furthermore, the empowering environment created during the focus groups in Phase 2 (Dream) encouraged participants to collaboratively develop priorities and design recommendations that could be passed on to service deliverers, thereby deviating from offering prescriptive solutions to addressing these issues, as is the case when using problem-solving approaches.

Trajkovski et al. (2013) highlighted that the versatility and adaptability of AI to fit the context within which it is applied is one of the unique methodological features of this framework. As the study developed, the insights shared at each stage facilitated the development of the various interview schedules implemented throughout the process. This helped to carry across the voices, narratives and ideas shared, especially in Phase 2, where only half of the participants from the Discovery Phase (1) were able to take part in the focus groups. Even so, the recommendations that had begun to surface during the interview phase were carefully considered in the Design of the Dream phases, thereby addressing the concern around voice being lost in the AI process (Reed et al., 2002).

The critical AI process applied in this study also led to discussions on new strategies for addressing issues around health inequalities and accessibility to culturally sensitive mental healthcare. Firstly, the application of this framework solely within Black African and African Caribbean communities in Birmingham is a novel approach, as it offers a unique perspective into the specific realities surrounding mental health in the Black community, beyond the BAME umbrella that is often applied in research of this nature. The unique insights and narratives shared encouraged an appreciation of the intracultural diversity that exists within Black African and African Caribbean communities, and how each story offered exclusive

knowledge into the lived experience of the different individuals represented. Synthesising these viewpoints, referred to as priorities (Phase 2), along with those shared by service providers within the statutory and voluntary sectors have supported the careful crafting of a versatile checklist/evaluative tool which has the potential to foster the continuity of the AI process beyond this research. This adaptable assessment tool, which is discussed in further detail in the next chapter, offers the opportunity for continuous, co-constructive learning that can be used to engage service users and providers in sustainable and equitable co-production partnerships.

O'Brien, Fossey and Palmer (2021) call for researchers and policy makers who engage minority ethnic communities in co-production processes to carefully consider and document any methodological concerns relating to the influence of power dynamics within the research context. Implementing standards to ensure that participants' views, particularly those pertaining to explanatory models of mental health, are respected, and carefully incorporated within the co-design process, is key to ensuring sustainability and long-term impact. In a bid to advance sustainability of such co-design frameworks, they further propose that researchers consider and document the process of integrating existing theoretical and explanatory models of mental health as a guide for future adaptations of co-production models. In connecting the 4D stages to the objectives of this critical appreciative inquiry process, this study has provided a comprehensive breakdown of the implementation process to offer in- depth insights into how the various theoretical paradigms, namely, relational constructionism, critical theory, critical race theory, salutogenesis and appreciative inquiry, were integrated within this co-production process. This outline of the methodological approach of Appreciative inquiry utilised in this study serves as a valuable contribution to the field of healthcare research, providing a roadmap for future researchers seeking to employ similar multi-theoretical, asset based and participatory research designs to address research on the complexities surrounding health inequalities among various populations.

7.7 LIMITATIONS

The findings of this research have added to the literature that already exists on mental health inequalities among Black African and African Caribbeans within the UK context. They also provide insight on the application of Appreciative Inquiry as a salutogenic approach to engaging these communities in the co-production of culturally sensitive mental health services. It is worth noting that the statements made pertaining to AI promoting equity and fostering power balances may initially appear counter-intuitive, given that community members were never in the same space as service providers in this study. Nevertheless, the initial actions taken to seek the opinions and discuss participants' visions towards the improvement of mental health service delivery positioned them as experts by lived experience who were given the power to propose changes to services compliant with the needs of the community. Thus, their valuable ideas and recommendations served as indicators for what service providers could prioritise to promote the provision of culturally sensitive services, further positioning them as equal partners in the co-design process.

However, as with any academic research, there are a number of limitations that need to be discussed to objectively highlight the weaknesses of this research and how they may impact the conclusions and outcomes drawn from this study.

7.7.1 Limitations in Sampling and Recruitment

The first limitation pertains to the method of sampling used in this study. As the aim of this research was to employ a salutogenic, critical appreciative inquiry approach to co-design culturally sensitive mental health services for Black African and African-Caribbean communities in the UK, by engaging community members and service providers as equal collaborators in addressing systemic issues and health inequalities, there was a clear justification for the exclusion of other ethnic groups represented within the city. However, there was a lack of representation of new migrant Black/African communities, such as the Somalian, Eritrean and Ethiopian communities, in this research. Even though sampling and recruitment efforts permitted an equal opportunity for the inclusion of such populations, the lack of access to translation services would have made it difficult for those interested, but

whose primary language was not English, to take part. Also, as this study was limited to only Birmingham, specifically West Birmingham and its neighbouring wards, due to the higher population of Black Africans and African Caribbeans living in the area, this narrowed down the scope of perspectives shared within this study, as the localised findings might not be representative of those in other areas within the city.

Even though qualitative research typically relies on smaller sample sizes, the results gathered from the participants in all 3 phases, may not efficiently capture the full scope of diversity and experiences represented within broader the Black African and African Caribbean populations in Birmingham, even though saturation levels indicated that the data gathered had sufficient information power. For instance, in the recruitment of service providers, while invitations were sent to a wide range of stakeholders and service deliverers, even those whose primary services extended beyond mental health support, there was still a low uptake. Thus, there was low representation of other stakeholders, such as religious leaders, whose value in supporting mental health was specifically highlighted throughout this study. Going forward, future researchers should seek to include a wider range of service providers who can provide comprehensive insights towards the process of co-production.

Also, the incidence of selection bias (Smith, 2020), may have been high, as participants who volunteered to take part in the study might have had unique experiences that were not representative of the wider population. This selection bias could also be due to research fatigue, where participants experience disinterest and reduced motivation to engage in research as a result of having been repeatedly engaged in similar scholarly activities (Mandel, 2003; Clarke, 2008). Ashley (2021) suggest that this may increase the risk of excluding some voices from being represented in research, which is common when conducting research among minority ethnic and marginalised populations. During the pandemic, the disproportionate effect of the virus on Black people in the UK led to a rise in research conducted within these communities (Patel et al., 2020), and some participants, even within this study, complained about having repeatedly been approached to contribute to various studies of similar nature. Even though the diversifying of qualitative methods within this study gave participants the flexibility to decline further participation at their convenience, future researchers must make considerations to mitigate the effects of dropouts due to this issue.

The COVID-19 pandemic, which warranted a nationwide lockdown, also greatly affected recruitment of participants, as it was difficult to go out into the community to undertake active recruitment, despite dispensing vouchers. The online methods of communication that were utilised were advantageous for reaching a wider population of potential participants, yet the uptake was low and there was heavy reliance on sharing information about the research by word of mouth. Working with the Birmingham City Council provided many opportunities to speak to large groups of people virtually; however, the difficulties with recruitment persisted. Further studies conducted in this area would benefit from making use of both online and in-person techniques for recruitment when conducting such research, particularly within hardly reached, minority ethnic communities.

Even though the critical AI approach adopted in this study is one that facilitates reflection at every phase, there is still the possibility of bias and subjectivity in any qualitative research design. As discussed in the methodology chapter (Chapter 3, p. 104; 114), my position as a worker within the communities I researched was beneficial for establishing trust and building relationships, but also might have influenced the way data was collected and analysed. Despite the rigorous process of following up data collection and analysis with my supervisors at every phase of this study, I independently carried out the analysis, which might increase the probability that some bias and subjectivity could have been overlooked. Subsequent studies may benefit from having multiple researchers reviewing data and codes to ensure that results are analysed more objectively to ensure transparency.

