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**Complex adverse childhood and adulthood experiences among Black
adults: improving access to services for complex trauma**



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Thesis submitted for the degree of Doctor of Philosophy (PhD) in Health Services Research

City St George's, University of London

Department of Health and Medical Sciences

November 2025

I, Lewis Benjamin, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Abstract

Black individuals are disproportionately impacted by complex traumatic events. Despite the higher prevalence of trauma within Black adults, significant barriers exist for these groups in accessing mental health services to address their trauma. This research aimed to understand how best to support Black adults with complex trauma to ensure they receive timely culturally appropriate and effective care.

This work utilised a mixed-methods design, firstly by understanding the current evidence base for cultural adaptations to trauma care when working with racialised minority groups through a mixed-methods systematic review with meta-analysis. This was followed by an electronic healthcare record quantitative component exploring demographic variations in the receipt of trauma care within a diverse inner-city London borough, exposing current routine practices. Finally, the research explored through qualitative work the direct lived experiences Black adults with complex trauma have when navigating current mental health services and paying attention to their journeys and views of mental health support.

This research contributes to a growing call for more established trauma-informed care approaches within services, with unique insights into ensuring these approaches are crucially culturally informed and sensitive to the needs of Black adults. A significant, system-wide shift is necessary within services to ensure services do not perpetuate further distress these groups have when accessing mental health care, maintaining cycles of racial injustices and harm. This work concludes with implications for future research, practice, and policy to reduce these inequities these groups have when seeking support for complex trauma through services.

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List of Abbreviations

ACE	Adverse Childhood Experiences
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Groups
CPD	Continuing Professional Development
CPTSD	Complex Post-Traumatic Stress Disorder
CQC	Care Quality Commission
CRIS	Clinical Record Interactive Search
CR	Critical Realism
CSA	Childhood Sexual Abuse
DHSC	Department of Health and Social Care
DSM-5	Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition
DV	Domestic Violence
EMDR	Eye Movement Desensitisation and Reprocessing Therapy
EUPD	Emotionally Unstable Personality Disorder
GP	General Practitioner
HCPC	Health and Care Professions Council
IAPT	Improving Access to Psychological Therapies
ICD	International Classification of Diseases
LEAG	Lived Experience Advisory Group
LGBTQ	Lesbian Gay Bisexual Transgender Queer
MHA	Mental Health Act
MMAT	Mixed Methods Appraisal Tool

NHS National Health Service

NICE National Institute for Health and Care Excellence

NIHR National Institute for Health Research

NLP National Language Processing

PCREF Patient and Carer Race Equity Framework

PPIE Public and Patient Involvement and Engagement

PRISMA Preferred Reporting Items for Systematic reviews and Meta-Analyses

PTSD Post-Traumatic Stress Disorder

RCT Randomised Controlled Trial

SAMHSA Substance Abuse and Mental Health Services Administration

SLAM South London and Maudsley NHS Foundation Trust

UK United Kingdom

1 CHAPTER ONE: INTRODUCTION

1.1 Chapter Overview

In this introductory chapter I highlight current service provisions and policy for mental health care in the United Kingdom and highlighting the experiences of Black adults accessing and navigating services through empirical literature. I expand on this, detailing attempts to achieve racial equity through mental health policy and services in the UK. I then include an overview of relevant trauma literature, including current clinical practices pertaining to the assessment and treatment of trauma, and a summary of culturally adapted approaches, as well as their application in addressing trauma among Black adults with complex trauma.

1.2 Empirical Literature Review

1.2.1 Terminology

Whilst historically race may have been framed as an inherent biological trait, academics have showcased how race is a socially and politically created classification system used to categorise individuals based on perceived characteristics, such as skin colour (Smedley, 1998). These classifications are not rooted through biology but rather reflect historical power structures that have justified the use of discrimination and marginalisation amongst racial groups (Smedley & Smedley, 2005). With the focus of my research in mind, it is important to understand how race does not exist in isolation, but is deeply entrenched within systemic inequalities, racism, and the process of racialisation, whereby individuals are assigned racial meanings and treated differently based on these differences. Exploring race through this angle is vital for critically understanding how trauma is experienced within racialised groups, including how this influences access to trauma care and pathways to mental health support.

Throughout this empirical review various terms are used to describe racialised minorities, including “BAME” (Black, Asian, and minority ethnic), “racial minorities” and “racial and ethnic minorities”. These terms are used interchangeably in the context of the empirical review to reflect the language employed within cited literature articles. However, I acknowledge the limitations of such terminology. Particularly with terms such as “BAME”, which homogenise varied cultural groups under a singular umbrella. This may inadvertently obscure the nuances and distinctiveness of experiences between diverse cultural groups.

In my thesis, unless I am being explicit about the experiences of Black adults, I favour the term “racialised minorities” as it depicts the socio-political *process* of racialisation (e.g., the ways by which certain groups are constructed as “other” and marginalised within societal power structures). I argue this term better captures the complex dynamics of systemic inequities racialised groups experience whilst also acknowledging the diversity of experiences between groups (Hochman, 2019). This reporting also follows guidance from the American Psychological Association on reporting race, ethnicity, and culture in research (American Psychological Association, 2023).

1.2.2 Overview of Relevant Mental Health Policy (2014-2025)

1.2.2.1 *Five Year Forward View (2014)*

Back in 2014 the Five Year Forward View (NHS England, 2014) was established by NHS England to commission ambitious policies dedicated to improving the national health service. The main consensus between stakeholders involved was to increase access to mental health services for the general population and reduce the parity of esteem between physical and mental health services. To achieve this, recommendations were for Clinical Commissioning Groups (CCGs) to increase spendings towards local mental health services to be on par with spending devoted to physical health services.

An Independent Mental Health Taskforce in response to NHS England’s Five Year Forward View reported on progress made in 2016 (NHS England, 2016). A series of recommendations were made which included an expansion and development of service provisions to improve mental health outcomes within the general population. These generally covered: further efforts to be made to continue to reduce the parity of esteem between physical health services with mental health services, an expansion of efforts to build relationships cross sectors, such as the social care, employment, and housing sectors, and efforts to reduce broader health inequalities. These efforts to reduce broader health inequalities included more targeted support for vulnerable at-risk groups and setting waiting time standards across services.

1.2.2.2 *NHS Long Term Plan (2019)*

In 2019, a national improvement initiative was released by NHS England to make further recommendations to develop healthcare services (NHS England, 2019). With support from the government, this was a plan set out to improve funding to mental health services annually for the forthcoming years, with key aims being: improving access to services, more funding to child and adolescent mental health services, crisis services, and community mental health

services, a focus on prevention and early intervention initiatives, expanding the mental health workforce, funding into technology and digital health, and addressing inequalities in healthcare (NHS England, 2019). Efforts to strengthen community-based integrated care (i.e., primary care, social services, and community organisations) was seen as a key factor in reducing inequalities within services.

1.2.2.3 Reform of the Mental Health Act 1983

The Mental Health Act (1983) is an active piece of legislation that involves the assessment and treatment rights of people with a mental health disorder in England and Wales (Mental Health Act, 1983). The MHA is independently regulated by the Care Quality Commission (CQC) and details lawful justification of compulsory admission to a psychiatric hospital to receive care (Care Quality Commission, 2025). Reviews of the MHA have described longstanding concerns around the Act disproportionately detaining individuals from Black and minority ethnic backgrounds (Gajwani et al., 2016; Barnett et al., 2019). The CQC has previously reported that ‘system-wide’ efforts need to be made to reduce the disparities seen for ethnic communities being detained (Care Quality Commission, 2020). Indeed, this has been backed by findings from several systematic reviews (Singh et al., 2007; Barnett et al., 2019). Comparing ethnic groups and detention rates of the MHA, Singh et al (2007) reported Black and minority ethnic groups are up to four times more likely to be detained compared to white groups, although effects were reduced when factoring for high quality studies. A review focusing on detentions between 1984-2017 showed higher rates of detention for racial minority groups, with associated factors predicting higher rates including migrant status and Black Caribbean ethnicities (Barnett et al., 2019). Critically however, amongst these reviews significant heterogeneity between participants was reported, as well as concerns raised around the reporting and classification of ethnic groups within the data. In this regard, the authors expected that succeeding reviews would yield further conclusive findings by improving methodology related to reporting ethnicity data, and to acknowledge the various ethnic identities beyond broad categorical systems (Barnett et al., 2019).

