

REVIEW PAPER

What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis

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Abstract

In the United Kingdom (UK), racially-minoritised (non-White) people are more likely to have poorer health outcomes and greater difficulties with accessing healthcare (Dyer, 2019). People face individual and societal adversity that can affect their physical and mental wellbeing (Gibbons *et al.*, 2012). There are clear mental health needs for racially-minoritised people, and we must go further in understanding the barriers to help to adequately meet the needs of diverse communities. The aim of this systematic review was to understand the barriers to accessing formal mental health support for racially-minoritised people within the UK. Qualitative empirical studies published between January 1970 to December 2020 were searched for using two databases: PsycINFO and Web of Science. Studies were searched for written in English, using a clinical or non-clinical population of adults with qualitative data collection and analysis methods. Database searches and reference mining gave a total of 283 studies, with 31 duplicates removed. Considering inclusion and exclusion criteria there were 15 final studies. A second researcher (S.O'H.) was used throughout, when selecting papers, quality assessment using the Critical Appraisal Skills Programme (CASP) checklist, coding and developing themes using thematic synthesis. The final four themes are 'internal and external stigma', 'understanding of distress and coping', 'competence of professionals and services' and 'perception and accessibility'. There are various barriers making it harder for racially-minoritised people to access mental health support. Further research is needed with individual communities and action must be taken by commissioners, services, CBT practitioners, and others to eliminate barriers and improve mental health care.

Key learning aims

- (1) To better understand the barriers to accessing mental health services, including Talking Therapies, for racially-minoritised communities.
- (2) Low and high intensity CBT practitioners to better understand the factors that impact the wellbeing of racially-minoritised communities and how to better support different communities.
- (3) Consider how to address these barriers to accessing support such as Talking Therapies services, with implications for practice and policy development.

Keywords: Access; Black, Asian and Minority Ethnic (BAME); Barriers; Mental health; Minoritised; Psychotherapy; UK

Introduction

The COVID-19 pandemic and Black Lives Matter (BLM) movement brought to light the longstanding social injustices that exist within society. Racially-minoritised (non-White) people

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have been disproportionately affected by COVID-19, with an increased risk of dying from the virus (Williamson *et al.*, 2020). Within the UK, there are mental health needs of diverse racially-minoritised communities, who are not being represented within primary care Talking Therapies services (previously known as IAPT: Improving Access to Psychological Therapies) (NHS Digital, 2020) but also within clinical psychology training (Clearing House for Postgraduate Courses in Clinical Psychology, 2020). This has generated the essential conversation and need for action in tackling systemic racism and inequalities within the NHS and healthcare provision.

Terminology and position

The primary researcher (S.A.) positions themselves as a British-Bangladeshi Muslim male trainee clinical psychologist in London, UK, at the time of writing this review. Much of the current UK research has used the terms 'BAME' (Black, Asian and Minority Ethnic), 'minority' or 'ethnic' so these terms have been used during the systematic review process. However, these terms are currently not universally accepted (Milner and Jumbe, 2020) and other terms such as 'global majority' or 'racially-minoritised' are (Lawton *et al.*, 2021). S.A. uses the term 'racially-minoritised' to acknowledge how people are actively minoritised by others as a social process shaped by power, rather than naturally existing as a minority (Predelli *et al.*, 2012).

Healthcare needs of racially-minoritised communities

In the UK, racially-minoritised people are more likely to have poorer health outcomes, greater mortality and greater difficulties with accessing healthcare (Raleigh and Holmes, 2021). People face individual and societal adversity such as racism, discrimination, and social and economic inequalities, which all have a major impact on mental health (Gibbons *et al.*, 2012). Individuals are likely to experience poverty, poorer educational outcomes, higher unemployment and contact with the criminal justice system, which are all risk factors to mental health difficulties (Equality and Human Rights Commission, 2016). Shade (2021) highlights how the way society is organised creates huge amounts of distress, and tackling these issues must not be only at an individual level; the discussion regarding health inequalities must also be a political one.

The historical and current societal context must be considered as mental health systems for marginalised groups can be oppressive and racially biased. For example, the American Psychiatric Association (APA) had upheld racist beliefs such as Black people being primitive and hostile and in 2021, they issued an apology (American Psychiatric Association, 2021). Black people are at increased risk of common mental health difficulties but are also more likely to receive pharmacological treatment and detention than psychological therapy (Lawton *et al.*, 2021). Continually, racially-minoritised people have been put in a position of disadvantage, with health inequalities being perpetuated by racism and discrimination in society, which also plays out within healthcare itself.

Mental health is not just a 'White problem' as needs are evident within racially-minoritised people. For example, suicide rates are higher among young Black African and Caribbean men, middle-aged Black African and Caribbean women, and South Asian women compared with the White population (Bhui and McKenzie, 2008). NHS Digital (2020) highlight in their annual report on the use of Talking Therapies services in England how fewer racially-minoritised people are referred to Talking Therapies services compared with the White British population. Therefore, there are mental health needs of racially-minoritised people, with clear disparities in access to early intervention, such as primary care mental health support.

Barriers to accessing mental health support

Racially-minoritised communities are less likely than White people to have contacted their General Practitioner (GP) about mental health difficulties, to be prescribed medication or be

referred onto specialist mental health services (Morgan *et al.*, 2005). This highlights how a barrier to accessing mental health support for minoritised communities could be that services are not being considered by GPs. Furthermore, there may be reasons why people do not speak to GPs about mental health difficulties, such as self-stigma and confidentiality concerns, which indicate internal and external barriers to accessing support (Edge, 2008).

Memon *et al.* (2016) state how there is little research into understanding the barriers that racially-minoritised people face when accessing mental health services in the UK. Therefore, they set out to research this qualitatively to inform the development and commissioning of effective and culturally competent services. Results identified barriers such as an inability to recognise and accept mental health problems, reluctance to discuss distress and seek help, identity, stigma and the positive impacts of social networks. They also found factors such as language barriers, long waiting times, imbalance of power, cultural naivety, and discrimination. This led to racially-minoritised people feeling misunderstood and less confident that services could adequately meet their needs. To overcome these barriers, suggestions included improved service access pathways, training for healthcare providers in culturally sensitive care, and improved engagement with racially-minoritised people within service development.

The Scottish Psychological Therapies Matrix (NHS Education for Scotland 2023), Welsh Matrics Cymru (NHS Wales, 2017) and the Strategy in Northern Ireland (Department of Health, 2010) all focus on equitable access to psychological therapies in these regions of the UK. The National Institute for Health and Care Excellence (NICE, 2018) in England highlight how racially-minoritised communities are less likely to access mental health treatment, which could be associated with stigma but also accessibility. Services must be visible, accessible and responsive to the needs of communities. Talking Therapies services have aimed to increase the availability of NICE-recommended psychological therapies in the NHS (Beck, 2019). However, racially-minoritised communities have been under-represented in services, with poorer outcomes (Baker, 2018). In the 2020 briefing paper (Baker, 2020) it is continued to be reported that racially-minoritised people are still under-represented in Talking Therapies services, for example Asian British people are 14% less likely than the White British population to be in contact with services. Begum (2006) states how racially-minoritised communities are traditionally seen as 'hard to reach', but there are key barriers that must be addressed rather than using this label.

NHS Race and Health Observatory (2023) published a report of ethnic inequalities in access, outcomes and experience for people who engage or try to engage with NHS Talking Therapies services. Progress and improved outcomes for some racially-minoritised groups are reported, but with continued inequalities between groups, including intersectional differences considering gender, age and socioeconomic status. Access, outcomes and the experience of Talking Therapies must improve for racially-minoritised people, especially for the Bangladeshi population who have some of the lowest outcomes [see Alam (2023) for further research within the Bangladeshi population]. The report suggested that those in leadership positions within mental health services should focus on understanding the needs of communities, looking at resources and funding. Recommendations are made such as continued recording and use of local data on access and outcomes, implementing the BAME Positive Practice Guide¹ (Beck *et al.*, 2019), services meeting the aims of the Patient and Carer Race Equality Framework² (NHS England, 2023) and recruiting, training and retaining a diverse and skilled workforce.