Finally, every researcher should consider the long-term evaluation implications associated with the outcomes of their study. As earlier highlighted, there is the potential for the checklist generated from the results of this study to be further tested within a controlled research context to establish validity and reliability. This could serve as an efficient evaluative tool for service providers to assess their service delivery and serve as a starting point that could be bolstered in individual communities by co-production and collaboration to identify any additional needs specific to the population. Even so, the sustainability and potential long-term impact of this study is yet to be determined, and upcoming research would benefit from utilising narrative inquiries and ethnographic research methods that assess the longitudinal impact frameworks, such as Appreciative inquiry have on enhancing community engagement and empowerment.

7.8 CHAPTER SUMMARY

In closing, this chapter has discussed the overall findings of this study, triangulating all three phases of this research, comprising the Discovery, Dream, Design and Destiny stages of the Appreciative inquiry framework. Drawing on initial findings from the pilot study (Chapter 3, pp. 97-98) conducted at the beginning of this study, the findings demonstrated that AI is a useful tool for facilitating community engagement and promoting co-production of culturally sensitive mental health services. With the goal of identifying the factors Black African/African-Caribbean community and service providers considered as important in the design and development of culturally sensitive mental health services in addressing health inequalities this critical AI approach brought a diverse group of community members and service providers together to discuss the barriers and facilitators to the co-design and co-delivery of culturally sensitive mental health services.

One key point covered included the need to re-evaluate resilience narratives and their impact on help-seeking behaviour, by objectively addressing the aspects of culture that perpetuate stigma and limit access to early mental health support. Emphasis was placed on challenging the systemic and institutional racism that influenced the outcomes of healthcare delivery and quality of life within the Black African and African Caribbean communities. Empowering members of the community through innovative approaches to mental health promotion and capacity-building initiatives was also deemed essential in the drive to reduce health inequalities. Also, by harnessing the social and cultural capital available within these communities, the potential to foster strategic and sustainable partnerships between statutory and voluntary services was emphasised in response to addressing the gaps that still exist in service delivery. Drawing on all these discussions, one thing that is apparent is the need to address the complex nuances that exist in navigating cultural competence and humility in mental health delivery and how these impact on service users' outlook on services and help-seeking behaviour, which speaks to the confidence of this study's unique findings. Appreciative Inquiry, as a change framework, shows promise for engaging various stakeholders in the design and implementation of culturally sensitive mental health services that are aimed at reducing health inequalities, particularly among minority ethnic communities in the UK.

The final chapter of this thesis offers concluding thoughts and recommendations for the application of this critical appreciative inquiry framework in policy, practice and in future research and introduces the checklist or evaluative tool that emerged from discussions with community members and service providers engaged in this study.

CHAPTER 8

CONCLUSION & RECOMMENDATIONS

"The seeds of change—that is, the things people think and talk about, the things people discover and learn, and the things that inform dialogue and inspire images of the future—are implicit in the very first questions we ask". - Cooperrider & Whitney, 2001.

8.1 INTRODUCTION

This chapter provides a summary of the outcomes of this study in line with the aim and objectives presented initially in Chapter 1. The unique findings and novel perspectives derived from this research are also be briefly highlighted, demonstrating the value of this research to the existing body of knowledge on the co-production of culturally sensitive mental health services. It also emphasises the significance of the use of salutogenic approaches in addressing health inequalities in Black African and African Caribbean communities in the UK. The key implications of this research, as well as the recommendations for future research, practice, and policy, will also be briefly outlined.

8.2 SUMMARY OF STUDY

The evidence that exists on the poor and disproportionate treatment of people of Black African and African Caribbean backgrounds within the mental health system in the UK is reflective of the systemic structures that still influence the delivery of healthcare within this population. Despite efforts of policy makers and healthcare practitioners to bridge the gap in health inequalities, there still exists a wide disparity between white and minority ethnic populations, leading to poorer health outcomes and quality of life for various populations, such as the Black African and African Caribbean communities. The BAME term, under which minority ethnic groups in the UK are classified and referenced in much of the literature on mental health inequalities, homogenises the experiences of the distinctive ethnic groups

represented and poses a challenge to addressing the specific needs that may hinder access to mental health services. Even though the evidence of stigma around mental illness still exists within the Black African and African Caribbean communities, this study sought to adopt a salutogenic approach to address health inequalities within this population, and to understand how protective factors embodied within culture supported mental health within this population.

The wider aim of this study, therefore, was to explore the factors identified by the Black African/African-Caribbean community and service providers as important in the design and development of culturally sensitive mental health services, using a salutogenic, critical appreciative inquiry process. Utilising the 4D stages of Appreciative Inquiry (Discovery, Dream, Design and Destiny), this study encouraged reflection on, and appreciation of culture and values, while developing strategies for overcoming the barriers to access to mental health services, towards improving cultural sensitivity in service delivery. This approach effectively achieved one of the study's objectives of exploring the cultural strengths, resilience narratives, and protective factors that contribute to the mental health and well-being of Black African and African-Caribbean communities. Although few intercultural variations were found between the groups on this topic, the approach used was designed to shed light on these types of differences, had they been identified. This was geared towards evaluating the current scope of cultural sensitivity in mental health service delivery with the goal of assessing the relevance of the salutogenic, critical appreciative inquiry (AI) approach for facilitating the co-production of services that meets the needs of the Black African and African Caribbean communities.

The social constructionist philosophical underpinning of AI permitted the use of qualitative methodologies to discuss the social realities surrounding mental health and service delivery in the Black community in Birmingham. Using online interviews and focus group discussions, broken down into 3 phases, the 4D stages of AI guided discussions on the current state of mental health and service delivery through the identification and appraisal of protective factors, such as cultural values and norms, resilience and coping strategies, against mental illness. In identifying the elements of culture and community that support resilience and well-being, the objective was to allow participants in the first 2 phases (Discovery and Dream stages) to contribute to the improvement of services by lending their voices, values and

strengths to the development and improvement of mental health promotion services. One of the most significant findings from this study was the perspectives around the resilience narrative within both Black African and African Caribbean communities and how that affected help-seeking behaviour. The concerns shared were still deeply rooted in the fear of vulnerability and a need to survive the deeply entrenched systemic and institutional racism that potentially led to a fear of mental health services within the community. Beyond the stigma and discrimination that surrounded mental illness within the Black community, there are many resources found within the rich cultural and social capital within these communities that were recognised as protective factors against mental illness, which could be capitalised on in efforts to improve the quality of services.

Dreaming and envisioning possibilities for mental health services that are tailored to efficiently meet the needs of the Black community and break the cycles of fear and stigma around mental health, participants made recommendations on the priorities that needed to be addressed within mental health service delivery. Much emphasis was placed on the importance of representation of people of Black ethnic background in positions of leadership and influence where their voices, skills and knowledge are valued, and where they are also given the opportunity to control the distribution of resources necessary for meeting the needs of their communities. Diversifying approaches to treatment, providing more innovative and creative therapeutic options, as well as engaging more community-oriented approaches, were deemed essential for improving accessibility to services, breaking down the barriers of mistrust and addressing stigma. Consequently, the need to provide better workplace-based support for Black workers to address microaggressions and racism was advocated for, owing to the impact of such actions on mental health. The pressing need to design and promote comprehensive educational curricula on mental health was also highlighted, where proposals were made towards the use of innovative techniques to empower young Black people to pursue excellence in their personal and professional growth.