1.2.2.4 Independent Review of the Mental Health Act (2018)

An announcement from the then Conservative government in the UK in 2017 was that there were to be an independent review of the MHA. Key aims of the review, published by the Department of Health and Social Care (DHSC), were to account for the increasing use of detentions under the MHA, address racial inequalities in detentions under the Act, and given the MHA was introduced in 1983 it needed to be ‘modernised’ to fit with current times

(DHSC, 2017). An established review team published a final report later the following year which enlisted important recommendations to policy that centred increasing autonomy and dignity for service users being detained (DHSC, 2017). Five years later with still no formal changes to policy, pressures on the government to introduce the recommended changes to modernise the MHA grew. In 2022, a draft mental health bill was published by the then Conservative government with key proposed changes to the MHA, discussed below.

1.2.2.5 Draft Mental Health Bill (2022)

In 2022, a significant mental health bill was proposed by the government which outlined refinements to the MHA. In summary, this included better regulations and provision for those with autism and learning disabilities detained under the Act, increasing the threshold for detentions, and greater review over the use of police involvement in detentions, including inappropriate use of prison cells for mental state examinations (DHSC, 2022).

However, the proposed law bill was questioned by a joint pre-legislative committee of UK parliament in 2023. This committee involved key experts in mental health, varying from academics, mental health organisations, clinicians, those with lived experience, among many more. Scrutiny involved a lack of clear accountability and monitoring to how broader inequalities would reduce under the Act, especially with regards to racial disparities in detentions. Recommendations therefore included better regulation and oversight over progress with an established national mental health commissioner role, the introduction of advance choice documents to improve dignity and choice within care, as well as abolishing compulsory treatment orders for the majority of those requiring psychiatric care given greater racial disparities in their use (Devonport et al., 2023).

1.2.2.6 Mental Health Bill – where are we at now? (2024/25)

After almost a decade of pressure and devoted work from many sectors citing vast inequity and the need to reform the MHA, the King's Speech in 2024 finally outlined a phased approach over the forthcoming years to reform the MHA. Comments from the speech urged reviews into broader inequalities in detention of the Act, with careful policy recommendations to the application of the act when detaining those with autism spectrum disorders and/or a learning disability, those from Black and racialised minority backgrounds, a review to detention thresholds, and enhancing patient autonomy, rights, and support, ensuring "dignity and respect throughout mental health treatment (NHS Confederation, 2024).

1.2.3 Race Equity Policies in Mental Health

1.2.3.1 *Department of Health and Social Care Policies*

“Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England” (DHSC, 2003) was a document that listed many challenges Black African and Caribbean communities face accessing mental health services in the UK, in particular their experiences across tertiary care and coercive treatment experiences. It was suggested that aversive pathways to mental health care were related to late referral and treatment delays from GPs, and also that GPs felt significantly less involved in the care of Black African and Caribbean groups with severe mental illnesses (DHSC, 2003). Experiences related to diagnosing and recognising mental health difficulties within these groups were reported as challenging.

Another finding was that the lack of care and involvement from GPs was strongly associated with police services operating in the care of Black communities, often involving compulsory admissions to services (DHSC, 2003). Supporting evidence at the time showed that increased contact with police and criminal justice services before admission and admissions under the Mental Health Act was also higher for Black British groups relative to White groups (Coid et al., 2000). The report promoted discussion amongst researchers and policy makers alike, and it was suggested that disparities for Black individuals being admitted to care through compulsory means suggested these individuals were accessing services at a point of crises (Bhui & Bhugra, 2002). Resultantly, recommendations were intended to support earlier identification of mental health illnesses and interventions aimed at supporting members of Black communities.

There have since been several government-led strategies in the UK since to improve race equity in mental health outcomes over the last two decades. In 2005, following the inquiry into the death of David Bennett (a Black male who died on a medium secure unit), the Department of Health and Social Care (DHSC) commissioned the “Delivering Race Equality strategy” (DHSC, 2005). The value and importance of community level interventions and approaches that directly engaged and collaborated with Black and minority ethnic communities were highlighted as key action points in the strategy. However, the policy was disbanded by the DHSC as a result from the Race Disparities Audit (DHSC, 2010), which highlighted that little had changed for Black people and their experiences within mental health services. Following debate and criticism, subsequent policies have been introduced

that ensure direct, quantifiable action is made to address inequalities for racial groups accessing services.

1.2.3.2 Patient and Carer Race Equality Framework (PCREF)

More recently in 2021, the DHSC published the work of Professor Simon Wessely's independent review of the MHA through a White Paper (DHSC, 2021) which set out key recommendations to tackle mental health inequalities. To summarise again, but in the context of racial equity, suggested reforms to the Act were made that directly tackled the racial disparities prevalent in compulsory detentions. These included: increasing diversity amongst mental health workforces, reduced law enforcement and police involvement in psychiatric emergencies, better funding for research into racial health inequalities, and the introduction of a novel co-produced systems wide initiative titled the Patient and Carer Race Equality Framework (PCREF).

This initiative is a transformative action plan involving co-production work between service users, families, carers, and professionals to reduce racial disparities in access, experience, and outcomes of Black Asian and Minority ethnic groups engaging with mental health services. PCREF allows for partnership between these stakeholders to prioritise reforming statutory and regulatory obligations as well as current organisational competencies to ensure racial equity is achieved in mental health services provided by the national health service. Key principles of NHS care involve “providing a comprehensive service available to all irrespective of sex, race, disability, age, sexual orientation, gender reassignment status, religion or belief” (DSHC, 2021). It has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. PCREF and suggested proposals from Wessely's independent review in this regard set forth a crucial opportunity for services and policy to improve the outcomes and care received by racial minority groups currently accessing services.

1.2.4 Trauma Literature

1.2.4.1 Adverse Childhood Experiences (ACES)

Adverse childhood experiences (ACEs) are known as distressing or traumatic experiences that occur in childhood (0-17) and have been studied since the mid-80s (Felitti et al., 1998). The ground-breaking CDC-Kaiser Permanente ACE study (Felitti et al., 1998) is one of the largest public health studies exploring the impact of ACEs and the role they play in

determining health and social outcomes in later adulthood. The study originally was conducted between 1995-1997 using physical examinations and collecting survey data on health and adverse childhood experiences from 17,000 participants based in Southern California, an area which at the time lacked racial diversity and those from lower socioeconomic classes, and thus, an understandable critique of lower uptake of diverse groups partaking in the study. Nevertheless, ACEs were originally classified across seven categories which included childhood physical, sexual, and emotional abuse, witnessing domestic violence, the incarceration of a caregiver, living with a mentally ill caregiver, or living with a caregiver with substance misuse difficulties. Findings of the study reported that a higher number of ACEs predicted worse health and social outcomes in later adulthood (e.g., obesity, heart disease, mental illnesses, substance misuse). The study prompted debate across the fields of public health, psychology, epidemiology, social work, and related fields to not only look at the assessment of the current health status among individuals, but an awareness of prior adverse childhood experiences to provide a well-rounded understanding of the social determinants of health (Dube et al., 2003).

The checklist used to determine ACEs (Dube et al., 2003) is rather straightforward and provides an overall score from adding up the total number of ACEs an individual has experienced. However, this does not allow for exploration of the impact, severity, and degree to which each individual adverse event may be considered harmful or traumatising to the individual, the questionnaire assumes equivalence between events. Research into trauma has indeed shown experiencing childhood trauma that was prolonged or chronic in nature has greater dysfunctional impacts later in life (Courtois, 2008). Much of the work in this area exploring these chronic and prolonged experiences of traumas has often been coined in the literature under the umbrella term 'complex trauma' (Cook et al., 2005; Kliethermes et al., 2014).