Harwood *et al.* (2023) researched into the variations by ethnicity in referral and treatment pathways for Talking Therapy service users in South London between 2013 and 2016. They found

¹The BAME Positive Practice Guide (Beck *et al.*, 2019) provides a framework to assist clinicians, services and commissioners of Talking Therapies services to work towards better access and outcomes for racially-minoritised communities.

²The Patient and Carer Race Equality Framework (NHS England, 2023) outlines a participatory approach to anti-racism that mental health trusts and providers should take to improve experiences of care for racially-minoritised communities.

that compared with the White British population, Black African, Asian, and mixed ethnic groups were less likely to self-refer. This may be due to invalidating experiences when being told by a GP to self-refer, after building up courage to speak. Black Caribbean, Black Other and White Other groups were more likely to be referred through community services and most racially-minoritised groups were less likely to receive an assessment and to be treated. Potential reasons suggested are due to stigma, fear and shame, but also discriminatory structures and attitudes within mental health services. This highlights how barriers exist at different stages on a pathway to accessing therapy and more must be done to address these. IAPT Workers Café (2023) had written a letter calling on NHS England to develop and implement tangible anti-racist initiatives in Talking Therapies services, where they emphasise the need for services to improve access and equity of outcomes, with the suggestion to incentivise services to do better. Overall, there are gaps within services and disparities that exist, with continued work needed to improve access, outcomes, and the experiences of racially-minoritised populations.

Systematic review

There is no existing systematic review which aims to understand the barriers to mental health support for racially-minoritised people within the UK. This systematic review is not a comparison to the White British population, rather it hopes to amplify the voices, views and experiences of racially-minoritised people. This review was registered in September 2020 on the international prospective register of systematic reviews in health and social care (PROSPERO).

Mental health services within the UK specifically aim to improve access to psychological therapies, although there are mental health needs of racially-minoritised people that could be better met (Faheem, 2023). This review broadly looks at barriers to varying levels of mental health support (primary and secondary care), due to the lack of research in this area. This review has the potential to help inform initiatives for services and professionals to improve accessibility of mental health services, which include Talking Therapies by exploring and highlighting the experiences of racially-minoritised people. This is essential to appropriately support communities who have greater need, considering the societal and contextual issues which put racially-minoritised people at risk of developing mental health difficulties (Shade, 2021). This would also be in line with the NHS ethos and values to reduce health inequalities (NHS Digital, 2020).

Method

This systematic review looked at qualitative papers related to the research question: What are the barriers to mental health support for racially-minoritised people within the UK?

Qualitative papers only were used to explore the experienced barriers of racially-minoritised people within the studies. The method was informed by Boland *et al.*'s (2017) guidance on undertaking systematic reviews for students and reporting follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher *et al.*, 2009). The thematic synthesis methodology was adapted from that described by Thomas and Harden (2008). See Table 1 for inclusion and exclusion criteria for the review.

Search strategy and selection criteria

Qualitative studies were searched for using two main databases: PsycINFO and Web of Science. Search terms were also reviewed to consider variations of the term 'ethnic' used within UK research. Final search terms are given in Table 2.

Table 1. Inclusion and exclusion criteria for systematic review

Inclusion criteria	Exclusion criteria
1) Empirical studies looking at barriers to mental health support. This included services offering psychological therapy, counselling and support groups 2) UK-based studies only, to control for the variation in healthcare provision internationally 3) Racially-minoritised (non-White) adult participants aged 18 to 65, from clinical or non-clinical samples 4) Qualitative studies only in the English language, consisting of interviews, focus groups or other qualitative methods, with access to direct quotations within the paper 5) Qualitative analysis of the data (for example, thematic, grounded theory etc.) 6) Studies published between 1970 to 2020, giving a 50-year window. This was the range allowed for Web of Science and initial searches indicated the oldest study from the two databases being from 1995	1) Studies that deviated from the subject. Excluded studies did not relate to help-seeking, mental health, or only had an intervention focus. Studies with non-adult samples, non-racially-minoritised communities, or only healthcare professionals were also excluded 2) Quantitative or mixed methods studies 3) Studies that were not published empirical research (including reviews, meta-analyses and grey literature)

Table 2. Search terms used for PsycINFO and Web of Science databases to identify eligible papers

Database	Search terms	Searched in	Search result
PsycINFO	'mental health' AND 'help-seeking' AND ethnic* OR minority OR race OR Black OR Asian OR BME OR BAME OR 'Black and minority ethnic' OR 'Black Asian and minority ethnic'	Searching 'ALL TEXT', Language: English, Ages: Adulthood (18 years and older), Population: Human, Qualitative studies, Published date: January 1970 to December 2020	139
Web of Science		Searching 'ALL FIELDS' (searches all the searchable fields), Language: English, refine for qualitative studies, Time span: all years (1970 to 2020)	164 Date: 31 December 2020 303 records, 31 duplicates removed Total = 272

Additional papers

Reference mining was done by searching references of papers by Alhomaizi *et al.* (2018), Mantovani *et al.* (2016) and Shefer *et al.* (2013), which were found from initial database searches. The main researcher was also familiar with these additional papers from the development of an empirical study (Alam, 2023). The researchers agreed that these papers related to barriers to mental health support involving racially-minoritised people. Three additional papers by Arday (2018), Memon *et al.* (2016) and Robinson *et al.* (2011) were found through Google Scholar, which were also relevant to the research question.

To account for the risk of bias, the primary researcher (S.A.) and an assistant psychologist (S.O'H.) screened all titles and abstracts. Independent searches were then compared to give an initial list of studies. The selection criteria were reviewed and if the citation matched, the full paper was obtained. Full papers were screened independently by the two researchers. Any disagreements were discussed, with arbitration available from the research supervisor (A.F.). Quality of the included studies was assessed using the Critical Appraisal Skills Programme (CASP) tool for reviewing qualitative studies (Critical Appraisal Skills Programme, 2018). This process is illustrated in Figure 1.