With the aim of facilitating the design of innovative strategies towards the delivery of transformative actions that encourage cultural competence and humility in service delivery, Phase 3 of the study (Design and Destiny Stages) involved service deliverers from both statutory and voluntary sector organisations to critically assess their role in the co-production process, in light of the evidence from Phase 2. Having been given the opportunity to share

evidence of best practice within their services, they discussed the priorities presented in Phase 2, assessing their current strategies, and considering different approaches to integrating these propositions into their current organisational visions. The call for better inter-organisational partnerships was the prevailing theme, prompting discussions around the need for Black-led organisations to champion the cause of challenging systemic and institutional barriers that hampered efforts to alleviate health inequalities within Black African and African Caribbean communities. Demonstrating this collaborative solidarity required putting aside differences and empowering each other and, consequently, community members, to make efficient use of the resources available, while still advocating for equitable treatment in all aspects of life.

Encouraging more discourses on what works best and what makes a community healthy are essential to transforming the mindsets around mental health within minority ethnic communities, which, as earlier highlighted, is usually seen from a deficit-based perspective. Adopting a critical, yet appreciative approach to addressing the social realities and multifactorial determinants of health, particularly when discussing concerns around health inequalities and cultural sensitivity, holds the potential to make unique discoveries, as is the case with this research. Appreciative Inquiry shows promise for bridging the gap between service delivery and community engagement, from a more salutogenic perspective, addressing what works best within a group or community, and capitalising on those strengths and capabilities to facilitate collaborative and generative efforts towards change.

8.3 REFLECTIONS ON DATA COLLECTION PROCESS

Conducting community-based participatory action research on sensitive issues, such as mental health, during a difficult period such as the COVID-19 pandemic, presented many challenges during this study; however, applying the AI process to my own research journey helped me to focus my strengths on addressing what worked best in view of the prevailing circumstances. Utilising a strength-based, solution-focused model to address a crucial issue, such as health inequalities, presented even more challenges, requiring extra efforts to establish trust and navigate the lack of interest because of research fatigue within the Black

community. Nonetheless, prioritising participants' well-being, fostering meaningful connections and creating a safe space by encouraging open dialogue and storytelling were crucial to sustaining engagement and interest over this length of time.

Discovering what works best meant being open to learning from participants and tailoring the appreciative inquiry framework and interview schedules to suit the research context, all in a bid to ensure that the cultural sensitivity being discussed began during the research. Allowing participants to ask questions, provide feedback, and contribute to the design of mental health services by sharing their stories and experiences, all facilitated the process of generativity that is at the core of the appreciative inquiry framework. Capitalising on the strengths that I possessed, such as my network within the community and the other forms of social capital I had the privilege of tapping into, such as my family, friends, and supervisory team, helped me to remain resilient.

Dreaming of what could be, I was motivated to constantly seek new ways to surmount the challenges posed especially during the recruitment process, evidence of which is seen in the multiple ethical considerations and applications that needed to be made to accommodate all the needs of the population. With the goal in mind to foster an empowering and collaborative process, where participants could make meaningful contributions to both practice and research, I persisted in the process of working with my supervisory team and other experts at my disposal, to co-construct an effective approach for research and practice towards fostering the co-production of equitable mental health. Engaging the design and destiny stages, required adopting a reflexive outlook on the entire process, where I adapted to the process of continuous learning to ensure that the findings from this study led to sustainable and impactful outcomes.

Some proponents of Appreciative Inquiry are of the view that *acting 'as if' is self-fulfilling*: in other words, be the change you want to see. Embodying this principle helped shape my perspectives as both an academic and a practitioner as I embarked on this data collection process and gave me hope that as I engage in the practice of continuous reflection, I can stay committed to my responsibility of fostering change, both in research and practice.

The next steps for this study, discussed in the recommendations section, outline the potential pathways for ensuring that the findings of this study are integrated into community mental

health initiatives, policy and future research, all with the aim of ensuring a lasting impact in minority ethnic communities in the UK.

8.4 RECOMMENDATIONS FOR FUTURE RESEARCH

As earlier stated, the Appreciative inquiry framework holds the potential as an efficient asset-based community-based participatory research (CBPR) methodology, that can be applied through a critical lens for addressing critical issues around healthcare and inequalities from a salutogenic standpoint. It is essential, however, to adapt the AI framework to meet the needs of the research context, taking care to acknowledge both negative and positive narratives, while still maintaining the positive solution-focused ethos that fosters generativity and constructive change.

When addressing the issue of mental health, stigma and poor access to mental health services, particularly within minority ethnic communities, researchers may benefit from striking a healthy, yet critical balance by asking, **'What works and how can we enhance it?'** AND **'How can we fix this issue?'**. This salutogenic solution-focused approach has the potential to transform thinking around research on health inequalities. The innovative method of affirmative questioning that appreciative inquiry adopts positions it as a powerful tool for engaging participants, reframing perspectives, as well as offering an evaluative opportunity for collaborative partnerships, in that, it helps to level the playing field and to reinforce social justice. This study does not purport that AI may be the sole solution to alleviating health inequalities in mental health services, but it is a good starting point for evaluating service delivery, promoting community engagement, and providing a platform for co-construction and co-delivery of culturally sensitive mental health services. The critical lens that is applied in this study provides a more unique outlook on an inherently positive change model that focuses on what works best within a particular context. The goal was to avoid utilising a deficit-focused, problem-solving approach to assess the relevance of Black cultural values and their place in the co-production of culturally sensitive mental health services.

A crucial principle highlighted within this study underscores the significance of avoiding the generalisation of the research outcomes across all racialised communities, as each distinct ethnic population has its experiences and perspectives that need to be considered and respected. Future research would benefit from conducting data collection and analysis with distinct ethnic groups and not merging them under the 'BAME' term, as has been the case in majority of healthcare research on racialised communities in the UK. Acknowledging the unique characteristics of individual ethnic groups will help researchers to better understand the interaction between culture and social and political structures and their effect on mental health and well-being, particularly within minority ethnic communities.

Another potential area that would benefit from further studies within the UK context is the effects of intergenerational trauma on coping and resilience among Black communities, particularly towards producing more evidence on the effects of resilience narratives on help-seeking behaviour. Further evaluations into resilience as a historical trauma response and the creation of safe spaces for such engagement would be beneficial for reframing community-based participatory research frameworks and, in turn, informing practice. Such research has been explored among indigenous groups and the Black American population in Australia and the USA, respectively especially through the application of critical race theory. But there is still a paucity of such evidence around the experience of Black communities and other minority ethnic groups in the UK and this gap needs to be addressed.

8.5 RECOMMENDATIONS FOR POLICY AND PRACTICE

The NHS's current mandate to embrace co-production efforts is commendable and a step in the right direction, yet the ultimate objective of significantly alleviating health inequalities among minority ethnic communities requires much more effort. The need for sustainable inter-organisational partnerships cannot be over-emphasised, especially following the pandemic when communication and collaboration within agencies, both nationally and internationally, was crucial to the survival of many. If any lessons were learned from COVID, it was that the voluntary sector plays a significant role in bridging the service delivery gap and

needs to be recognised and empowered more to meet the needs of the populations they serve (Rees et al., 2022). Empowering grassroot service providers and service users through more equitable partnerships and co-production initiatives will help provide more opportunities for growth and increase ownership and shared responsibility for improving mental health service delivery. Services must also be willing to incorporate more innovative methods of therapy, taking advantage of art, music, and drama-based therapies to support clients from minority ethnic backgrounds, such as those represented in this research. Such creative techniques align well with the cultures of many minority ethnic communities and offer an alternative to the traditional Western medical practices that have alienated the role of culture in promoting health and well-being. Social prescribing is also another avenue which needs to be further supported to provide diversity in the range of services delivered.