Since the original ACEs study, adaptations have been made to include other forms of negative childhood experiences, which include aspects of social disadvantage such as discrimination, homelessness, and community violence (Maguire-Jack et al, 2020). These varied adaptations have been tested globally producing rich data on the impact of ACEs among racialised populations and have shown alarmingly a greater number of ACE events reported amongst these groups (Maguire-Jack et al., 2020). However, little input into the global research on ACEs has come from experiences in the United Kingdom (UK), and in particular, those experiences of Black adults residing in the UK. Here, it is important to note

that ACEs represent just one component of the broader ‘complex trauma’ umbrella. My work expands beyond childhood adversity to explore complex trauma across multiple life stages, recognising complex trauma can occur and have lasting effects well into adulthood, especially in the case for those from racialised minority backgrounds who experience the chronicity of racial trauma and racism, which I expand on further below.

1.2.4.2 *PTSD, Complex Trauma and Complex PTSD*

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that involves significant distress and disruption of daily functioning that follows exposure to a traumatic event (NICE, 2018). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2022) illustrates that in order to meet criteria for diagnosis of PTSD, the following categories must be met: (a) exposure; to threatened death, actual or threatened serious injury, or actual or threatened sexual violence (b) intrusion symptoms; involving flashbacks or nightmares of the event (c) avoidance; of people, places, objects or dialogues which act as reminders of the event (d) negative changes in cognition and mood; involving distorted thoughts or memories of the event, low mood or anxiety and (e) changes in arousal and reactivity; involving hyper-aroused states, hypervigilance, and irritability. Difficulties must persist greater than one month and cause significant distress for the individual exposed to trauma.

However, not all those that experience trauma will develop PTSD symptoms or meet diagnostic thresholds. Experiencing distress or dysfunction following experiences of trauma are generally considered a natural part of trauma and recovery (Ehrenreich, 2003). When these psychological effects persist for greater than one month, they are typically classified in the DSM-5 as PTSD symptoms. National guidance for treating PTSD includes cognitive therapy, trauma-focused cognitive behavioural therapy, prolonged exposure therapy, eye movement desensitisation and reprocessing therapy (EMDR), and narrative exposure therapy (NICE, 2018), and several published meta-analyses show positive outcomes of effectiveness for these treatments (Cusack et al., 2016; Powers et al., 2010; Seidler & Wagner, 2006; Lely et al., 2019). However, it is unclear if the effectiveness of trials can be fully generalised to racial groups due to low uptake of racial groups participating in clinical trials and remaining underrepresented at a global level (Turner et al., 2022).

Significant developments in our understanding of trauma have developed over the decades. This includes the complexity behind varying responses to trauma as well as critique on diagnostic criteria for PTSD. For example, trauma may manifest through maladaptive coping

mechanisms among individuals, such as deliberate self-injury or substance misuse, without those individuals meeting diagnostic thresholds for PTSD (Auxéméry, 2018). Others may meet diagnostic criteria for PTSD but present with complex clinical presentations, including co-morbidities such as depression or anxiety disorders (Auxéméry, 2018). These variations expose the heterogeneity of responses to trauma and underscore the importance of a nuanced understanding of trauma and its dysfunctional impacts on individuals.

Further debate has emerged over diagnostic criteria around PTSD, which exclusively centres on experiences of single trauma exposure. Criticisms have contested this diagnosis by highlighting the greater functional impacts of repeated or prolonged incidences of trauma, such as childhood abuse (Brewin et al., 2017). These non-isolative trauma experiences may typically be termed under the umbrella of “complex trauma”. Initiated through the academic work of Judith Herman, experiences of complex trauma involve exposure to prolonged, repeated, or multiple traumas (Herman, 1992). Supported in the literature, research exploring complex trauma experiences has indeed depicted far worse mental health outcomes when compared to those who experience single-event traumas (Ford & Courtois, 2013). Difficulties often associated with complex trauma include disturbances in emotion regulation, self-identity, and in relationships, causing significant functional impairments and distress (Ford & Courtois., 2013). These experiences are captured within a diagnostic framework of Complex post-traumatic stress disorder (CPTSD), which was formally introduced in the eleventh revision of the International Classification of Diseases (ICD-11) by the World Health Organisation in 2018 (WHO, 2018).

The ICD-11 describes CPTSD may develop following exposure to an event or series of events of an extremely threatening nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, prolonged domestic violence, repeated childhood abuse). All diagnostic requirements for PTSD must be met, and in addition, CPTSD is characterised by severe and persistent (a) problems in emotion regulation; (b) beliefs about oneself as diminished, defeated, or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and (c) difficulties in sustaining relationships and in feeling close to others. These symptoms typically cause significant impairment across personal, family, social, educational, occupational or other domains of functioning. Like PTSD, CPTSD may commonly occur among with other psychiatric conditions or comorbidities such as depression or substance misuse disorders.

A critical debate that has emerged within the field of psychiatry and research communities is the overlap between CPTSD and Emotionally Unstable Personality Disorder (EUPD), otherwise known as borderline personality disorder (BPD) in the DSM-5 (American Psychiatric Association, 2022). Prompting much of this debate is that both diagnoses involve notable difficulties with emotional regulation, self-identity, and interpersonal relationships (Ford & Courtois, 2021). However, important distinctions do exist among the two diagnoses which are rooted through the underlying etiological frameworks and symptom presentations.

Experiences of CPTSD are rooted through an etiological framework of chronic trauma exposure (e.g., childhood abuse and neglect). This condition is typically conceptualised through an adaptation to repeated accounts of trauma that have disrupted experiences of safety or violations in autonomy (Resick et al., 2012). Ultimately, repeated exposures to these traumas over time eventually emerge long-term disruptions in self-image, regulating emotions, and difficulties in relationships. Within this framework, CPTSD as a formulation directly highlights the link between CPSTD symptoms developing as an adaptive *response* to the enduring impact of chronic or prolonged traumatic events (Resick et al., 2012).

On the other hand, BPD is typically formulated through biosocial and developmental models and highlight a complex interplay of genetic vulnerabilities and environmental factors. Biosocial models of BPD position individuals have increased biological sensitivities to emotional stimuli, which provokes intense emotional responses and prolonged states of emotional recovery (Crowell et al., 2009). Often this biological predisposition is combined with unmet childhood needs (e.g., invalidating experiences where emotions expressed by children are dismissed or punished by a caregiver). Consequently, these environments do not allow healthy or effective ways for children to regulate difficult emotions. The focus on these models is more so highlighting how these adverse environmental experiences during crucial developmental periods, often *interact* with innate temperaments and biology to shape patterns of behaviour and personality over time.

The conceptualisation of self-identity in CPTSD and BPD reveals both overlaps and differences. In CPTSD, disturbances within self-identity are viewed through consequences of trauma whereby those exposed to trauma may internalise feelings of worthlessness tied to traumatic events (e.g., a sexual abuse victim may internalise feelings of shame following abuse) (Resick et al., 2012). In contrast, self-identity in BPD is characterised by an unstable sense of self, often shaped by inconsistent caregiving and fear of abandonment, resulting in

rapid shifts in self-image to maintain relational connections (Crowell et al., 2009). However, the relational difficulties and emotional dysregulation central to CPTSD bear strong resemblance to hallmark features of BPD, reflecting significant symptomatic overlap (Ford & Courtois, 2021).

These nuances have implications for treatment. Trauma-focused therapies like EMDR are currently recommended primarily for PTSD, as outlined in NICE guidelines (NICE, 2018). However, there is no official standardised guidance specifically addressing treatment for CPTSD, which involves additional relational and emotional dysregulation symptoms beyond classic PTSD clusters of intrusion, avoidance, and hypervigilance. Therefore, it cannot be assumed that treatments effective for PTSD will translate seamlessly to CPTSD.