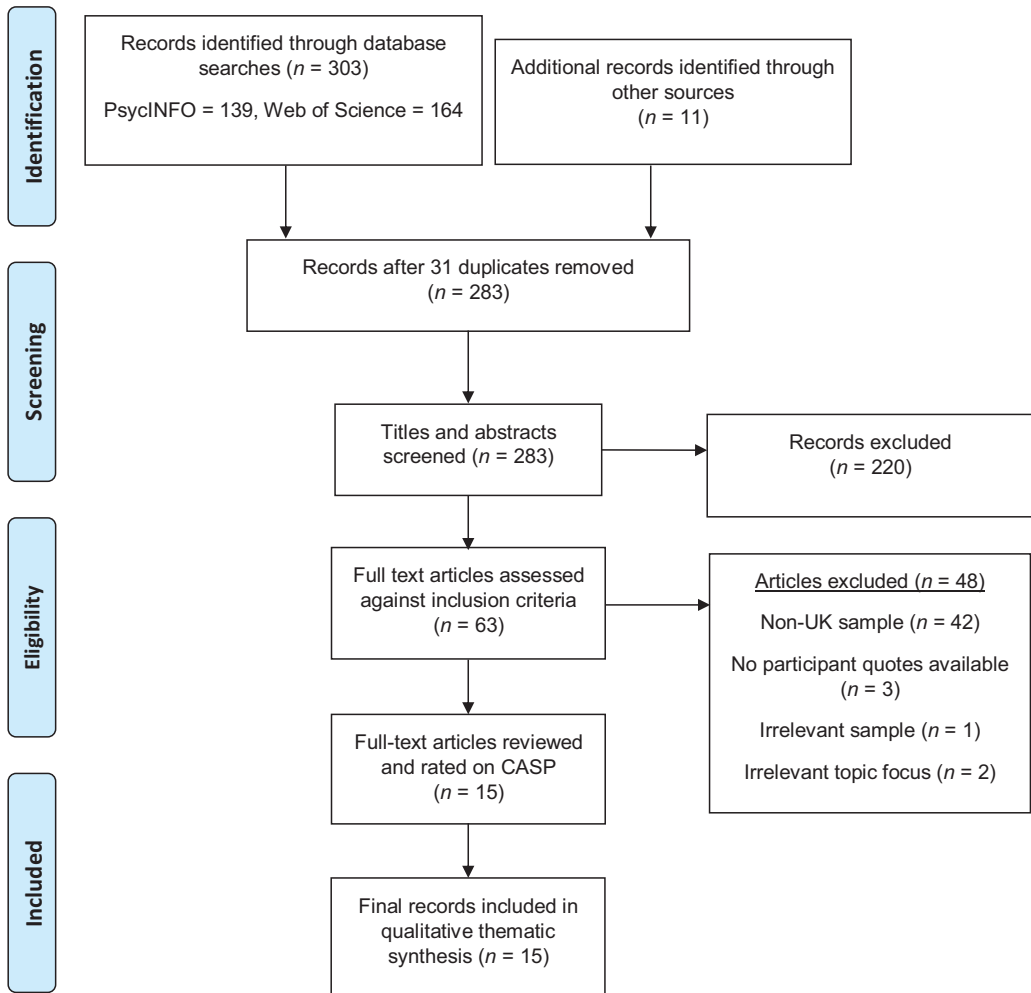


Figure 1. PRISMA flow diagram summarising the stages in eligibility screening from the database searches (Moher *et al.*, 2009).

Quality assessment

Reporting on the quality appraisal of the studies was done using the CASP checklist (Critical Appraisal Skills Programme, 2018). Criticisms of the CASP tool are that it can be less sensitive and valid as a measure of methodological quality compared with other tools such as the Evaluation Tool for Qualitative Studies (ETQS) and the Joanna Briggs Institute (JBI) tool (Hannes *et al.*, 2010). However, the CASP tool is a commonly used quality appraisal checklist in health and social care-related qualitative evidence syntheses and is endorsed by Cochrane and the World Health Organisation for use in qualitative evidence synthesis. This uses 10 questions to evaluate qualitative research, being suitable for use by new researchers (Hannes and Macaitis, 2012). Each paper was rated independently by each researcher (S.A. and S.O'H.) and the scores were compared, to check inter-rater reliability. There was agreement between both researchers on the CASP score for each research paper.

The decision was to include all identified studies, regardless of quality, as initial searches indicated relatively few research papers. This allows the chance to observe all potential valuable

insights (Thomas and Harden, 2008). The details of each study including the agreed CASP ratings can be found within the Results section (see Table 3).

Data extraction and thematic synthesis

Thematic synthesis was used to bring together findings from the included studies and draw conclusions. Cruzes and Dybå (2011) state how this approach draws on principles of thematic analysis to identify recurring themes in multiple studies, by interpreting, explaining, and drawing conclusions in systematic reviews. There are limitations of this approach such as it being subjective and individual studies being de-contextualised (Thomas and Harden, 2008). However, summaries of studies provide context (see Table 3) and a second researcher (S.O'H.) was used throughout.

The thematic synthesis process

The process used a transparent research trail, noting the decisions made, using two researchers (S.A. and S.O'H.) and a researcher supervisor (A.F.), considering researcher bias and opening the data to a broader range of possible interpretations (Noyes *et al.*, 2001). The researchers worked together on the systematic review between January 2021 and April 2021. The steps for thematic synthesis following Thomas and Harden (2008) are as follows:

- (1) Free line-by-line coding of the findings in primary studies. The researchers independently reviewed each paper, extracting 233 quotes and meeting to agree on codes. There were 44 initial codes from the 15 papers.
- (2) Organisation of these 'free codes' into related areas to construct 'descriptive themes'. The researchers looked for similarities and differences between codes, which helped group them into a map (which can be found in the Supplementary material). This was to see what the codes were describing, which gave a total of 13 descriptive themes.
- (3) Development of 'analytical themes'. The researchers independently generated analytic themes, to then discuss and jointly agree on four final themes, in the context of the review question. Themes were finally compared with the original quotes to ensure the thematic framework was suitable.

Results

The systematic review found 15 relevant studies, which include racially-minoritised people within the UK. Characteristics of the studies are shown in Table 3, including the aim of the study, sample characteristics, data collection methodology, analysis, findings, how trustworthiness was ensured, and agreed CASP ratings.

Participant characteristics

The review searched for papers covering the UK; however, the papers found were all with racially-minoritised people in different regions of England only and some papers did not specify. This highlights the lack of research in other nations such as Scotland, Wales and Northern Ireland. Additionally, this may reflect a lack of centralised data in these parts of the UK, where there may also be poor access and outcomes to therapy. The Republic of Ireland was not included as it is not within the UK and a sovereign country.

There is a lack of specificity in the reporting of identity. Some research papers specify the ethnicity of the participants, whereas others use fewer specific terms. Ethnic groups identified are

Table 3. Characteristics and context of the 15 eligible studies included for the systematic review

Study	Aim	Sample and characteristics	Qualitative and data collection methodology	Method of data analysis	Findings	Ensuring trustworthiness and critique	CASP criteria met (out of 10)
Arday (2018)	To address the problems facing ethnic minorities regarding accessing mental health services at university. This would fall under primary care	32 BAME students. Asian/Asian British ($n=6$), Black/Black British ($n=14$), mixed heritage ($n=9$) and Latin-American ($n=3$) from 14 UK universities. Aged 18 to 34 years, 18 female, 14 male	Unstructured focus groups and individual semi-structured interview Audio-recorded and transcribed	Thematic analysis	Ethnic minority service users' experience discrimination and a lack of access to culturally appropriate services that reflect the racialised challenges faced by BAME individuals	Use of a second researcher during analysis It is unclear if ethical issues and limitations were considered. The method was suitable for the aim and the researcher's position is stated	8
Edge (2008)	To explore the factors that might account for low levels of consultation for perinatal depression among Black Caribbean women and their absence from perinatal UK research. The specific focus is on services providing care for perinatal depression	12 Black Caribbean women from antenatal clinics in Manchester (Northwest England), aged 18 to 43 years. Purposive sample	In-depth individual interview Audio-recorded, notes taken and transcribed	Thematic analysis	Personal and social means to minimise distress, reluctance to discuss problems, and stoicism in the face of adversity were barriers to help-seeking. Black Caribbean women were willing to counter personal barriers and fears of engaging with services to seek help. However, professionals were felt to be unable/unwilling to diagnose perinatal depression	Use of constant comparative approach (Glaser and Strauss, 1967) The use of 1:1 interview was suitable to qualitatively explore women's views with a homogenous sample. But the researcher does not state their own position to account for bias and credibility is not mentioned	7
Gunasinghe <i>et al.</i> (2019)	To explore how Pakistani Muslim women interpret cultural concepts of izzat (honour and self-respect), what role, if any, it has in their lives and whether there is interplay between upholding izzat and the participants' help-seeking strategies for mental health and well-being	Six Pakistani women in London, England, aged 24 to 40 years. Purposive sample Help-seeking is broadly mentioned and not associated to a specific service	Individual semi-structured interview Audio-recorded and transcribed	IPA	New insights were found into the understanding of izzat and the implications these cultural concepts have for strategies in managing or silencing psychological distress	The co-authors provided further review of the transcripts, theme development and consultation during the process of analysis The method is appropriate for the aim, but the researcher's own position is not stated in the process and credibility is not discussed	7

(Continued)

Table 3. (Continued)