Initiatives, such as the Working Well Together resource, developed by the National Collaboration Centre for Mental health (NCCMH, 2019), are worth highlighting as a step in the right direction towards achieving the NHS Long-Term Plan which advocates for more partnerships between various community and statutory services, as well as clinical commissioning teams. Nonetheless, this study brought to light the effects of systemic and institutional racism on the delivery of mental health and well-being; hence, in the quest to promote cultural sensitivity in healthcare delivery, there is a greater need to confront the structures and policies that perpetuate these inequalities.

The findings of this research present several implications for policymakers and healthcare commissioners to supplement the existing discourse on how these stakeholders could improve health outcomes among minority ethnic groups, such as the Black African and African Caribbean communities in the UK.

8.5.1 Inclusivity and Diversity

Implementing policies that ensure equitable representation of people of Black African and African Caribbean backgrounds on executive and non-executive governing and decision-making bodies is essential to promoting inclusivity and diversity in the healthcare leadership structure. Targeted recruitment drives and other initiatives that offer such opportunities to people within these communities, particularly those with lived experience of mental illness, will have far-reaching effects by promoting community engagement and addressing long-

standing barriers to health services delivery. Given the historical exclusion of people of Black African and African Caribbean backgrounds and the current evidence of the prevailing inequalities within this population, there is no better time to give Black communities in the UK a seat at the decision-making table, where they can also influence the distribution of resources suited to their specific needs.

8.5.2 Training and capacity building

Providing the right training and capacity building support to upskill service users and service providers, who will be engaged in the development of policies and procedures aimed at improving mental health, is also worth considering. Policies should be encouraged that promote initiatives aimed at providing financial assistance and empowerment to community-led organisations, particularly before pursuing partnerships between statutory and voluntary sector services. In addition to ensuring that community-led organisations are equipped to meet the needs of the communities they serve, it will also help bridge the competency gap between statutory and voluntary organisations, that contributes to the power imbalances often reported within such collaborations. To ensure that the strengths and expertise of both parties are respected and well utilised, there is the need to develop clear operational protocols on communication and project implementation, as well as evaluation. The evidence from this study suggests that there is still more work to be done towards improving the training and education of healthcare professionals in cultural competency. Prioritising the implementation of well-structured, strategic policies that encourage reflective practices and foster cultural safety and humility will help promote mental health delivery that considers the influences of political and social structures on service provision within minority ethnic communities.

8.5.3 Holistic, community-tailored mental health support

Finally, health policymakers should give more attention to the implementation of strategies that target a holistic, community-tailored approach to mental health treatment and promotion. Recognising the need to integrate non-Western medicalised mental health support will require the provision of funds and resources for the promotion of culturally

specific initiatives that promote diversity and improve access to innovative health practices which cater to the needs of minority ethnic communities. Co-production should be particularly encouraged to promote the involvement of service users of Black African and African Caribbean backgrounds in the design of such programmes. Consequently, a transparent process should be executed to ensure that they are also actively engaged in the implementation and evaluation processes. Once communities are convinced that commissioners and policymakers are working to ensure services and mental health promotion initiatives align with their values and beliefs, it is likely that there will be more scope to facilitate sustainable change.

8.6 NOVEL CONTRIBUTIONS

8.6.1 Deconstructing Black resilience in relation to help-seeking behaviour

An original and noteworthy contribution of this research to the existing literature is the finding that resilience is viewed as an identity rather than a choice within the Black African and African-Caribbean communities. Understanding the profound impact that racism and discrimination have had on the development of a sense of self-preservation was highlighted as one of the key reasons behind the emergence of a resilient outlook on life. Participants expressed that one had to maintain a "stiff upper lip" or avoid any sign of vulnerability to survive the deleterious effects that racial discrimination and other inequalities had on mental health. As one participant poignantly stated, "You were either a resilient fighter or a resilient doormat," and this deeply ingrained mindset greatly affects the way individuals within these communities seek support, especially when it comes to accessing mental health services, given the pre-existing lack of trust in the system.

As discussed in the methodology chapter (Chapter 3, Pg 94-95) engaging critical race theory (CRT) offers a powerful lens through which to understand and contextualise this finding. CRT centres the lived experiences of oppressed racial groups and critically examines the systemic nature of racism, providing a framework for unpacking how the historical and ongoing realities of racial oppression have shaped the development of resilience as an identity within

these communities. This novel contribution aligns with CRT's recognition of the need to disrupt oppressive power structures and challenge the racial status quo, as it sheds light on the ways in which resilience has been both a necessity for survival and a potential barrier to seeking support or acknowledging vulnerability.

Moreover, this finding opens new avenues for research that seeks to understand how resilience, vulnerability, and the generational and gender shifts in ideologies around narratives such as "the strong Black woman" could impact the future of health research and service delivery. By acknowledging the complex interplay between resilience as an identity and the systemic structures that have shaped this reality, this study's contribution paves the way for a more nuanced and contextualised understanding of the unique experiences and perspectives of Black African and African-Caribbean communities, ultimately informing the development of more culturally sensitive and equitable mental health services.

8.6.2 An Evaluative tool derived from shared priorities and strategies for promoting culturally sensitive mental health services

Wagemakers et al. (2010) suggest that following a co-production initiative, developing a coordinated action checklist is a feasible means of ensuring that the partnerships developed are sustained through a thorough and transparent evaluation framework that supports all parties involved. While the findings from all three phases informed the development of the checklist, the Dream phase played a crucial role in setting the priorities that were later discussed and compared with the current service delivery within the communities. By aligning Phase 2 priorities with the strengths of existing services, and incorporating ideas and strategies shared by providers, the final checklist reflected a co-created set of guidelines that could be used as an assessment or evaluative tool for services. The development of this checklist not only ensured that the contributions of community members were pertinent to the co-production process but also facilitated mutual accountability among service providers. While the Design and Destiny phases may have further refined the checklist, the collaborative visioning and priority-setting of the initial Discovery and Dream phases by members of the Black African and African Caribbean communities were crucial to the step-by-step co-

production process significant in the implementation of this critical appreciative inquiry process.

The checklist developed which reflects the themes, priorities and strategies derived from this study, is, thus, one of the novel contributions of this study and offers potential for further testing within a controlled research context to determine its validity and reliability as an evaluative tool for community service providers and other stakeholders. Furthermore, if training is provided on how the AI framework can be efficiently utilised, service providers can adapt this checklist as the tool to engage with communities to obtain community-specific information.

Below is a summary of the key questions which shaped this checklist, derived from the Dream stage (Phase 2), representing the key priorities that participants believed needed to be addressed by service providers as well as strategies shared by these mental health services, all aligned with the goal of improving inclusivity, promoting cultural sensitivity in service delivery, and enhancing community engagement.