Furthermore, frequent comorbidity of CPTSD and BPD (Ford & Courtois, 2021), along with the potential for misdiagnoses between the two, complicates clinical decision-making and risks overshadowing other treatment needs (Giourou et al., 2018).

The debate that has emerged within the literature argues that perhaps both conditions may reflect different expressions of trauma-related pathology given their shared features, particularly given a compelling evidence base showing high proportion of those with BPD have experienced childhood trauma (MacIntosh et al., 2015; Cattane et al., 2017). Given the overlap and complexity between the two conditions, evidence is beginning to explore the benefits of integrated treatment approaches for those with complex traumatic presentations or co-morbid PTSD and BPD (Zeifman et al., 2021). However, significant gaps remain in our understanding of BPD and CPTSD, and much more conclusive research is needed to explore these differences and similarities between the conditions, to then inform adequate and responsive treatments.

1.2.4.3 Complex Trauma among Black populations

While the empirical literature surrounding complex trauma is growing, the application to the experiences of Black adults is less so. Black adults face unique socio-cultural and historical factors that not only render vulnerability to traumatic events, but additionally maintain and influence the harmful impacts of complex trauma experiences. Yet the concepts within the literature used to describe these experiences, such as racial trauma (Comas-Díaz et al., 2019), complex racial trauma (Cénat, 2023), racial stress (Williams et al., 2021), and race-based traumatic stress (Carter et al., 2004), often overlap, creating challenges in understanding clear

distinctions between them. However, I do not view this conceptual complexity as a limitation of the topic but rather a reflection of its depth, to which I go on to explore further below.

A notable issue within clinical practice is that, regardless of racial background, many individuals who experience trauma do not receive a diagnosis of PTSD or CPTSD despite displaying diagnostic symptoms (da Silva et al., 2018). However, this under-recognition is especially pronounced for Black individuals who face notable barriers in recognition and accessing appropriate treatments. Clinician biases and current diagnostic frameworks that fail to acknowledge cultural diversity in trauma and mental health behaviours have been proposed issues that may contribute to these disparities (Blair et al., 2013; Pérez-Stable & El-Toukhy, 2018). Further, access to non-pharmacological treatments (e.g., evidence-based psychological treatments) is disproportionately low among individuals from racialised minority backgrounds, including those with common mental health disorders (Sharland et al., 2023), as well as severe mental illnesses (Das-Munshi et al., 2018). This gap may reflect the underlying assumptions about the appropriateness of psychological treatments for these populations, assumptions implicitly echoed in how services are structured and delivered.

However, even when Black individuals do receive a diagnosis of PTSD or CPTSD, trauma-focused psychological therapies offered within services may still be ill-equipped to address needs. For example, cognitive interventions may be designed to help individuals reframe irrational cognitions such as “I was going to die”, which indeed may be appropriate in cases of an isolated and non-interpersonal traumas, such as a robbery. However, these interventions may fall short when addressing the needs of Black adults whose distress may be rooted in structural harms such as racism. Racism is a tangible and ongoing lived reality (Feagin & Ducey, 2018), not a cognitive distortion, and attempts to “correct” rational responses to racism risks invalidating the experiences of Black adults. These broader impacts must be acknowledged if services are to become more inclusive. The discussion around trauma and treatment must therefore expand beyond current diagnostic categories and frameworks to fully account for the lived realities of Black individuals and the structural forces (i.e., racism) that shape and manifest in their trauma experiences.

When exploring the experiences of trauma among Black adults it is vital to acknowledge historical and systemic roots, too. The history of the transatlantic slave trade and colonisation have largely imposed generational traumas that continue to influence the mental health outcomes of Black adults today (Hankerson et al., 2022). The history of slavery greatly

inflicted trauma among familial bonds and normalised violence towards Black adults, generating a painful legacy of adversity and trauma passed through generations. This is largely referred to within the literature through the term “intergenerational trauma” (Yehuda & Lehrner, 2018). This term captures how trauma is passed down through generations and may influence aspects of epigenetics (Yehuda & Lehrner, 2018), as well as cultural norms and behaviours (Tam, 2015).

Present day structural racism also plays a significant role in maintaining trauma experiences among Black adults. Discriminatory systems, such as within housing, education, employment, and criminal justice systems, create chronic conditions of adversity that disproportionately impact Black populations (Bailey et al., 2017). These systemic harms not only generate conditions of trauma and adversity but equally maintain them. In addition, they may also constrain access to protective resources (e.g., financial security, social support) known for stabilising mental health (Martin et al., 2016). In this regard, structural racism functions as a clear source of trauma experienced by Black adults.

These structural traumas often manifest psychologically, and are often referred to as “racialised or racial trauma”, or “complex racial trauma” (Comas-Díaz et al., 2019; Cénat, 2023). These terms capture the psychological or emotional injuries caused by chronic exposure to racism across an individual’s lifespan. Unlike isolated and non-interpersonal traumas such as car accidents, racialised trauma is chronic and embedded within daily life, amplified by social and cultural contexts. It may arise from repeated experiences of racial microaggressions, stereotyping, and overt discrimination (Chaney & Robertson, 2013; Taylor et al., 2019; Kirkinis et al., 2021). These exposures are not isolated. They accumulate over time, from childhood through to adulthood, and generate chronic stress responses that ultimately impact how racialised groups may view themselves, those around them, and the wider world. Over time, these chronic exposures may result in trauma presentations that closely align with complex trauma, such as disruptions in self-identity, emotion regulation, and interpersonal relationships (Ford & Courtois, 2013).

To better capture these psychological injuries of racialised trauma, some academics have proposed concepts such as “racial stress” or “race-based traumatic stress” (Williams et al., 2021; Carter et al., 2004). These terms capture the PTSD-like symptoms that may form in response to racial trauma, such as avoidance (Carter et al., 2004). Neither of these conceptualisations are formally recognised in current diagnostic manuals, such as the DSM-5

or ICD-11. However, they still provide a useful framework for understanding how chronic racial harms can establish distress comparable to that seen in traditional trauma frameworks.

These compounded forms of trauma are further exacerbated within mental health services. A barrier to accessing trauma support that is relative to Black adults involves discrimination and bias that exists within institutions such as health services (Sim et al., 2021). Black adults are more likely to report discriminatory experiences within the NHS and report worse outcomes relative to other racialised groups (Memon et al., 2016). In addition, Black adults may feel misunderstood by healthcare practitioners and find care impersonal (Cuevas et al., 2016). This may infer greater levels of mistrust, and consequently act as a strong barrier to formally getting support through services. Worse, misdiagnosis and inappropriate treatments may be offered to Black adults due to a lack of culturally responsive care that acknowledges the socio-cultural dimensions of trauma among Black adults as mentioned above. These experiences as a result perpetuate the ongoing harmful cycles of injustice and trauma that Black adults experience.

Addressing complex trauma that is unique to Black adults therefore warrants an approach that captures the social, historical, and cultural needs of Black adults. By contextualising complex trauma within the lived realities of Black adults, mental health services can better develop more culturally responsive trauma care sensitive to their needs. This contextual analysis may inform more effective policies, and indeed calls have been made for incorporating trauma experiences associated with racism into clinical guidelines (Williams et al., 2018) as well as for current clinical practice to make adaptations that account for the cultural diversity present within services (Rathod et al., 2018). Whilst NICE guidance for assessing and treating PTSD and trauma refer to recognising culture in practice (NICE, 2018), this largely follows diagnostic criteria for PTSD from which there are no current provisions acknowledging developments of trauma that may be associated with racism (i.e., racial trauma). With all these points in mind, it may be both pertinent and essential for clinical guidelines to adapt and include racialised trauma experiences in the assessment and treatment of trauma in services.