Study	Aim	Sample and characteristics	Qualitative and data collection methodology	Method of data analysis	Findings	Ensuring trustworthiness and critique	CASP criteria met (out of 10)
Islam <i>et al.</i> (2015)	To examine the cultural appropriateness, accessibility, and acceptability of the Early Intervention (EI) for Psychosis Services in Birmingham (England) in improving the experience of care and outcomes for BAME patients EI services fall under secondary care and include a therapeutic offer	EI service users (British Pakistani, $n = 9$ and Black British-Caribbean $n = 5$, mean age 22 years, equal male and female), carers (Black British-Caribbean, $n = 5$ and British Pakistani, $n = 3$, mean age 42 years, 8 female, 3 male), community and voluntary sector organisations (4 female, 2 male), service commissioners ($n = 10$), professionals ($n = 9$), and spiritual care representatives (3 female, 5 male)	13 focus groups Audio-recorded, notes taken and transcribed	Thematic and framework analysis	BAME carers and service users have many explanatory models of illness. For service users, help-seeking involves support from faith or spiritual healers, before seeking medical intervention. Clinicians have limited spiritual, religious or cultural awareness training and little collaborative working with mental health services, voluntary and community organisations	All focus groups were led by the same researcher and themes were developed with another researcher Focus groups with a topic guide were appropriate to provide rich data from broad groups of participants related to EI services. However, the researcher does not state their own position and relationship with the participants	8
Mantovani <i>et al.</i> (2016)	To explore the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK	14 African Caribbean and 12 African participants. Includes six faith leaders (5 males, 1 female), 13 congregants engaged in outreach (7 males, 6 females) and seven congregants attending mental health awareness events (2 males, 5 females). Aged between 24 and 75 years Help-seeking is broadly mentioned and not associated to a specific service	Individual semi-structured interview Audio-recorded, and transcribed	Thematic analysis	Beliefs about the causes of mental illness, 'silencing' from heightened ideological stigma and stigma at the community level impact help-seeking. People with a diagnosis of mental illness experience a triple jeopardy of stigma. A 'one-size-fits-all' approach cannot be used with diverse populations	Credibility checks (Lincoln and Guba, 1985) to increase internal validity through developing early familiarity with the culture of the faith-based organisations before data collection The method of interview was appropriate for the aim, but the researcher's own position and relationship with the sample is not considered. Findings are valuable to meet the needs of the population and identifying barriers to help	8

(Continued)

Table 3. (Continued)

Study	Aim	Sample and characteristics	Qualitative and data collection methodology	Method of data analysis	Findings	Ensuring trustworthiness and critique	CASP criteria met (out of 10)
Mclean <i>et al.</i> (2003)	To address perceptions of mental health services among the African-Caribbean community in a South England town The study broadly seeks to understand local perspectives on mental health services (including therapy) so services may be improved to better appeal to local users	30 individuals from, or working with, the African-Caribbean community. Participants were in four over-arching categories: members of statutory organisations; members of voluntary organisations; mental health users and carers; and lay African-Caribbean community members. Purposive sample	Semi-structured interviews and focus groups Audio-recorded	Unclear	Key factors preventing early access of mental health services are experience and expectation of racist mistreatment by mental health services. This can perpetuate mental health inequalities. Participation and partnership are vital	The use of interview and focus groups is appropriate to address perceptions in the community. This study provides key insights for this systematic review However, the researchers did not state their position and relationship with the sample, accounting for any bias. It is also unclear which analytic method was used, if credibility was considered and ethics are not mentioned	6
Memon <i>et al.</i> (2016)	To determine perceived barriers to accessing mental health services among people from BAME populations to inform the development of effective and culturally acceptable services to improve equity in healthcare This study broadly looked at access to mental health services	26 participants from the Asian/Asian British ($n = 4$), Black/Black British ($n = 6$) and mixed ($n = 3$) communities; 13 participants did not respond to the question on ethnicity. Eleven participants were aged 18 to 34, 10 were aged 35 to 64 years and two were aged 65 and over (three participants did not report their age). 13 female, 13 male. Brighton and Hove, England	Two focus groups Audio-recorded and transcribed	Thematic analysis	BAME populations require mental health literacy and practical support to raise awareness of mental health and reduce stigma. Relevant training and support for healthcare providers, improving information about services and access pathways is needed	Two researchers familiarised themselves with the scripts and developed an iterative coding scheme using NVivo qualitative data analysis software Focus groups were appropriate for the aim, however the researchers own position is not discussed to account for bias	8

(Continued)

Table 3. (Continued)

Study	Aim	Sample and characteristics	Qualitative and data collection methodology	Method of data analysis	Findings	Ensuring trustworthiness and critique	CASP criteria met (out of 10)
Moller <i>et al.</i> (2016)	To explore the attitudes and beliefs that second-generation South Asian women living in Britain hold about counselling, with a particular focus on how these beliefs may impact on help-seeking for psychological distress	82 second-generation British South Asian women aged 18 to 40 years (mean = 24), the majority of whom (92%) had no experience of counselling, responded to a qualitative survey in Northern England. Opportunity sample	Qualitative survey	Thematic analysis	Participants identified attitudes and beliefs about counselling, counsellors, and psychological distress, highlighting generalisations and stereotypes. Some views were culturally specific to act as potential barriers to help-seeking	Independent multiple readings of the data were undertaken by two authors, ensuring familiarisation with the whole data set, and providing the opportunity to record any key ideas as they occurred This study uses a large sample and the relationship between researcher, participants and their stance is stated. The method is suitable for the aim	10
Rabiee and Smith (2013)	Examining the views and experiences of using and providing mental health services from the perspectives of Black African and Black African Caribbean mental health service users, carers, voluntary services, statutory mental health professionals and commissioners. Mental health services were defined as any support that people accessed	97 respondents. Participants included 15 voluntary organisations, 25 service users, 24 carers, 16 statutory health professionals, 2 commissioners and 15 key members of statutory service providers. Similar numbers of female ($n = 49$) and male ($n = 48$), a higher proportion of African Caribbean than African (51 vs 29) and a small number of White British ($n = 10$) and Asians ($n = 7$) as service providers. Birmingham, England	Focus group, face-to-face and telephone interview Digitally recorded, some participants declined, so notes were taken in these cases	Krueger's framework and Rabiee's guidelines to identify themes and subthemes (Krueger and Casey, 2000)	Findings showed differences in the experiences of mental health services amongst African Caribbean and their African counterparts. The impact of social inequality on mental health and the needs of asylum seekers and refugees is highlighted. There is an important role of voluntary organisations in providing support. Insufficient provision of psychological therapies and concerns about high dosage of medication were also expressed	Analysis was systematic, sequential, verifiable, and continuous, providing a trail of evidence and increased dependability and consistency. Each interview was analysed separately and triangulated to identify five themes Researcher's position and relationship with the participants is not considered. Findings are useful in identifying actions to improve experiences of UK mental health services	8

(Continued)

Table 3. (Continued)

Study	Aim	Sample and characteristics	Qualitative and data collection methodology	Method of data analysis	Findings	Ensuring trustworthiness and critique	CASP criteria met (out of 10)
Rae (2016)	To explore how Somali male refugees understand and perceive the Western concept of depression, alongside their views on coping and professional help (a mental health service or primary care GP) in the UK	12 Somali male refugees in London, England, ages ranging from 20 to 59 years	Three focus groups and eight individual semi-structured interviews Audio-recorded and transcribed, with the use of vignettes	Constructivist grounded theory approach	‘Depression’ appeared to be from difficulties associated with migration and disconnection. ‘Health’ of the community links to the ‘health’ of the individual, highlighting collectivist appraisals of self-worth. Help-seeking from Western professionals was seen as rare and lacking awareness of the needs of the Somali community	Recordings were transcribed prior to the next interview, allowing for ongoing analysis (Henwood and Pidgeon, 1992). Understanding of data was checked with the participants There is clear discussion on using the qualitative approach and the researcher’s position is considered	10
Robinson <i>et al.</i> (2011)	To provide a better understanding of men’s beliefs about mental health and their experiences of mental health services This study broadly looks at men’s experiences of different mental health services	African Caribbean, African, Indian, Pakistani, Bangladeshi and Chinese men aged from 18 to 55 in London and West Midlands, England A purposive sample was used but the total number of participants is not stated	12 focus groups stratified by age Groups were audio-recorded and transcribed verbatim. Transcribed data were entered into NVivo software	Thematic analysis	A complex mix of gendered and racialised experiences, including social stigma, the power of institutions, and men’s own perceptions of services, and vice versa, can contribute to cycles of disengagement and isolation for marginalised BAME men with mental health problems	Analysis used a constant comparative method (Glaser and Stauss, 1967) It is not stated if another researcher was used during analysis or considerations of the researchers own position, to account for bias	8