ASSESSMENT PRIORITY	ASSESSMENT PARAMETERS	RESPONSES
Cultural Sensitivity and Responsiveness	• Are services tailored to meet the cultural and linguistic needs of both Black Africans and African Caribbeans?	YES ☐ NO ☐
	• Is cultural diversity reflected in service materials, policies and practices?	YES ☐ NO ☐
	• Are all staff members, regardless of race, trained in cultural competency and sensitivity to effectively engage and support individuals from these communities?	YES ☐ NO ☐

	• Is there an organisational culture that promotes respect for diversity and continuous learning about cultural issues? • Are services flexible in their approach to adapting their strategies to accommodate the needs of the communities they serve?	YES ☐ NO ☐ YES ☐ NO ☐
Representation and Leadership	• Is there diverse representation within the organisation's leadership positions, including individuals from Black African and African Caribbean cultural groups? • Are decision-making processes inclusive and informed by the perspectives and needs of these communities?	YES ☐ NO ☐ YES ☐ NO ☐
Accessibility and Outreach	• Are mental health services easily accessible to Black Africans and African Caribbean populations, considering factors, such as location, transportation, and opening hours? • Are efforts made to actively reach out to and engage with these communities, including through community partnerships with religious	YES ☐ NO ☐ YES ☐ NO ☐

	institutions and through targeted outreach initiatives?	
Holistic Mental Health Support	• Are culturally relevant mental health practices and approaches recognized and integrated within the physical and primary service delivery system? • Are there options for individuals to access alternative mental health support, such as art, music or sports-based therapy, if desired?	YES ☐ NO ☐ YES ☐ NO ☐
Interorganisational Collaboration and Communication	• Is there effective communication and collaboration between voluntary and statutory sector mental health services? • Are there established mechanisms for sharing best practices, coordinating care, and addressing gaps in service provision? • Are the providers within similar catchment areas working in unity and partnership to collaboratively meet the diverse needs of the communities they serve?	YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐
Co-production and Community Engagement	• Are there processes in place to monitor and evaluate the impact of mental health services on Black Africans and	YES ☐ NO ☐

	African Caribbean populations? • Is feedback actively sought from service users, and are their voices incorporated into service improvements and decision-making processes?	YES ☐ NO ☐
Outcome Evaluation and Feedback	• Are there processes in place to monitor and evaluate the impact of mental health services on Black Africans and African Caribbean populations? • Is feedback actively sought from service users, and are their voices incorporated into service improvements and decision-making processes?	YES ☐ NO ☐ YES ☐ NO ☐

Table 3: Checklist for Service Providers

8.6.1 Potential application of this checklist for future research and practice

Below are fundamental criteria that may be considered in future research and practice, where the implementation of this checklist is concerned, as a guide to ensuring an equitable and transformative co-production process that yields sustainable outcomes for all stakeholders involved.

1. Future researchers and practitioners should consider engaging in continued consultations with a wider range of service providers in refining the 7 proposed categories. The appreciative inquiry process is one that encourages continuity and sustained interest in promoting adaptability and generativity. Engaging the perspectives of multiple stakeholders is essential to fostering the process of mutual learning that underscores the solution-focused ethos of appreciative inquiry.

2. There is scope to expand further on the various priorities outlined by setting out distinct parameters that will support the assessment of the significance of the various recommendations to the needs of the research or practice setting, particularly in a manner that addresses the cultural sensitivity and provides an empowering environment for co-production.

3. Piloting this checklist within the study or practice catchment area would be crucial for justifying the tool and effectively interpreting the significance of the various recommendations to the specific community context. This would permit or facilitate the gathering of feedback from service providers on the relevance of the various parameters to their current service delivery strategies.

In piloting such a checklist, it is important that a few criteria are considered to ensure that the tool adopts a multifaceted approach to addressing the various priorities outlined to engage the needs of the population within which it is implemented. Following an evaluation of systematic reviews on the development of healthcare quality assessments, Grimshaw et al (2001) proposed that the comprehensiveness of the structural process and outcome measures, the relevance of the measures to the capacity of service deliverers as well as the granularity, which is the specificity of details pertaining to measures needed to be considered. In addressing the factors of comprehensibility and granularity, the systematic 4D process of AI offers an outline for the structural process that is needed to evaluate the various dimensions of quality, especially during the Discovery and Dream stages where specific details and nuanced feedback on best practices and service quality can be assessed. The feedback process that AI facilitates between stakeholders also addresses the factor relating to relevance in that during the co-production process, service providers are given the opportunity to communicate how best the priorities proposed by service users align with and reflect areas of healthcare delivery that they can immediately address based on their current capacity. Critical stakeholder input would also be crucial in the further development of this assessment tool to ensure that the needs and values of the community of interest are well integrated in its design. With the goal of optimising the comprehensibility and granularity of the assessment tool, clear, operational definitions of each quality parameter could also be provided to align with the priorities of all stakeholders and should constantly undergo reviewing and refinement where necessary. In addition, to effectively capture the extent of

quality and facilitate grouping within the various evaluation criteria, each parameter will be rated on a scale of 1-5, where the average score for each category could be calculated to identify the areas that require improvement. Including these recommendations during the piloting of this checklist will enhance the process of standardisation for evaluating and capturing the multidimensional parameters that must be considered in the delivery of culturally sensitive mental health services.

The appreciative inquiry process complements these quality assessment aims as it engages stakeholders' values, generates insights that are relevant to shaping assessment criteria and builds on ongoing participation to enhance evaluation and improve quality outcomes. There is no shortage of possibilities for implementing and piloting the parameters proposed in this checklist within various research and practice contexts. The main goal should be that the outcomes of its implementation are community-driven and reflective of the needs of the population within which they are applied.

8.7 DISSEMINATION

To ensure the impact and reach of this research, there is a need for effective dissemination of the findings of this study. One of the main concerns discussed was the lack of long-term sustainability of research findings towards facilitating change within the research context, particularly when research was conducted in minority ethnic communities. Therefore, to respect the perspectives shared and foster opportunities for further dialogue and engagement with stakeholders, the findings of this study will be summarised and distributed through various mediums. First, the checklist/assessment tool above will be sent round to all providers serving the Black community in Birmingham, where they can review some of the suggested changes to services with the aim of improving culturally sensitive services. Also, by collaborating with service providers, a directory would be created which maps out the available services within Birmingham, particularly those who provide culturally specific services for people of Black African and Caribbean backgrounds. This directory would be widely disseminated within the community to create awareness of the services that provide

culturally specific mental health support and would be a crucial step towards addressing concerns around the poor visibility of culturally competent services within the community.

The outcomes of this research will be shared at academic events using both oral and poster presentations to offer opportunities for other academics to offer feedback and even foster collaborations with like-minded researchers whose interests lie in exploring similar subjects. The results will also be published in reputable, peer-reviewed journals and open-access repositories as a contribution to knowledge on the use of community-based participatory action research methodologies, such as appreciative inquiry towards alleviating health inequalities in minority ethnic communities in the UK. Also, there are intentions to begin the piloting of this checklist, among some service providers in the near future. This will also enhance the transparency of the research process for the benefit of grassroots organisations that may be seeking to conduct similar research within their communities. The systematic process AI offers through the 4D stages is replicable and can be tailored to the context within which the process will be applied.

Social media platforms also offer many opportunities for a wider audience reach. When appropriate, the findings of this study will be shared through podcasts, radio shows, blogs, and video blogs (vlogs) to help normalise discussions around mental health, resilience and the influence of culture on well-being within the Black community. Also, engaging statutory organisations in this study has already created some opportunities for sharing the outcomes of this study with policymakers and commissioning bodies, such as the Birmingham and Solihull Mental Health Trust and the Birmingham City Council. It may be helpful to use appreciative inquiry to continue this research in other areas of the UK, or internationally. Disseminating the findings of this study through the above stated media as well as community engagement initiatives can further contribute to the growing body of knowledge on culturally sensitive mental health promotion and inspire similar asset-based participatory research aimed at addressing health inequalities and fostering culturally sensitive mental health services among various communities.

"When I dream alone, it is just a dream. When we dream together, it is the beginning of reality. When we work together, following our dream, it is the Creation of Heaven on Earth".
—Adapted Brazilian Proverb

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APPENDICES

APPENDIX 1

PARTICIPANT INFORMATION SHEET

Study Title: APPRECIATIVE INQUIRY FOR MENTAL HEALTH PROMOTION AMONG BLACK AFRICAN AND CARIBBEAN COMMUNITIES IN BIRMINGHAM

You are being invited to take part in a research study. Before you decide whether or not you wish to take part, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss any questions you may have with the researcher or their supervisors. Please ask questions if there is anything that is not clear to you or if you would like any further information.