1.2.4.4 Trauma Informed Care Approaches

Growing efforts are being made to integrate trauma-informed approaches within patient care across mental health services globally (Purtle, 2020; Dawson et al., 2021). Trauma-informed care involves approaches used within services that acknowledge the widespread impact of

trauma experiences among service users (Jennings, 2004). Commonly associated with trauma-informed practice is a shift from ‘What is wrong with you?’ to ‘What happened to you?’, and an encouraged focus is on service environments to sensitively respond to the contextual needs of patients with trauma rather than formal standardised practices (e.g., “one size fits all” approaches) (Sweeney et al., 2018).

One of the most widely adopted trauma-informed care frameworks was established through the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA argue six key principles that inform trauma-informed approaches (Huang et al., 2014). These principles are 1) trustworthiness and transparency 2) peer support 3) collaboration 4) empowerment and choice 5) safety and 6) cultural, historical and gender issues. SAMHSA argue these principles should be embedded into organisational practices and culture to assure sectors and systems of care meet the needs of those exposed to trauma (Huang et al., 2014).

Despite this relevancy of trauma-informed care, there remains a notable gap in how these approaches are adapted (or not adapted) for Black service users with complex trauma. SAMHSA’s principles do pronounce “cultural and historical issues” as one key domain, however this often remains a neglected and potentially a superficial component in clinical practice. Without direct attention to the racialised forms of trauma detailed above, trauma informed care principles risk becoming a universalised “one-size-fits-all” approach that does not fairly reflect the realities of Black adults with complex trauma. My work seeks to address this very gap by exploring the unique support needs of Black adults with complex trauma to help identify how trauma-informed care can move from abstract principles to applied, culturally responsive practices.

1.2.4.5 Severe Mental Illnesses and Trauma

Meta-analyses have shown strong associations between childhood abuse and the onset of schizophrenia and psychosis (Varese et al., 2012; Bailey et al., 2018). In a systematic review of childhood trauma and bipolar affective disorder, Aas et al (2016) reported strong indications that experiencing trauma in childhood is associated with an earlier onset of severe mental illness, psychotic features, lifelong episodes of illness, and increased suicide attempts. Other reviews have reported prevalence rates of up to 55% of PTSD in those living with schizophrenic spectrum disorders (Dallel et al., 2018), with high prevalence rates potentially overlooked in services (Bardol et al., 2020).

There is a growing and compelling body of evidence that has explored associations between severe mental illnesses in Black and ethnically minoritised groups. Meta-analyses have reported a two-fold increased risk for psychotic symptoms and experiences (Leaune et al., 2019; Tortelli et al., 2018) and a two-threefold higher risk for developing psychosis (Radua et al., 2019) in racially and ethnically minoritised groups relative to White ethnic groups. A socio-developmental model has been presented in the literature that examines the complex nature between social risk factors (i.e., racial discrimination), genetic, and individual factors in increasing risk for psychosis (Morgan et al., 2010). This model in theory highlights how exposure to social adversities (e.g., racial discrimination) can lead to cumulative chronic stress and consequently pose risk to the development of psychotic experiences.

These adverse experiences may also foster cognitive vulnerabilities (e.g., threat anticipation, paranoia) which may manifest or be formulated through psychotic experiences such as hallucinations and delusions. For racially and ethnically minoritised groups who are overrepresented in acute care receiving treatments for severe mental illnesses, it may be unsurprising that reports of both discrimination and lifelong adversity do exist (Halvorsrud et al., 2018). Moreover, for these groups accessing acute care systems there is higher risk for developing additional trauma, which include being involuntarily detained and hospitalised (Berry et al., 2013), experience coercive care and seclusion (Nyttingnes et al., 2016), and report victimisation and bullying experiences across inpatient wards (Berry et al., 2013).

The relationship between the aforementioned factors and complex trauma lies in the chronic and cumulative nature of adversity faced by Black adults. Yet, this very connection between complex trauma and severe mental illnesses among these groups remains significantly overlooked and under researched. This neglect in recognition means underlying trauma that may be rooted through severe mental illnesses remains untreated. The evidence base that informs psychological treatments that may treat underlying trauma among Black adults with severe mental illnesses also then remains non-existent. Given Black adults are more likely to be diagnosed with severe mental illnesses (Halvorsrud et al., 2019), on top of little to no research exploring complex trauma among these groups, it may be argued that this gap in recognition within services and the wider empirical literature perpetuates ongoing cycles of adversity and injustices that Black adults with severe mental illnesses and trauma experience.

1.2.4.6 *Cultural Adaptations*

To ensure health services offer inclusive practice, provisions must be made to ensure interventions offered to those accessing services are acceptable and relative for service users. This is in line with professional standards of care set out by mental health regulatory bodies such as the Health and Care Professions Council (HCPC). The HCPC states that professionals must “be aware of the impact of culture, equality and diversity on practice” (HCPC, 2015). Standards of proficiency require healthcare professionals to acknowledge the cultural identities of service users and adapt their practice to best meet the needs of service users.

Accordingly, a growing interest to strengthen the acceptability of interventions has been made for evidence-based treatments to be adapted to meet the cultural needs of service users. This has largely followed from criticism of current evidence-based interventions are often modelled through an ‘Eurocentric’ lens and neglects cultural values and beliefs outside of Western cultures (Hwang, 2011). As Koç & Kafa argue (2019), what informs the development of many of these evidence-based treatments often include explanatory models of illnesses that are not valid cross-culturally. It is argued that Western practices tend to individualise trauma and neglect explanations of trauma that occur through social and political contexts (Koç & Kafa, 2019). This is particularly problematic, as trauma among racialised minorities may not just be shaped by individual harms but wider, structural forces such as racism and discrimination. As a result, treatments may feel irrelevant or inaccessible to a wide range of diverse cultural groups accessing services, should what be offered fail to capture the wider socio-political manifestations of distress service users may be experiencing.

Consequently, there has been a growing momentum to culturally adapt mental health interventions to improve their acceptability and effectiveness across diverse groups (Escoffery et al., 2018). Cultural adaptations in healthcare may include adjustments to interventions (e.g., content, language, modes of delivery) to align treatments to patient’s cultural backgrounds (Bernal et al., 2009). In the UK, NHS Talking Therapies for Anxiety and Depression, formally known as Improving Access to Psychological Therapies (IAPT), have increasingly begun implementing cultural adaptations into care planning (Faheem, 2022). However, little evidence has explored the effectiveness of these interventions, and crucially the experiences of service users who are receiving them.

Whilst there have been published meta-analyses in global literature comparing effectiveness of culturally adapted psychological interventions across racial groups and indicating positive results (Hall et al., 2016; Griner & Smith, 2006), little exists comparing adapted interventions in the context of trauma and complex trauma, including references to adaptation processes or mechanisms that may be more effective or matter most to racial groups. It is therefore unclear and remains a current gap in knowledge around the efficacy of adapting trauma interventions for racial groups, and inferring what these cultural adaptation processes typically may involve when adapting them in the context of trauma care.

1.3 Chapter Summary

This chapter presented an overview of relevant mental health and race equity policies, as well as empirical literature on trauma care in the UK and globally. I expanded on their relevance to Black populations, both globally and in the UK, including gaps where more research is needed. In the following chapter I detail an overview of what how this doctoral work aims to address much of these gaps, as well as my overarching research aims and methodologies employed.

2 CHAPTER TWO: STUDY OUTLINE

2.1 Chapter Overview

This chapter introduces my research and its three key components, outlining the development of the mixed methods design and the research paradigms that guide the methodology. I expand on the research frameworks employed and how they are best suited to answer the broader aims of the research. I also discuss research reflexivity, positionality, axiology, and why this was important in the context of the research topic being studied.