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(Continued)

Table 3. (Continued)

Study	Aim	Sample and characteristics	Qualitative and data collection methodology	Method of data analysis	Findings	Ensuring trustworthiness and critique	CASP criteria met (out of 10)
Sancho and Larkin (2020)	To understand the barriers and facilitators that Afro-Caribbean undergraduates perceive towards accessing mental health services in the UK This study broadly looks at barriers to accessing any mental health service	17 Afro-Caribbean undergraduates (18 to 25 years old, 10 females, 7 males) at Aston University, England that had lived in the UK for a minimum of five years. Most participants were psychology students (65%) and had Black African (70%), Mixed (24%) or Black Caribbean (6%) heritage	Five focus groups (three to four participants per group) Groups were audio-recorded and transcribed verbatim	Inductive thematic analysis	Psychological, sociocultural, and structural factors were perceived by Black British students, impacting mental health service access. The importance of mental health literacy, social networks, cultural sensitivity, and concerns surrounding services underpinned the findings	The critical factors that contribute to or detract from a specific experience using a critical incident technique. Credibility checks were also done using an independent judge, where there was 98% agreement Participants reviewed and agreed with the researcher's interpretation of the data, but their position and role are not considered	
Shefer <i>et al.</i> (2013)	To extend knowledge about cultural beliefs surrounding mental illness held by BAME communities in London, England. To analyse how these beliefs influence experiences of stigma and relationships with family for individuals with mental illness	South Asian (Indian, British Indian, Asian and Kenyan Asian), Black African (Somali, African, British African and Black African) Ages and the total number of participants is not stated This study broadly looks at help-seeking behaviour related to mental health services and psychiatry	Five service user and five layperson focus groups Groups were audio-recorded and transcribed verbatim	Thematic and content analysis	Cultural beliefs regarding mental illness reflect four different voices present within the BAME communities. The self-critical, medical critical, traditional and integrating voice	Transcriptions coded using NVivo software. Primary and secondary analysis was conducted, with the researchers assisted by experienced facilitators from BAME backgrounds There is no other mention of credibility checks or the researcher's position. However, useful insights are given on BAME people communicating distress to people and stigma	8

(Continued)

Table 3. (Continued)

Study	Aim	Sample and characteristics	Qualitative and data collection methodology	Method of data analysis	Findings	Ensuring trustworthiness and critique	CASP criteria met (out of 10)
Sisley <i>et al.</i> (2011)	To explore African Caribbean women's conceptualisations and experiences of distress and help-seeking, including access to mental health services Help-seeking includes GP and services (community workshops, therapy, or psychiatric hospitals)	Seven African Caribbean Women in Central London, England experiencing distress, who self-referred to community mental health workshops. Aged 30 to 50, majority UK born. Purposive sample	Semi-structured interviews Digitally recorded with verbatim transcripts	IPA NVivo computer software was used, and a description of the analysis process is given	Five themes were identified: explanations of distress, experiences of distress, managing distress, social and cultural influences and seeking help. Each theme consisted of several subthemes which described participants' experiences	Internal reliability and validity checks were done. The first transcript was examined by an independent party and themes were discussed. There was an independent audit by the research team and respondent validation from participants giving feedback on the findings. Reflexivity is stated and the sample is positioned	10
Wales <i>et al.</i> (2017)	To identify the reasons for why referrals to specialist eating disorder services from the South Asian community are under-represented, to inform ways to encourage help-seeking	28 participants (23 South Asian women, 5 men) in the UK city of Leicester, England. Recruitment was through a university, local charities and Children, Young People and Family Centres Two focus groups were conducted with young people aged 18 to 25 (a mix of men and women). Four groups were with women aged between 25 to 65 years	Six focus groups Groups were audio-recorded and transcribed verbatim	Thematic analysis	Themes were identified as possible factors for delaying help: lack of knowledge about eating disorders and their potential seriousness; ideals regarding body shape; family living circumstances, and the role of food in the community Mental health stigma in the community, including eating disorders, and concerns about confidentiality when approaching services was also identified	Staff members from the local eating disorders service formed a key informant group to provide reflective experiences of working with individuals from a South Asian background Thematic analysis was conducted by the first author using NVivo software. Codes and themes were refined and discussed with the other authors. However, the researcher's own position is not stated. The research provides useful insights into barriers to help-seeking for the South Asian community	8

The term 'BAME' is included here due to its use within the individual studies. The location within the UK is not stated for some studies, as this was not specified.

Black Caribbean (Edge, 2008), Pakistani (Gunasinghe *et al.*, 2019), Somali (Rae, 2016), Indian, Bangladeshi and Chinese (Robinson *et al.*, 2011). Other studies used broader terms to describe participants such as African (Mantovani *et al.*, 2016), South Asian, Latin American or Mixed Heritage (Arday, 2018). Participants ranged from students (Arday, 2018; Sancho and Larkin, 2020), service users (Edge, 2008), people in the community (Gunasinghe *et al.*, 2019) and a mix with people from voluntary sector organisations, commissioners, professionals (Islam *et al.*, 2015) and faith leaders (Mantovani *et al.*, 2016). Ages ranged from 18 to 65 years old with both men and women used in the sample, from different religions such as Islam (Gunasinghe *et al.*, 2019) and Christianity (Mantovani *et al.*, 2016). Socioeconomic status or sexuality is not recorded for the majority of the studies, so this is not reported here.

Quality appraisal

The CASP checklist (Critical Appraisal Skills Programme, 2018) does not have pre-determined cut-off points to indicate if a study has good quality; it is up to the researchers to decide. The majority of the 15 papers rated well on the CASP checklist, with all of them scoring 6 or more. The average score for the papers was meeting 8 out of the 10 criteria, which the researchers agreed indicated a very good quality of the studies used on the 0–10 rating scale. Lower numbers indicated studies with lower quality, with 6 or 7 being good, and 8 and above indicating very good quality. Studies scoring below 5 would have been studies rated as having poorer quality.

Themes

Using thematic synthesis, the researchers (S.A. and S.O'H.) identified 13 descriptive themes and four final analytical themes, which are 'internal and external stigma', 'understanding of distress and coping', 'competence of professionals and services' and 'perception and accessibility'. Barriers can be thought about at the individual, practitioner, team, and access level. Information highlighting the contribution of each of the 15 papers to each theme can be found in the Supplementary material, and additional quotations can be found in the Appendix.

1. Internal and external stigma

Descriptive themes: 'perception of self' and 'consequences'

Racially-minoritised people within the studies reported stigma as a barrier to accessing formal mental health support, as a participant stated 'I think there's a stigma as well about failure and not being able to cope. The word depression, it's got such negative connotations so perhaps that actually keeps us from going to ask for help' (Edge, 2008; p. 386). People reported self-stigma in the form of being 'weak', feeling like a failure and this being shameful. One participant said: 'Sometimes that's why they [racially-minoritised people] don't seek help early enough because they feel ashamed, they feel it is a weakness, they have to hide it: we mustn't tell the family, we mustn't tell the community. The parents will be blamed' (Shefer *et al.*, 2013; p. 359).

Disclosure was seen to have negative consequences, such as becoming isolated from the community or family. It is not the cultural 'norm' to access formal support from services, as a South Asian female participant states: '[South Asian women would be] scared of people finding out about the situation because if found out they would be shunned upon by the Asian community . . . People would not see it as a norm to go to a counsellor, therefore even if they wanted to, they wouldn't' (Moller *et al.*, 2016; p. 207).

People can see themselves as 'weak', fearing negative judgement and losing social support as consequences. Stigma seems to present internally for individuals but also externally from other people, with stigma related to experiencing mental health difficulties but also accessing help, which could stop someone from accessing support.

2. Understanding of distress and coping

Descriptive themes: 'understanding of mental distress', 'spirituality', 'managing problems within the system' and 'expectations within culture'

Racially-minoritised participants show how mental health is understood differently compared with the White Western population. Findings suggest how mental health is seen as not as serious as physical health, with a South Asian male saying, 'someone who has diabetes something like that is more severe and they need to go to a doctor. Someone who has anorexia, sort it out yourself' (Wales *et al.*, 2017; p. 11).