The purpose of the study:

This study is part of my PhD research within the Birmingham City University (BCU) Public Health Department and is designed to gain an understanding of resilience and mental wellbeing within the Black Community living in Holyhead, Birmingham. In identifying the elements of culture and community that support resilience and wellbeing, the objective is that you will be able to contribute to the improvement of services within your community by lending your voice, values and strengths to the design and development of mental health promotion services. As the rates of mental illness rise, it is pertinent that more efforts are made towards improving mental health promotion services, especially among Black, African and African-Caribbean. Appreciative inquiry, the model that will be used to guide these discussions, focuses on discovering what works best for a specific community, in a particular time frame based on the available resources and cultural context. It also seeks to understand how these resources within a community can be used to support community wellbeing.

This study will be conducted as an online focus group discussions and will explore the following objectives:

- To identify cultural variations and similarities in strengths and coping abilities among Black African and African Caribbean population in Birmingham that foster resilience and mental wellbeing
- To identify the role third sector mental health service providers', play in embedding/reflecting strengths and coping abilities of Black African and African Caribbean population in service delivery
- To determine the relevance of the appreciative inquiry model towards the further development of culturally sensitive mental health promotion for Black African and African Caribbean service users and providers.

The tentative start date for this study will be the 15th of March, 2021.

Why have I been chosen?

I am inviting individuals living within Black African and African-Caribbean communities in Holyhead, as well as organisations registered in the voluntary/charity sector providing mental health and wellbeing services in these communities in Handsworth to participate in an online Focus Group Discussion (OFCD). You will be invited to take part in an online session hosted on Microsoft teams that will last between 60-90 minutes to give room for thorough discussions and engagements with fellow participants.

By consenting, you are agreeing for this session to be recorded and findings included in publications and a final thesis, which will in no way be traceable to you or your organisation. Verbal consent will also be sought before the beginning of the session to verify that consent and participation in this study are voluntary. Consent will also be sought for an independent notetaker to be present to help coordinate discussions. The strictest measures to ensure confidentiality and anonymity will be upheld.

Video settings will be officially disabled for each participant on entry into the meeting to facilitate privacy and confidentiality. If you choose however, to enable the video function, you will be advised to utilize the background blur function to ensure that no personally identifiable objects in the background may be seen.

Do I have to take part?

No – your involvement in this study is voluntary. If you decide to take part, you are still free to withdraw at any time during the focus group discussion session without needing to give reason for this. Any decision you make to withdraw will have no effect on you or your organisation.

Will I remain anonymous?

All contributions you make towards this research study will be anonymous and confidentiality will be maintained. No names will be used and any personally identifiable information will be made to anonymized to ensure that data in any publications is not traceable to any specific organisation and the specific location of your organisation will not be printed in any external publications. Numbers will be given for identification during transcription and analysis of the result of this discussion and you will be referred to by this number throughout the study to ensure that your identities are not revealed.

Please be advised if you disclose any unethical, professional misconduct or unlawful practice the researcher is obliged to pass this information to relevant authorities. Please be mindful of Service Users' confidentiality when providing your answers.

The recording of this Online Focus Group Discussion will be transferred to a secure Birmingham City University (BCU) OneDrive folder no later than 72 hours after the focus group discussion takes place. Files will be accessed and transcribed by the researcher alone, anonymised, organised in an aggregated database and securely stored in Birmingham City University encrypted, password protected devices only. Interviews will be analysed by the researcher Angela Kumah, a doctoral student and the results will be organised in aggregated database in which no individual or their responses will be identified.

BCU is the sponsor for this study based in the United Kingdom. We will be using anonymized information from you and your organisation in order to undertake this study and will act as

the data controller for this study. This means that we are responsible for looking after your information and using it properly in accordance with GDPR policies.

BCU will retain evidence of your participation in this study through the electronic consent form for stored on a password protected OneDrive account.

Who has approved the study?

The Faculty Academic Ethics Committee for the Faculty of Health, Education and Life Sciences at BCU reviews this research and protects your safety, rights, wellbeing and dignity.

What are the potential benefits of this study?

Your participation in this study aims to encourage contributions towards the design of pragmatic recommendations for the development of relevant and successful mental health promotion interventions that are applicable to the identified cultural needs. Based on the aims of this study, the need for the identification of strengths in ensuring personal and communal wellbeing will contribute to your active participation in the design and development of services delivered to you and your communities, all of which are relevant factors in mental health promotion.

Support

The topics covered in the Focus Group Discussions are unlikely to pose harm beyond those encountered in everyday discussions. If you however, feel upset as a consequence of questions asked during the sessions or feel distressed by any other members of the group, you are at liberty to withdraw from the study. You will also be advised to access counselling support from our supporting partner:

Beresford Dawkins: 0121 301 1019 or **Email**: Beresford.dawkins@nhs.net

You have the right to withdraw

You have the right to withdraw during the focus group session and **10 working days** from the day of the focus group discussion session**.** However, after 10 working days) once data has been aggregated into a database for analysis, withdrawal will not be possible.

All recordings will then be deleted after transcription has been done. However, evidence of participation from electronic forms and verbal consent at the beginning of the online session (which will be stored separately from all data transcripts) are anticipated to be retained securely up until 2026. This is in accordance with the University's legal obligations and the time available in which participants may wish to raise any issues or concerns with the researcher about participation in this study. After this period, BCU will securely destroy information held about you.

You can find out more about how we use your information by contacting ANGELA KUMAH (angela.kumah@mail.bcu.ac.uk) and my supervisors DR. FOUAD BERRAHOU (fouad.berrahou@bcu.ac.uk) or DR. ANGELA HEWETT (angela.hewett@bcu.ac.uk)

What will happen to the results of this research?

At the end of the research, the findings will contribute to the production of a doctoral thesis. They will also be shared through articles and presentations with voluntary sector organisations in Birmingham and the UK and abroad, as well as stakeholders involved in the delivery and services to BAME communities. Again, confidentiality will be upheld and no personal or traceable details will be included in any of these publications and presentations.

What if there is a problem?

If for any reason, you wish to complain about any aspect of this research study then you should initially contact the lead researcher. If I cannot satisfy your concerns then you should contact the BCU Ethics Committee at (HELS_Ethics@bcu.ac.uk) or Dr Natasha Kriznik - Faculty Research Compliance Lead. Contact: HELS_researchintegrity@bcu.ac.uk

PRINCIPAL INVESTIGATOR	SUPERVISORS	
ANGELA KUMAH	***DR FOUAD BERRAHOU***	***DR ANGELA HEWETT***
Phd Researcher And Graduate Research Teaching Assistant Birmingham City University Faculty Of Health, Education and Life Sciences City South Campus Westbourne Road Edgbaston Birmingham B15 3TN angela.kumah@mail.bcu.ac.uk	Senior Lecturer, Subject Lead Health Leadership and Management Programme Lead MBA in Healthcare Management Department of Public Health Birmingham City University Seacole, Rm SCT208 Westbourne Road Edgbaston Birmingham B15 3TN fouad.berrahou@bcu.ac.uk Office: 0121 331 7115	Senior Lecturer in Health Psychology Deputy Course Leader, PGCert/PGDip/MSc Health Psychology Birmingham City University Curzon 332 4 Cardigan Street Birmingham B4 7BD angela.hewett@bcu.ac.uk Office: 0121 202 4205

APPENDIX 2

CONSENT FORM- ONLINE FOCUS GROUP DISCUSSION

Study Title: **APPRECIATIVE INQUIRY FOR MENTAL HEALTH PROMOTION AMONG BLACK AFRICAN AND CARIBBEAN COMMUNITIES IN BIRMINGHAM**