2.2 Research Aim and Objectives

2.2.1 Overall Study Aim and Research Questions

The overarching aim of the study was to use mixed-methods to critically examine the unique experiences Black adults with complex trauma have when accessing and engaging with mental health services to address trauma. As outlined through the empirical literature review in Chapter 1, Black adults continue to face significant challenges in having their trauma acknowledged within services which may be contributing to poor service outcomes amongst this population. The research aimed to answer the following questions:

- a) How is trauma assessed and treated among Black adults with complex trauma?
- b) Do existing interventions within services adequately meet the needs of Black adults with complex trauma?
- c) What are the strategies that could be implemented within and across services to improve access, engagement, and outcomes for Black adults with complex trauma?

2.3 Rationale for Current Project, Study Phases and Objectives

Given the lack of clear guidance around management of complex trauma in services more generally, but especially for racialised minority groups, this research aimed to provide insight into how best to support Black adults with complex trauma by exploring experiences of Black service users themselves, as well as analysing relevant healthcare data and empirical literature in a trauma context. The research had three core phases.

2.3.1 Phase One: Mixed-methods Systematic Review and Meta-analysis (Chapter 3)

The first phase was a systematic review, that explored cultural adaptations to the assessment and treatment of trauma among racialised minorities and initiated a strong foundational knowledge base for this work. I was able to explore on an international level the current approaches that are used to support racialised minorities with trauma and employ a thorough synthesis of the evidence in the review.

I wanted to explore how cultural adaptations were applied across healthcare and to research interventions, as well as understand their effectiveness when supporting those with trauma from racially minoritised backgrounds. Whilst tempted to explicitly centre this review on cultural adaptations to the assessment and treatment of trauma among Black adults, I anticipated the review would not generate much evidence given the notably small proportion of papers investigating this area from a preceding literature scoping review. It felt appropriate to widen the eligibility criteria to include racially minoritised groups. This still allowed me to pull evidence pertaining to the specific experiences of Black populations, as well as including other racialised minority groups. The intention was then to do more in-depth sensitivity analysis comparing cultural adaptations and their effectiveness across varied racialised minority groups.

The specific objectives of the review were to:

- a) Scope the adaptations and/or design features of assessment and interventions for trauma among racially and ethnically minoritised groups
- b) Determine the experiences and effectiveness of adapted or specifically designed interventions for racially and ethnically minoritised groups with trauma.

A systematic review of both qualitative and quantitative studies was conducted. A search across six databases was considered to identify empirical research papers. Eligibility for the review included: studies using quantitative, qualitative or mixed-method designs, included adults aged 18 years or over from racially and ethnically minoritised groups, focused on target participants' experiences and outcomes of culturally-adapted or specifically designed trauma assessments, and/or psychological interventions for trauma experiences (e.g., PTSD, CPTSD, or related symptoms without diagnosis threshold met or specified) and related mental health symptoms (e.g., depression). Initial titles and abstracts were screened followed

by a full-text screening of papers that met eligibility criteria. Additionally, a quality risk assessment (MMAT; Hong et al., 2018) was conducted to measure levels of bias across papers.

Analysis of findings comprised three stages. The first stage involved a narrative synthesis of data pertaining to study designs and approaches used in the assessment and/or intervention for trauma. The second stage of synthesis involved describing cultural adaptations used across intervention and assessment studies, using a narrative approach described by Popay and colleagues (Popay et al., 2006). Third, meta-analyses were conducted to examine the intervention effects of culturally-adapted interventions on PTSD symptoms and common co-morbid difficulties (i.e., depression and anxiety symptoms). Taking varied synthesis strategies together, this concluded a more robust methodology to capturing my research aims for this study. Further details of methodology informing this research component are detailed in Chapter 3.

2.3.2 Phase Two: Clinical Records Study (Chapter 4)

The second component of this research looked at de-identified electronic healthcare records. I explored demographic variations in the receipt of trauma assessment and treatment referrals among service users accessing NHS mental health services within an inner-city London borough. The purpose was to explore real-time current clinical practices and critically examine how services are responding to those with trauma needs, and crucially any gaps which could potentially perpetuate inequities in mental health care.

The specific objectives of the clinical records study were to explore:

- a) The demographic variations among those accessing services and associated entries related to trauma
- b) The types of trauma entries being recorded on clinical records
- c) The outcomes following trauma entries and any variations by demographic groups

The clinical records study formed the quantitative strand of the research component, and was influential in looking at patterns or variations within care delivery by demographic group, which is crucial when understanding these systemic barriers or disparities groups have when navigating services.

The study design was cross-sectional and descriptive in nature. This allowed me to establish which demographic groups are being underserved and require more careful attention from services. Like my review, I expanded an explicit focus from Black racial variations in care to an exploration of ethno-demographic variations. This still allowed me to explore racial variations among other demographic variations in care and to make comparisons to the experiences of Black adults. Further details of methodology informing this research component are detailed in Chapter 4.

2.3.3 Phase Three: Qualitative Study (Chapter 5)

Whilst both the review and clinical records phases provided powerful and meaningful data, what was left missing was the direct, lived experiences Black adults with complex trauma had when seeking support for their trauma within services. The qualitative nature of this study offered insights into the nuanced realities of trauma from those Black adults with lived experiences. Furthermore, this component allowed me to explore specific support needs of Black adults with complex trauma, in order to make more concrete implications of this work drawing on the qualitative findings, and further findings of all research methods together.

The methodological component used in-depth qualitative interviews with Black adults who had experiences of complex trauma and sought help from mental health services, both formally and in the voluntary sector. The objectives of the qualitative component were to explore:

- a) The journeys Black adults had when seeking support for complex trauma
- b) Their experiences and views of mental health services and support

In-depth interviews allowed the platforming of lived experiences to the forefront of the work. This approach captured more rich accounts of their experiences and allowed me to also enquire about specific barriers, facilitators, and experiences of support directly. Platforming of these experiences and voices felt incredibly important to complement my review and the clinical records research findings with the direct lived experiences of Black adults with complex trauma. Further details of methodology informing this research component are detailed in Chapter 5.

2.4 Research Paradigms and Study Design

In this section I describe the epistemological positioning and critical realist underpinnings situated within the framework of this research.

An important process to undertaking any research is to describe the philosophical paradigm that underpins the research. This is to allow the research to be layered with a philosophical lens that explains how knowledge is acquired and understood for the research process. Most commonly, theory of epistemology (i.e., theory of knowledge), and ontology (i.e., theory of existence and reality) are referenced through these processes, as they importantly ground the research philosophy and phenomenon of interest. Epistemological and ontological positioning of the research allows researchers to be guided throughout the research process and engage appropriate methodology to conduct the research (Scotland, 2012). I will explain the epistemological and ontological positions relevant to this work and describe how a critical realist approach is best suited for this research.

Ontology refers to the philosophy of ‘being’ (Scotland, 2012). Realist ontology refers to the existence of a single reality through which it can be studied, understood, and experienced as a ‘truth’ (Jenkins, 2010). Within a realistic ontological framework, it is assumed that there is a single reality that exists independently of our perceptions (Scotland, 2012). This framework asserts that the world operates according to observable structures and processes regardless of subjective interpretations. However, this singular reality is complex and often mediated by multiple layers of understanding.

Epistemology on the other hand relates to theory of knowledge and refers to what knowledge is and how knowledge is constructed (Scotland, 2012). Epistemology allows us to understand how we conceptualise knowledge that aligns with how we make sense of reality (Klakegg, 2016). Constructivist epistemology relates to knowledge being made through the social realities we experience (Scotland 2012). That is, knowledge can be seen as subjective, relative, and informed by cultural, political, social, and wider contexts (Madill et al., 2000). Consequently, constructivist epistemology accepts there is no objective truth to our understanding of knowledge (Bhaskar & Hartwig, 2016).

Critical realism (CR) brings together both realist ontology and constructivist epistemology (Willig, 2013). Whilst reality is seen as stable and ongoing, one’s individual values and beliefs shape their own perception of reality, and in this regard, perception of reality differs

between individuals (Bhaskar & Hartwig, 2016). CR claims the experience of reality is therefore ‘real’ to the individual who is experiencing it, despite their reality perhaps being different to another individual’s interpretation (Willig, 2013). In other words, these interpretations may be influenced by socio-cultural factors that leave varied perceptions of the same underlying reality.