Mental health is understood considering the lens of religion and culture, with spiritual coping methods being an early source for support. A Somalian male states, 'the Quran [religious text in Islam] will kill this kind of things . . . Evil eye [misfortune from another's jealousy or envy] and all this. So yes, spiritual is very important factor' (Rae, 2016; p. 66).

Problems tend to be kept to oneself or within the family, which could delay help-seeking from formal services, as alternative sources of help are relied on such as religion and family: 'In the West Indian community . . . people do not trust psychiatrists particularly . . . in terms of where my family and friends would turn in experiences of bad mental health or whatever is towards family structures. Informal structures, friends' (Arday, 2018; p. 13).

From the studies reviewed, findings show differences between men and women, with men not talking about their emotions; culturally expected to be 'strong' and manage themselves: 'Society accepts the woman being more emotional than men . . . it's erm amplified in the Afro-Caribbean society as well because now you're adding that in general . . . Afro-Caribbean people are meant to be strong, but now – Afro-Caribbean men it's even 10 times worse. Cos a lot of the time they don't talk about their emotions or feelings so having them admit it is even harder I feel' (Sancho and Larkin, 2020; p. 72).

Intersectionality must be considered, as everyone has their own understanding of mental distress, considering age, gender, culture, religion, and other aspects of identity. Assumptions should be avoided, and individual factors acknowledged, explored and understood which impact understanding of mental health, access to services and outcomes.

3. Competence of professionals and services

Descriptive themes: 'diversity', 'discrimination', 'need for understanding' and 'negative experiences'

From the studies reviewed, the perceived competence of services and professionals is a barrier to racially-minoritised people accessing formal support. There tends to be limited choice and less diversity within services, as an Indian male participant states: 'for men there have been no Asian male counsellors, no specific support scheme' (Robinson *et al.*, 2011; p. 87). A man of mixed heritage also states, 'to be honest, it would just be nice to speak to a person that looked like you . . . who can relate to you culturally and understand what you are experiencing as a person of colour' (Arday, 2018; p. 15). Some people prefer to see someone from their own culture, others not, but at least wanting this option as a South Asian woman states: 'it all depends on the situation. If it was something that was stigmatised in my culture, then I would definitely go to a White person' (Moller *et al.*, 2016; p. 206)

Racially-minoritised people within the research reported to have negative experiences of professionals and experienced discrimination from services, considering power imbalances, fearing judgement from those professionals holding power. A participant states: 'I got an English friend and she said to me that she has got the same problem . . . her GP transferred her to her consultant to see her problem and her problem was solved. Why would my GP not transfer me to a consultant instead of giving me a different tablet every time? I just feel like I am really angry and really frustrated because they transferred her because she is English and I am not English' (Memon *et al.*, 2016; p. 6).

There was a need for understanding of people from racially-minoritised groups, as it was often felt that professionals would misunderstand or not hear what the person was saying, with a feeling that this was not taken seriously. A Muslim Pakistani man states: ‘we can’t blame them because they’re upbringing is like Westernised, they can’t understand if we talk about Jinns [evil spirits] . . .’ (Islam *et al.*, 2015; p. 747). Services must address their internal structures and systems in how competent they are in working with diverse populations, being aware of their own biases and how this can impact their interaction with service users: ‘The staff that manage these services have to be culturally aware and not have their hang-ups. A lot of them come in with their baggage and they’re not leaving it at the door. They practise it every day. They see – if there’s a mental health patient who is big, a big Black man, six-foot two, somehow they are afraid of him more than a six-foot, seven-foot, White man’ (McClean *et al.*, 2003; p. 664).

Findings also highlighted there being less diversity in the promotion of therapy in the media and how services lack meeting the needs of racially-minoritised people: ‘And I think if they tried to use more Afro-Caribbean men, women, dark skin men, women and start to use people that actually look like us in their sort of media representation then they can maybe see it as this issue isn’t just a Caucasian – it’s not a White issue it – it’s an issue that can affect anyone’ (Sancho and Larkin, 2020; p. 74).

4. Perception and accessibility

Descriptive themes: ‘access to appropriate help’, ‘practical barriers to help’ and ‘trust’

Professionals must consider if services are visible, accessible, and how they are perceived. When talking about her community, a female participant reports: ‘it’s not that they don’t want to access the service, it’s just they don’t even know about the services. They’re not aware of it for one’ (Islam *et al.*, 2015; p. 745). ‘It could be a good service. It could be a brilliant service. Perception is key. If I perceive, if the community perceives that the facility is not really sensitive to me or geared to my needs, no matter how good it is, I ain’t gonna access it . . . I ain’t gonna spread the word’ (McClean *et al.*, 2003; p. 667).

Racially-minoritised people are not aware of what help is available for mental distress or what help would involve. There are difficulties in accessing help and inappropriate options can be offered, such as medication rather than talking therapy. There are also barriers in the form of services not being accessible in terms of language. A female Asian participant said: ‘As a student who is a recent immigrant, my understanding of English is improving daily. As a result, sometimes I struggle to articulate clearly and accurately what I would like to say to the healthcare professionals provided at university. For this reason, I prefer not to discuss my psychological issues as they will misjudge what I am saying and then heavily medicate me’ (Arday, 2018; p. 14).

If alternative support options are offered to racially-minoritised people, these may not be feasible due to financial constraints. This raises the question as to those people in higher socioeconomic groups being able to afford alternative therapeutic options, compared with those who are minoritised: ‘You know, you can’t access alternative therapies unless you’ve got the finances, and then you’ve got to remember that the sort of economic circumstances of a lot of African-Caribbean communities is disadvantaged. So, knowledge of the alternatives might be there, but access to them isn’t’ (McClean *et al.*, 2003; p. 667).

Services must build up trust in their ability to support people, as confidentiality and the need for safe spaces are essential to remove barriers in access. A Pakistani woman states: ‘You know that whole thing I said to you that about erm, not having people from outside come and know your business. That’s the whole, that’s whole izzat [honour] thing as well. You know, to, not, to not air your dirty laundry in public’ (Gunasinghe *et al.*, 2019; p. 23).

Discussion

This review aimed to summarise qualitative empirical evidence related to the question: what are the barriers to mental health support for racially-minoritised people within the UK? This was not a comparison with White people's experiences, as some of the findings may also relate broadly to the White population, such as stigma or being seen as 'weak' being barriers to help (Lynch *et al.*, 2018). This review was to better understand the barriers to support for people from different racially-minoritised communities, as relatively little is known in this area. Furthermore, it is important to hold in mind that papers were searched for throughout the UK; however, only papers in regions of England were found, highlighting the lack of research in other nations. The findings of this review will be summarised, considering CBT practice implications and discussion of the strengths and limitations.

'Mental health' is associated with stigma in wider society but also in an individual's culture from the community or family, as there are negative associations with being 'weak' or a 'failure' (Shefer *et al.*, 2013). There is also self-stigma with a sense of shame (Mantovani *et al.*, 2016), a fear of disclosure due to what others in the community may think, and a fear of being isolated from the family or wider community (Islam *et al.*, 2015). It can be thought about how the term 'mental health' is constructed in the West and this is not the 'norm' in other non-Western cultures, with the experiences of emotions related to mental distress often not being spoken about (Arday, 2018). There is less awareness in what mental health support is available for racially-minoritised people, with there being a lack of relatable and visual promotion (Sancho and Larkin, 2020). Stigma is a key factor at individual and wider societal/cultural levels which would stop a person from reaching out for help.

Intersectionality of aspects of identity (such as age, race, gender, religion and class) was clear in how people from racially-minoritised communities within England understand, experience and cope with mental distress. For example, culture naturally impacts every aspect of illness, such as responses to symptoms, explanations, patterns of coping, help-seeking, adherence to treatment, and emotional expression. There are cross-cultural differences with how depression presents, such as somatic symptoms acting as cultural expressions of distress and feelings of guilt and suicide rates varying across culture. Depression may therefore be under-diagnosed, due to these variations and how they may not match-up to Western diagnostic criteria (Aichberger *et al.*, 2008; Bhugra and Mastrogiani, 2004). Therefore, it is essential to consider the lens of each individual and how this influences their experiences and expression, to focus on their goals rather than rigid diagnostic set treatment methods.