Name of Researcher: ANGELA KUMAH

1. I confirm that I have read the information sheet [version 2] for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	Yes, I confirm this
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	Yes, I understand this
3. I understand that relevant sections of my data collected during the study may be looked at by individuals from Birmingham City University and from regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	Yes, I understand this
4. I understand that personal data about me will be collected for the purposes of the research study including name and description of my work, and that these will be processed in accordance with the consent form […, version 1]. I therefore, agree for my name and a description of my work to be anonymised and kept confidential.	Yes, I understand this
5. I fully consent to taking part in this online focus group discussion and I understand that the transcriptions of the video recordings are to be used as part of a PhD thesis and other publication purposes without my identity or that of the organisation I represent being revealed	Yes, I consent to this
6. I agree to the use of anonymised quotes in research reports and publications	Yes, I agree

7. During the online focus group discussion, I agree to settings which will automatically turn off my camera and will be advised to keep it that way. If however, I choose to enable the video conferencing feature, I agree to make use of a virtual background or blurred background to conceal any personally identifiable contents in the background	Yes, I agree [ ]
8. I agree to take part in this study.	Yes, I agree to take part [ ] No, I am not interested in taking part [ ]
9. I agree to take part in a follow-up focus group discussion to discuss further findings.	Yes, I agree to take part [ ] No, I am not interested in taking part [ ]

_____ _____

Name of Participant **Name of Organisation**

Ethnicity

Black- African [ ]

Black- Caribbean [ ]

Black/African/Caribbean - Mixed/Multiple ethnic background [ ]

Link to online survey:

https://bcu.onlinesurveys.ac.uk/appreciative-inquiry-a-tool-for-mental-health-promotion-6

APPENDIX 3

ETHICAL APPROVAL

Faculty of Health, Education & Life Sciences Research Office

Seacole Building, 8 Westbourne Road

Birmingham

B15 3TN

HELS_Ethics@bcu.ac.uk

17/Feb/2021

Miss Angela Kumah

angela.kumah@mail.bcu.ac.uk

Dear Angela ,

Re: Kumah /#8123 /sub2 /R(A) /2021 /Feb /HELS FAEC - APPRECIATIVE INQUIRY – A tool for mental health promotion among Black African and Afro

Caribbean people living in Holyhead, Birmingham

Thank you for your application and documentation regarding the above activity. I am pleased to take Chair's Action and approve this activity.

Provided that you are granted Permission of Access by relevant parties (meeting requirements as laid out by them), you may begin your activity.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must

submit an Amendment application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or

change of Project Lead.

Please also note that the Health, Education and Life Sciences Faculty Academic Ethics Committee should be notified of any serious adverse effects arising as a result of

this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising

which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact HELS_Ethics@bcu.ac.uk

I wish you every success with your activity.

Yours Sincerely,

Professor Joanne Brooke

On behalf of the Health, Education and Life Sciences Faculty Academic Ethics Committee

APPENDIX 4
AI INTERVIEW GUIDE
PHASE ONE: DISCOVERY

OBJECTIVE: *To identify the similarities and differences in cultural values that foster resilience and mental health among Black African and African Caribbean communities.*

INTRODUCTION

This study is designed to gain an understanding of resilience and wellbeing within our Black Community. In identifying the elements of culture and community that support resilience and wellbeing, the objective is that you will be able to contribute to the improvement of services within your community by lending your voice, values and strengths to the development and improvement of mental health promotion services. As the cases of mental illness rise, it is pertinent that more efforts are made towards improving mental health promotion services, especially among Black African and Caribbean (BAC) people.

USEFUL DEFINITIONS

MENTAL HEALTH: Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to his or her community (WHO, 2018).

MENTAL HEALTH PROMOTION: is the creation of individual, social and environmental conditions and initiatives to support the process of achieving positive mental health and enhancing quality of life. It is an empowering process, done by, with and for the people (Jane-Llopis et al, 2007)

RESILIENCE: American Psychological Association (2014) defines resilience as "*the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress such as family and relationship problems, serious health problems, or workplace and financial stressors*".

APPRECIATIVE INQUIRY: AI focuses on discovering what works best for a specific group, in a particular period based on the available resources and the current socioeconomic and cultural context. It makes use of 4 stages to achieve this:

PHASE 1: DISCOVERY: WHAT IS GOING WELL?

Preamble: ***A good half of the art of living is resilience." ~ Alain de Botton***

Life tends to present us with many situations where we are given the chance to make use of personal values and mental strength as well as community support to get through difficult times. We would like to discuss some of the times when the support provided enhanced your wellbeing, and discover what made it possible to get through these difficult times, as an individual and as part of a community. These responses will help frame our focus in the next stage of this study towards contributing to the design and improvement of mental health promotion programmes that take individual, cultural and community values into consideration.

A. MENTAL HEALTH AND RESILIENCE

1. What does **mental health** mean to you?

1a. What is your understanding of mental health and wellbeing?

1b. What is your view of mental health promotion?

1c. Which aspects of our culture actually promotes mental health?

1d. What have efforts toward mental health promotion looked like in the Black community?

2. What does **resilience** mean to you?

2a. Can you share a story about a time when you displayed resilience and how it made you feel?

2b. What was it about you (unique qualities, values or strengths) that made it possible to adapt during these difficult times?

B. FAMILY AND COMMUNITY: THEIR ROLE IN SUPPORTING RESILIENCE

3. I am going to ask you about how different groups of people supported your mental health resilience during this period.

- Family members and friends
- Community leaders
- School leadership & staff

3a. Are there any specific values and beliefs unique to the Black community that encourage resilience?

3b. Music, art forms and sports are a big part of our community and our culture as Black people. How has music, an art form, or sports that you have used acted as a means for improving your resilience and wellbeing?

C. MENTAL ILLNESS STIGMA AND MENTAL HEALTH SUPPORT

4. Within our culture and communities, mental illness is rarely spoken about and many people are discouraged from voicing their struggles or seeking help for fear of being discriminated against (mental illness **stigma**) (Mermon et al, 2016).

4a. What are some of the reasons surrounding mental illness stigma in your community?

4b. Have you witnessed any recent improvements aimed at reducing this stigma in your community that are commendable?

5. From time to time, we all need help. Take a moment again to think about a time when you sought support for mental health and what your experience of the support received from these groups of people has been like:

    - your family and friends

- a religious leader, mental health professional, a counsellor
- community centres/groups, sports clubs, online services).

D. EXPERIENCES OF SERVICE DELIVERY

- Government sector mental health services
- Voluntary sector mental health services

E. There is a general mistrust of Mental health services (government and voluntary sector) in the Black community because people have had negative experiences & do not trust providers because they lack the cultural awareness needed to support Black people.

Have you had or know someone who has had a:
a. POSITIVE experience with mental health providers within the community? What was this experience like?
b. NEGATIVE experience with mental health providers within the community? What was this experience like?

7. What is worth celebrating about mental health and wellbeing support in the Black community?

APPENDIX 5

PHASE 2

DREAM

***OBJECTIVE**: To determine the relevance of appreciative inquiry for engaging community members in the co-production of culturally sensitive mental health service delivery for Black African and African-Caribbean community.*

This study is designed to gain an understanding of resilience and wellbeing within the Black African and Caribbean Community. A method called appreciative inquiry will be used in this discussion. It focuses on what works well within an organisation or community and tries to understand how the resources identified can support the organisation or community, in this case, promote mental health.