CR therefore has great strength as an applied epistemology that can inform complex social research (Danermark et al., 2019). For the current research, I believe adopting a critical realist approach would be suitable given the research context. CR can be used to understand how social contexts shape our realities (Bhaskar & Hartwig, 2016). I agree in that context plays a large part in how we interpret and make sense of realities, and through this, how we make sense of our experiences. The experience of Black people navigating and accessing mental health services cannot be understood without a critical examination of wider structural, societal, cultural, and historical contexts. A CR approach to exploring how race may shape Black people’s realities with engaging with mental health systems, including how these groups make sense of their experiences, would therefore be appropriate. Furthermore, CR allows for the integration of multiple research methodologies which is in line with the mixed-methods approach of this project. By integrating CR with mixed methods research I can critically examine and understand how social context shapes the experiences of Black adults with complex trauma engaging with our mental health systems.

In addition to combining realist ontology with constructivist epistemology, critical realism offers conceptual frameworks that are particularly valuable for mixed-methods research. One such framework, relevant for this type of work studying Black adult’s experiences, is the “four planes of social being” (Bhaskar & Norrie, 2013), which posits that lived experience is shaped simultaneously across natural (“bodies in relation to nature”), interpersonal, social structures/institutional, and personal (“inner human being in the mental-social-embodied personality”) dimensions. This view is useful for the present work in two ways.

First, it justifies the adoption of a mixed-methods design by recognising that quantitative service-level data and qualitative lived experience data provide complementary insights into different but interconnected planes of being. Second, it provides a lens for reflecting on how trauma is simultaneously embodied, relational, institutionally mediated, and personally narrated. While the clinical records analysis (Chapter Four) engages more implicitly with these levels (e.g., institutional structures shaping service pathways, interpersonal sense-

making shaping clinical notes), the qualitative study (Chapter Five) makes explicit use of the four planes framework to explore how Black participants' narratives are embedded in wider social, personal, and structural contexts. This layered approach strengthens the integration of findings and reflects a critical realist orientation to understanding complex social phenomena.

2.4.1 Mixed Methods Design

The mixed-methods design employed in this thesis is underpinned by critical realism, which holds that different methodological approaches illuminate distinct dimensions of reality (Bhaskar & Hartwig, 2016). For example, service-level data can capture patterns shaped by institutional structures, while qualitative narratives highlight personal narratives. By bringing these strands together, the research design recognises that no single method can fully capture the complexity of trauma experiences, but that a layered, pluralist approach can better approximate the interplay across the planes of social being (Bhaskar & Norrie, 2013).

A mixed-methods design was incorporated into this study to also allow for a more robust understanding of the experiences of Black adults with trauma engaging with mental health services. The overarching research questions posed, such as how trauma is assessed and treated, whether interventions meet the needs of this group, and how services can be improved, are complex and multi-faceted, justifying the need for both quantitative and qualitative insights. Plano Clark (2017) argues mixed-methods designs are best suited in this context to answer complex research questions.

The research employed a concurrent triangulation approach informed by Plano Clark (2017) to establish the cross-validation of findings from different data sources. This approach meant that each study component was weighted equally and analysed separately before being merged during the interpretation phase and synthesis of findings as a whole. This also mitigated against potentially biases inherent in singular method designs. The research included three interrelated components (Phases 1-3), each contributing distinct yet complementary insights into the experiences of Black adults with complex trauma.

The first component of the research included a systematic review that explored cultural adaptations to the assessment and treatment of trauma among racialised minorities. The review synthesised both quantitative data (meta-analysis of intervention effects) and synthesis of participants' experiences to establish a foundational understanding of current practices in trauma care on a global level. This analysis therefore identified existing interventions, their

effectiveness, and important gaps in current trauma care that would generate data to compliment and contrast to other research phases and findings.

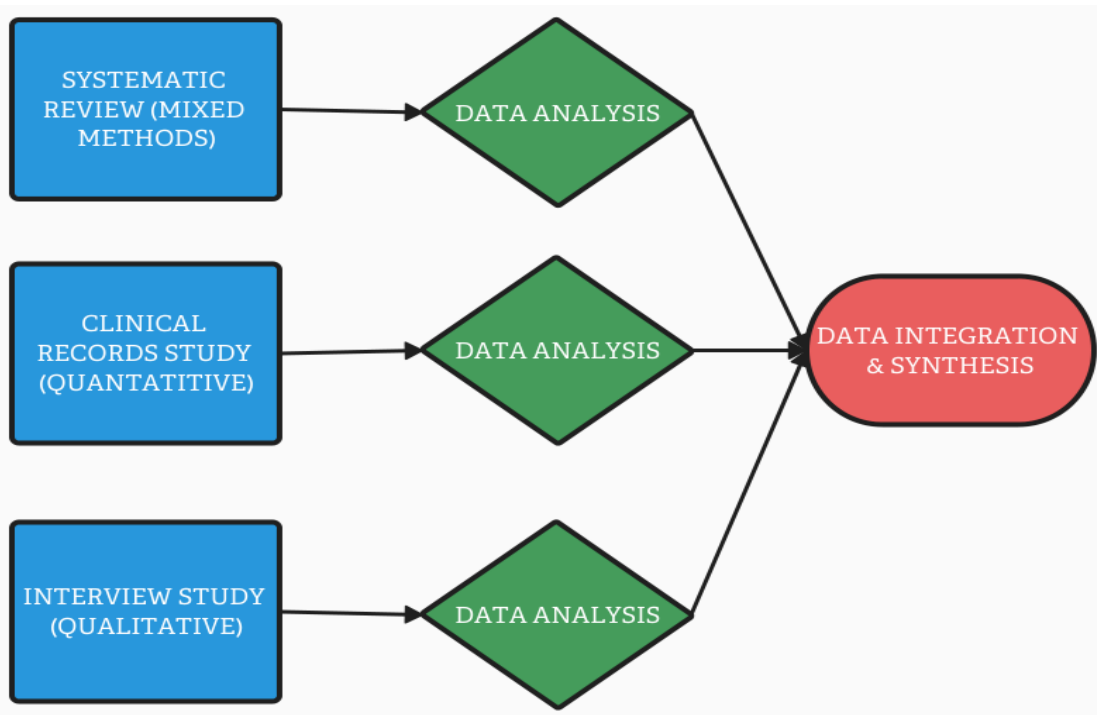
The second phase analysed de-identified clinical records to examine demographic variations in the assessment and referral for trauma care in South London and Maudsley (SLaM) NHS Foundation Trust. This phase aimed to provide evidence of patterns or disparities in trauma care within NHS settings. This was particularly helpful to understand access towards services as well as exploring current practices in assessing or treating trauma, important for further qualitative exploration in Phase Three.

The final phase of the research employed qualitative interviews with Black adults with complex trauma. This was to understand personal narratives, journeys, and experiences of trauma care within services. A thematic analysis approach was employed (Clarke & Braun, 2017), which was additionally situated within a critical realist epistemological framework (De Souza, 2014; Bhaskar & Norrie, 2013). This aimed to identify key themes within the data, particularly with regard to barriers and facilitators to care, and what effective culturally competent trauma care may look like. The critical realist approach also contextualised findings within the social realities of Black adults, particularly trying to understand perhaps some of the structural drivers behind individual experiences. This contributed to rich, in-depth insights that helped contextualise the quantitative findings from prior phases.

2.4.1.1 Data Integration and Interpretation

In line with a mixed-methods concurrent triangulation strategy (Plano Clark, 2017), the findings from all research phases were compared and integrated during the interpretation phase. This meta-synthesis during the interpretation phase enabled me to cross-validate patterns identified within each quantitative and qualitative data strand. It allowed me to also see whether empirical literature or empirical evidence from healthcare records aligned with the lived experiences and realities of Black adults themselves. This triangulation method was comprehensive at its core and allowed for a multidimensional understanding of the experiences of Black adults with trauma, and identify areas for improvement within mental healthcare provision. As a result, I was able to use these findings integrated together to develop evidence-based recommendations that would improve access and outcomes for Black adults with complex trauma engaging with mental healthcare, to which I expand on in more detail in Chapter 6. A visual figure depicting the concurrent triangulation strategy is outlined below in Figure 1.