A common theme was how there are expectations within each community to keep problems within the home or to oneself, with more value placed on 'informal' support structures such as family or friends (Shefer *et al.*, 2013). There are spiritual coping methods people turn to, such as religious leaders in the form of pastors within the African Christian population (Mantovani *et al.*, 2016). There is a difference with how help is understood in the West in the form of mental health professionals, but people find alternative sources of support such as through religion and family. It is important to highlight how some aspects of Western psychological therapy can be contradictory or incompatible with the values and cultural assumptions of individuals from non-Western cultures. It is therefore important to be competent in being guided by the individual, to avoid causing harm. An example of good practice of cultural adaptations in CBT comes from Jameel *et al.* (2022) who used proverbs, local stories and simplified terminologies to facilitate positive outcomes with Indian clients. Therapists should be flexible and open to understanding the varying resources and sources of support people value and bring this into assessment, formulation and therapy.

From the review, racially-minoritised people tend to have a view of services as not being able to meet their needs (Rabiee and Smith, 2013), with a need for a safe and understanding space (Shefer *et al.*, 2013). People have felt discriminated against by professionals, being treated differently from

White people (such as being offered medication rather than therapy; Memon *et al.*, 2016). Professionals and services were seen to hold power that impact the outcomes for minoritised people, with common misunderstandings in communication (Sancho and Larkin, 2020) and people fearing judgement from professionals (Arday, 2018). There are common concerns about confidentiality, which show how important it is for services to be warm, inviting and trustworthy. Considering socioeconomic status, minoritised people said how alternative options or quicker routes may be harder to access due to financial barriers (Memon *et al.*, 2016). It should be considered if there are alternative support options that the NHS could offer or if private/charitable services could offer reduced rates for people who have a lower income. Therapists must also consider the discrimination minoritised people may have experienced in society but also within services and how this has affected them in the past and present. Therapists and managers must uphold an anti-racist ethos using a top-down and bottom-up approach, attending relevant CPD (continuing professional development), using self-practice/self-reflection and supervision to turn towards their own biases (Thwaites *et al.*, 2014).

This review looked at many different communities, but it is essential to remember that these communities cannot be grouped into one, as having the same needs. A ‘one-size-fits-all’ approach cannot be used, as each person will have their own experiences. The differences between communities are seen such as some people talking to faith leaders (Mantovani *et al.*, 2016) but others perceiving it as being shameful to discuss issues outside of the household (Memon *et al.*, 2016). This is important: to acknowledge the unique context and experiences of individuals, especially by professionals within therapy. Considering how racially-minoritised people are less represented within Talking Therapies services with lower recovery rates (NHS Digital, 2020), therapists must do more to better support individuals, such as providing tailored culturally sensitive therapy (Faheem, 2023). Many healthcare settings expect people to come forward to access them, but we have seen barriers and inequalities continue to exist and perception is key. As the BAME Positive Practice guide (Beck *et al.*, 2019) outlines, there must be more work done within communities to reach out and co-produce services, with easier access and positive experiences, which may be shared amongst communities to then recommend the service to others (McLean *et al.*, 2003).

Implications for clinical practice

Practitioners should recognise how difficult it is for racially-minoritised people to access support, considering the additional barriers faced. Within clinical practice, time should be given to consider intersectionality, hearing more about the individuals experience and the narrative around ‘mental health’ within their specific community accounting for age, gender, ethnicity, religion, and other aspects of identity. Time should be taken to understand the individual’s understanding of distress, being curious and building a genuine rapport. Distress should be normalised, whilst holding a safe and non-judgemental space. More promotion is also needed in the media with racially-minoritised people accessing mental health support and this being visible, to help consider ways to reduce the stigma that exists (Sancho and Larkin, 2020); for example, service websites, posters, and leaflets with representation from different communities.

People understand mental distress differently based on areas of social difference, which may be visible/invisible, voiced/unvoiced (Social GRACES; Burnham, 2013). For example, spirituality and religion impact how people understand distress and their subsequent valued coping resources (such as religious leaders or prayer). The strengths of communities must be acknowledged and incorporated within psychological intervention, which may not always be seen as the ‘traditional’ approach (Beck *et al.*, 2019). Furthermore, mental health services should link in with community religious leaders, considering collaboration to support the community to overcome stigma and offer support options. Overall, co-production is needed with the community to increase awareness

and conversations about mental wellbeing, and the support options available. Here are some questions that therapists should consider:

- Are there religious leaders in the community or place of work who can be consulted?
- Can specialist CPD be sought focused on specific populations within the community?
- What research is currently available in working with specific communities?
- Can the therapist be active to find out more about religion/culture and thinking about how this can be incorporated into therapy?
- With consent, would the individual benefit from a family member or friend being involved?

Specialised professional development, training and reflective spaces could raise awareness within teams and for professionals in the specific considerations when working with racially-minoritised people. The experiences of racism and discrimination from services reported by participants in this review is shocking. Clinicians should be able to sensitively discuss experiences of racism if this is important to the client, to validate and support them using written guidance, such as Williams *et al.* (2023) who developed an evidence-based approach for treating stress and trauma due to racism. Services that feel unsafe or unsuitable to meet one's needs are likely to have an impact on engagement in treatment and could reinforce negative views that are reported (Memon *et al.*, 2016). Considering how hard it is to take the initial step to access help, there is a danger that this can be traumatising for an individual and put them off accessing support again in the future. Much more effort is needed to restructure services in terms of diversity and culturally sensitivity of the workforce (Rae, 2016). Services must continually support and include people from minoritised communities within the workforce, which could help in giving service users more autonomy of choice in who they see.

Clearer and accessible referral pathways must be available, for people to know what options are available for support. As highlighted by findings from Rabiee and Smith (2013) and Rae (2016), at the commissioning and community level, funding should be considered for smaller community services that are valued and more accessible for racially-minoritised populations. Making links with community and grassroots organisations is essential, with protected time to allow therapists to do this essential work. However, services must first be able to work effectively with the communities they serve, before inviting them to access their service. This is to avoid an increase in referrals but then people dropping out, due to harmful experiences with structures and practitioners who are not equipped to best support them. Responsibilities do not just lie with the client or therapist, but with all aspects of healthcare systems. The BAME Positive Practice Guide (Beck *et al.*, 2019) indicates essential action at the service level, better engagement with communities and improved staffing with the use of an audit tool to monitor progress and areas to improve on for Talking Therapies services to offer culturally safe and effective care.

Strengths and limitations

Strengths of this review include how the qualitative findings help to further our understanding of the barriers that exist for racially-minoritised communities in accessing mental health support, bringing forward the voices and real-life experiences from the participants. A second reviewer (S.O'H.) was also used throughout the systematic review process to avoid bias. The second reviewer is a White Irish female and the main researcher (S.A.) is a South Asian British male, bringing different perspectives to the systematic review process. The thematic synthesis methodology by Thomas and Harden (2008) was adapted and followed closely by the two researchers. This was conducted in a rigorous way, with transparency of the process providing context for each of the 15 studies.

The use of a mix of participants is a limitation with varying mental health services (e.g. primary care and secondary care which use a range of treatment approaches), as samples were not

homogenous. Furthermore, across all studies there is variation in how the research was conducted and analysed. This means greater variation in the data and less generalisability and external validity, with findings reflecting English-speaking service users, community members, professionals, and others in England. Furthermore, it is important to emphasise that all racially-minoritised populations cannot be collated into one single group, although there is a shared position that racially-minoritised groups hold in the UK context, both socially and politically (Bhui *et al.*, 2007), which is highlighted by this review. Considering the limited research in this area, research papers in different regions around England were only found, with a lack of research in Northern Ireland, Scotland and Wales. A broader search was needed, over 50 years; however, only papers from the last 25 years were found, which further puts a spotlight on the need for further research with specific minoritised communities and this to be a priority for researchers and clinicians. A recommendation is made for local Talking Therapies service leads to allocate protected time for this research to be undertaken and disseminated widely, whilst supporting researchers during the publication and dissemination process.