In identifying the elements of culture and community that support resilience and wellbeing, the objective is that you will be able to contribute to the improvement of services within your community by lending your voice, values and strengths to the development and improvement of mental health services.

DREAM- Allows you to envision an ideal future, in this case, one characterized with positive community growth and support as well as individual wellbeing, all towards the promotion of mental health and wellbeing.

CONTRIBUTING TO SERVICE DELIVERY: The Bigger Picture

'Both voluntary and NHS services have been good. There is still a big gap in cultural sensitivity as white therapists do not understand our backgrounds'.

'It can be frustrating having to explain oneself and culture every time'.

Our experiences of service delivery vary in many ways but there is a common theme of a lack of cultural sensitivity in services. We will be discussions our visions and dreams for mental service support services within our community in this section.

1. You are given the opportunity to run a mental health service within the community for a day, with access to all the power and resources needed to make this happen

a. What will be the top 3 priorities/things you will address in the existing mental health services?

b. How do you envisage these priorities promoting mental health and wellbeing in a culturally sensitive manner within the community?

c. Preamble (Religion and spirituality play a big role in our mental health and wellbeing) What kinds of contributions can these groups make to improving mental health and wellbeing in relation to the priorities you listed?

d. Community centres were also mentioned as safe spaces for supporting mental health and wellbeing. What kind of activities would they be providing to promote mental health and wellbeing within the Black community in relation to the priorities listed?

INTEGRATING OUR VALUES WITHIN OUR MENTAL HEALTH SERVICES THE BLACK COMMUNITY

Our values (eg. Community support, family, hard work etc) and the things we value (music, arts, food) are a big part of our identity and affect various aspects of our lives, including our mental health. Let's explore some of these values in relation to our dreams for communities.

1. Think about those 3 priorities you mentioned. Do you think our values are represented in these priorities? Yes/no. Why?

(Brief introduction of values represented in data)

a. Visualise us living in communities where these the things we value (music, arts, food) are incorporated in our services. Align them with the priorities you have identified. How do you envision innovation in services through the following:

- Music and arts
- Food
- Sports

2. It is sometime in the future and your grandchildren are being told a story about your role in encouraging the inclusion of our values into service delivery.

a. What are you most proud of that you would like them to hear about?

b. How do you see yourself taking part in fully integrating our values into services and improving services for future generations?

ENCOURAGING HELP SEEKING BEHAVIOUR AS AN ACT OF RESILIENCE

Our opinions on individual and communal resilience differ, but the one thing we all agree on is that the Black community has no choice but to be resilient. Having this in mind, let's reflect on how we may apply our various stance on resilience, towards contributions to promoting mental health and wellbeing, in relation to the priorities we stated earlier.

1. Think back to your definition of resilience. If you could define resilience in a way that encourages others to seek support for their mental health, how would you do things differently?

a**.** Picture yourself addressing those 3 priorities you stated earlier. What measures will you put in place to encourage a balance in Black resilience and help seeking behaviour

b. How do you see these measures supporting the creation of safe space for people to discuss mental health without fear of stigma?

c. We are seeing significant changes in the way our community addresses mental health as a result of these contributions you have made.

d. How do you see these priorities applied to mental health and wellbeing in the community, workplace or school?

e. How do you see yourself to supporting the creation of safe spaces for this?

APPENDIX 6

PHASE 3

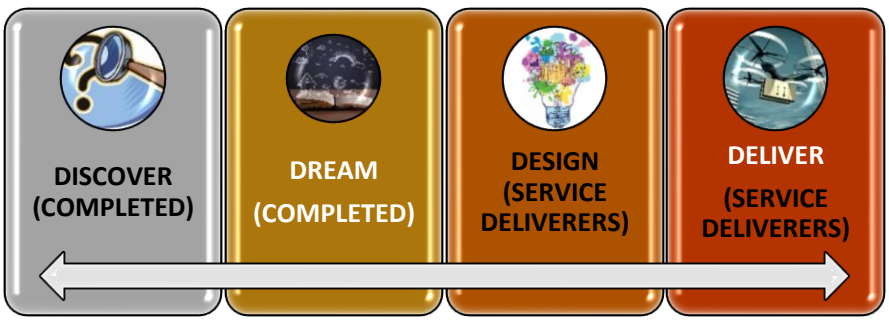
DESIGN AND DESTINY

***OBJECTIVE**: To assess the relevance of the co-design process towards the further development of culturally sensitive mental health services for Black African and Caribbean service users and mental health providers*

This study is designed to foster an understanding of resilience and mental health wellbeing within the Black African and Caribbean Community in an attempt to facilitate culturally sensitive mental health promotion. A method called **appreciative inquiry** will be used in this discussion. It focuses on what works well within an organisation or community and tries to understand how the resources identified can support the organisation or community, in this case, promote mental health.

The Design and Delivery stages of appreciative inquiry focuses on generating visions and ideas in a co-constructive format, that leverages on responses provided in the previous phases to strategically plan for positive growth and development. By asking the questions, '***What would that look like and how will we get there?***', the goal is to address the gaps in service delivery as pointed out by community members, while still acknowledging the strengths and efforts of the service providers represented here. The aim is to further facilitate the co-design and co-delivery of culturally sensitive services in the Black community, tailored to better meet the mental health and wellbeing needs of the communities you serve.

STAGES OF APPRECIATIVE INQUIRY



We will now discuss the themes generated from PHASE 2 of this study, in line with the goals for the Design and Delivery phase discussed at the beginning of this session.

***Summary of Phases 1 and 2**

1. What services do you provide within the community and how long have you operated within these communities?

A. LEADERSHIP FOR AND FROM THE BLACK COMMUNITY

1. What strategies do you currently have in place to support the inclusion of members of the communities you serve in the leadership structure of your organisation?
2. How effective has the inclusion of community leaders and people with lived experience been towards mental health in service delivery?
3. What is your shared vision for the Black community in the area of leadership and mental health?
4. What resources are needed to see to it that this vision materialises?
    a. What further support can the community offer to your organisation to facilitate co-design and co-delivery of culturally sensitive services?
    b. Which other stakeholders can you involve in achieving and what capacity do you see them supporting in?

B. COMMUNITY TAILORED SUPPORT MENTAL HEALTH SUPPORT

1. What strategies do you currently have in place to provide community tailored support within the Black communities you serve?
2. How effective have these strategies been towards increasing your reach in Black communities?
3. What is your shared vision for the Black community in terms of improving community and culturally tailored mental health support?
4. What resources are needed to see to it that this vision materialises?
    a. What further support can the community offer to your organisation to facilitate co-design and co-delivery of culturally sensitive services?
    b. Which other stakeholders can you involve in achieving and what capacity do you see them supporting in?

C. WORKPLACE-BASED MENTAL HEALTH AND WELLBEING SUPPORT

1. What strategies do you currently have in place to provide workplace- based support for members of Black community?
   a. How effective have these strategies been?
2. What is your shared vision for the Black community in terms of improving mental health and cultural awareness in the workplace?
3. What resources are needed to see to it that this vision materialises?
   a. What further support can the Black community offer to your organisation to facilitate?
   b. Which other stakeholders can you involve in achieving and what capacity do you see them supporting in?

D. EDUCATION AND SCHOOL BASED MENTAL HEALTH PROMOTION

4. What strategies do you currently have in place to provide promote mental health in schools?
   b. How effective have these strategies been?
5. What is your shared vision for young people in the Black community in terms of the promotion of mental health (early years-college/university)>
6. What resources are needed to see to it that this vision materialises?
   a. What further support can the Black community offer to your organisation to facilitate?
   b. Which other stakeholders can you involve in achieving and what capacity do you see them supporting in?

Are there any other comments?

THANK YOU!