Future research

Research could look at barriers to mental health support for specific communities in focused mental health services, such as local Talking Therapies service sites. This will help to appreciate each community as their own, with their own needs and considerations on how services can better meet these individual needs. For example, Alam (2023) demonstrates specific research with British-Bangladeshi men. This would also increase generalisability of findings to specific populations and how best to target initiatives to reduce barriers to mental health support. This review focused on a UK-wide population; however, the papers found were only those conducted around England. More focused research is needed in other UK nations such as Scotland, Wales and Northern Ireland with specific racially-minoritised populations that reside in these areas. It would also be useful to explore what barriers exist in other countries due to the international variation in healthcare. A final suggestion could be looking at the needs of staff and Talking Therapies services to better meet the needs of the populations they serve (e.g. adaptations to CBT).

Conclusion

This review aimed to summarise and synthesise qualitative research evidence looking at the barriers to mental health support for racially-minoritised people within the UK. The findings show that there are multiple barriers such as stigma, understanding of distress and coping, lack of competence of teams, how or if services are perceived and the access barriers. Further research is needed, looking at how the needs of specific racially-minoritised people can be better met, not only at the individual level but within the community, services, and also on a wider more political and social level (Shade, 2021).

Essentially, there is a need to continue striving for inclusive and improved healthcare provision for all. This systematic review and thematic synthesis leaves the reader to consider how 'mental health' is constructed across different populations, what barriers exist to access care such as Talking Therapies services, but also where these barriers are located, which may not always be acknowledged. The answer is not only to remove barriers, but services and therapists must also turn inwards to address their gaps, biases and be flexible in how communities are supported. This is essential to avoid harm to racially-minoritised service users and staff who step into services which must be equipped to offer support sensitively and safely. Consider what changes can be made in the context you are in, and what further research is needed to indicate action to better support racially-minoritised individuals.

Key practice points

- (1) Talking Therapies services and therapists must embody an anti-racist ethos to improve the care of racially-minoritised communities. Gaps in skill and knowledge must be identified, to continuously access quality CPD, reflective spaces and supervision (e.g. cultural adaptations or having sensitive discussions related to the experiences of racism).
- (2) More research needs to be done looking at the mental health needs of specific communities and how to work in different ways to meet these needs in culturally sensitive ways (e.g. consider intersectionality; linking culture and religion into therapy). Service leads must prioritise research and support staff during the process, from conception to dissemination.
- (3) Once Talking Therapies services are better able to support minoritised communities, services must become more accessible. Some suggestions include improved referral pathways, visible promotion, and referrers (such as GPs) keeping therapy in mind for everyone.
- (4) Talking Therapies services must diversify the workforce to increase representation of different communities and to give people choices in who they therapeutically work with. Racially-minoritised staff must be continually supported.
- (5) Professionals must do more outreach work in the community and collaborate with service users and grassroots organisations to remove barriers to access (e.g. stigma) and co-produce services.

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- Special issue of *tCBT* Journal with cultural adaptations: <https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/volume/56E6BA290A1C75D68A50E80E70A1FCDA>
- Special issue of *tCBT* Journal on being an anti-racist therapist: <https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/special-issues/being-an-anti-racist-cbt-therapist>

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Appendix – Additional quotes to support the themes

Theme	Quote and reference
Internal and external stigma	Arday (2018)
-Perception of self	'If I ever told my parents that I was struggling to get mental health support at university, they would possibly disown me. This is not the kind of thing we openly discuss in my culture particularly as a black, female Muslim' (Black female)
-Consequences	Mantovani <i>et al.</i> (2016) 'Mental illness is not given the appropriate attention as, say, maybe a broken arm or high blood pressure. It's not given that same level of attention because it's seen as weakness, and we don't handle weakness very well' (African Caribbean) 'It breaks down communities in terms of communication. It develops – people are isolated. It's almost self-perpetuating; a self-perpetuating snowball. The more it goes on the less we talk, the less we talk the more it goes on' (African faith leader) Rae (2016) 'But the biggest one is, is ... is the shame that come to the family, of the person is doing bad things ... it's not the person ... anything bad that person does ... will come back to the entire community or extended family' (Somalian male) Wales <i>et al.</i> (2017) 'I've had 2 or 3 (Asian males) who were more bulimic who've presented years after it started, always avoided coming. The ones I've seen have been very ashamed ... something that's hidden' (Clinician 2)
Understanding of distress and coping	Arday (2018)
-Understanding of mental distress	'Men kind of prefer keeping things to ourselves ... I always think that, as a Black man, I am judged differently, and I do not want to provide anyone with the ammunition to judge me differently ... even more than I am already judged' (Black male)
-Spirituality	Mantovani <i>et al.</i> (2016)
-Managing problems within the system	'If somebody comes into the church with a mental health issue, they [pastors] are most likely to pray for this person and annoy the person with asking them to try things, rather than asking the person to seek professional help [...] Pastors think a person taken over by an evil spirit has mental illness, so, the evil spirit must be exorcised out of them. Once you exorcise people, they do not progress to become better, they progressively become worse' (African)
-Expectations within culture	Sancho and Larkin (2020) 'It's not really treated as serious it's like oh it's all in your head or you must be possessed ... pray it away' (female) Sisley <i>et al.</i> (2011) 'The family unit may know what's going on but to the outside world ... we're absolutely fine' (African Caribbean female) Wales <i>et al.</i> (2017) 'Our parents don't know much about it [mental health], especially if they're from places like India and Pakistan and Africa' (female)
Competence of professionals and services	Arday (2018)
-Diversity	'As a student who is a recent immigrant, my understanding of English is improving daily. As a result, sometimes I struggle to articulate clearly and accurately what I would like to say to the healthcare professionals provided at university. For this reason, I prefer not to discuss my psychological issues as they will misjudge what I am saying and then heavily medicate me' (Asian female)
-Discrimination	'To be honest, it would just be nice to speak to a person that looked like you ... who can relate to you culturally and understand what you are experiencing as a person of colour' (mixed heritage male)
-Need for understanding	Edge (2008)
-Negative experiences	'... You need someone who's on the same wavelength as you, who shares the same cultural experiences as you, which sometimes isn't available ... I wouldn't wanna particularly unburden myself to some White woman, if I'm

(Continued)

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Theme	Quote and reference
Perception and accessibility -Access to appropriate help -Practical barriers to help -Trust	honest about it . . . And that's the bottom line. It's about having someone who you can chat to who understands where you're coming from' Mclean <i>et al.</i> (2003)
	'We express ourselves a bit different, you know, because we're not White and we talk differently, so we might express ourselves differently and they feel that we are paranoid schizophrenia' Moller <i>et al.</i> (2016)
	'Just fill this form in and say how your mood is and I will give you some antidepressants' (female)
	'They do not want to be aware of what we are trying to say. So, they just put in a category. Just White British way' (female)
	'The fact that a White counsellor is incapable of relating to a South Asian, they are very ignorant to culture as you can see in GPs etc.' Robinson <i>et al.</i> (2011)
	'For men there have been no Asian male counsellors, no specific support scheme' Islam <i>et al.</i> (2015)
	'... It's not that they don't, don't want to access the service, it's just they don't even know about the services. They're not aware of it for one' (female) Memon <i>et al.</i> (2016)
	'If we don't know that something is available, how are we going to access it?'
	'There is no money. We just cannot afford it [...]. You just have to do it yourself. Then you end up just leaving it' (male) Rabiee and Smith (2013)
	'These organisations you talk about are not publicly known' 'The barrier for providing talk therapy is working through interpreters, and not having sufficient resources' Shefer <i>et al.</i> (2013)
	'[When] living in an extended family sometimes there is little space 'cos there is so much activity going on, you need a safe place and maybe there are times when you just don't feel safe because you don't want to disclose what you are feeling, and you just keep bottling it up' (South Asian)

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