Figure 1. *Mixed-methods Concurrent Triangulation Design*



2.5 Researcher Reflexivity and Standpoint

2.5.1 Personal Connections to the Project

This project carries significant personal importance as it is grounded in my own lived experiences and knowledge I have cumulated across my career. With regards to my personal history, I am a male of Black Caribbean heritage and have experiences accessing mental health services for complex trauma. My interest in psychology and the mechanisms of trauma has been shaped by a combination of personal experiences and a broader understanding of mental health. This personal connection naturally guided me toward pursuing psychology academically, first at secondary school and later at university for my undergraduate degree in psychology.

I remember my first working role after my undergraduate degree working across forensic medium secure hospital settings, most notably with young Black men living with severe mental illnesses. It was through listening to experiences within this role that allowed me to understand the journeys these men had embarked on up until admission. I was perpetually both angered and saddened at how pervasive inequality and adversity had played in their

journeys to accessing support, but also worryingly, how often their trauma and pain had been dismissed or ignored at the hands of services.

I became disheartened seeing the damaging ways trauma had shaped the journeys and experiences of these men, yet remained a neglected area of clinical concern. I observed how often feelings of being misunderstood and mistrust of services were common amongst these men. I started to understand the role trauma and chronic unmet needs had in potentially shaping these behaviours and beliefs. But also, I struggled with the duality of the person I presented with professionally when faced with working within systems of care that had potential to further harm, misunderstand, and maintain injustices among other Black people. I became curious of the role of research could play in tackling issues relating to addressing inequalities within mental health care and empowering untold narratives.

To explore these issues further, I then went on to study academic approaches to mental health research and did my Masters degree in Mental Health Studies at King's College London, and then further post-graduate clinical training at UCL. I remained curious to question my values and practice within academic research and clinical practice. I developed an understanding of community approaches to research and began to value methods and approaches that aligned with 'the person *is* the political' (Cahill, 2007). This highlights that our beliefs, experiences, and opportunities are not just confined to individualism but also examines the wider role social, political, and cultural context in determining our social realities (Cahill, 2007). I learned about the cumulative impacts of adversity on mental health outcomes across the lifespan and critically understood health and social inequalities apparent within current mental health care.

It is here, on top of my personal and professional experiences, that I feel determined to explore the lens of the social realities of Black adults accessing care through the current research project. Most importantly, I want to platform the narratives and stories that historically have often gone unheard and untold within the mental health research landscape.

2.5.2 Axiology and Research Positionality

Axiology refers to the role of values in research, including how values influence not only *what* is studied but also *how* it is studied and interpreted (Killam, 2013). Given the sensitive nature of trauma research and my personal connections to the project outlined above, it is crucial to acknowledge how my values and positionality shape the research process.

My personal and professional experiences have guided my values in committing research that is ethically sound and aligned with the needs of the communities affected. Rather than working from a researcher position of complete neutrality, I recognise that my values, particularly around a commitment to reducing racial disparities in mental health services and amplifying unheard stories in the landscape of mental health research, have strong influences on the research questions I ask, the methods I employ, and the way I interpret findings.

Throughout the research process, I engaged in critical reflexivity to remain aware of how it informed my interpretations. Following a reflexive thematic analysis approach (Braun & Clarke, 2019), subjectivity was viewed as an analytic resource, a lens through which rich, meaningful insights could be generated. This view aligns with the critical realist position that while reality exists independently of our perceptions, all knowledge is mediated through our interpretive frameworks (Bhaskar & Hartwig, 2016). My reflexivity allowed me to question and make transparent the ways by which my interpretations were shaped by my own perspectives and experiences.

In line with critical realism's acknowledgement of multiple ways of knowing, I also recognise that different parts of this mixed-methods study required different epistemological stances. For instance, while the qualitative study explicitly embraced interpretive depth, the systematic review and clinical records analyses adhered more closely to positivist principles of transparency and reproducibility. These components sought to minimise bias and foreground objectivity in data handling and interpretation. However, I acknowledge that complete objectivity is neither attainable nor desirable, and researcher decisions, such as which variables to analyse or how to frame inclusion criteria, inevitably carry traces of subjectivity. Maintaining transparency about these choices was therefore central to upholding methodological integrity across paradigms.

Rather than attempting to suppress the influence of my positionality, I embraced it as part of transparent research practice. This included drawing on multiple perspectives, including a lived experience advisory group of Black adults with complex trauma and feedback from my supervisory team. I also maintained reflexive journals throughout the research to continually question my own assumptions and analytic decisions.

By working reflexively and critically engaging with my values, I aimed to ensure that the research remained grounded in participants lived experiences and informed by social and cultural context, while still maintaining analytic robustness across all methodological

approaches. In this way, axiology and reflexivity served to the ethical and epistemological dimensions of the research, consistent with a critical realist understanding of knowledge as both value-informed and reality-oriented (Bourke, 2014).

2.6 Lived Experience Advisory Group

I worked with a lived experience advisory group (LEAG) of Black adults who self-identified as having complex trauma and experiences of accessing mental health services. Their involvement was central to the design and delivery of the qualitative component of the study. The inclusion of a LEAG aimed to enhance contextual relevance and ethical sensitivity of the research, especially given the historically marginalised position of Black individuals within UK mental health systems as well as within research contexts.

Despite initial recruitment challenges, I successfully recruited three members to the Lived Experience Advisory Group (LEAG), using paid involvement and a combination of digital and third-sector recruitment channels. However, retaining participants proved more difficult. Although I offered flexible participation options, including asynchronous engagement via email and opt-in rather than mandatory meetings, two of the three members withdrew after the recruitment stage. Both cited limited capacity due to acute mental health challenges.

This experience reflects a broader issue in undertaking meaningful Public and Patient Involvement and Engagement (PPIE) with marginalised communities (Kawn et al., 2018). For many Black adults managing ongoing trauma, participation in a research advisory role may not be feasible due to mental health needs or competing priorities. Their openness about these difficulties was deeply appreciated and highlighted the emotional labour often inherent in PPIE work, especially when research topics, such as trauma and systemic harm, may resonate on a personal level. All LEAG members who participated helped shape the development of interview questions, recruitment materials, and interview strategies, with a focus on fostering relational safety and minimising potential harm.

While the LEAG was not involved from the earliest conceptual stages of the doctoral project (i.e., during the systematic review stage) due to logistical and capacity constraints, their engagement during the qualitative stage proved invaluable. This timing was deliberate. It aligned with the part of the study most focused on lived experience narratives and experiences. Concentrating LEAG involvement at this point allowed for greater depth and relevance in how participant voices were engaged with, interpreted, and protected.

In summary, while working with a LEAG presented challenges, including recruitment and retention, it also provided crucial insights that strengthened the methodological and ethical foundations of this study. These reflections may serve as a modest contribution to the growing literature on the complexities and possibilities of meaningful PPIE in community-based research (Kwan et al., 2018).

2.7 Chapter Summary

This chapter provided an overview of the philosophical, contextual, and methodological underpinnings that shaped my work. By discussing these approaches, I outlined an overview and rationale and justification to the methodologies and approaches used. This chapter summarises how my pragmatic methodological framework seeks to provide answers to better supporting Black adults with complex trauma.

3 CHAPTER THREE: SYSTEMATIC REVIEW

3.1 Chapter Overview

In this chapter I discuss the preliminary work conducted in my research that explored the current empirical evidence base on trauma research. Through a mixed-methods systematic review and meta-analysis, the purpose was to comprehensively understand on a global level current adaptations to trauma care for racially and ethnically minoritised groups. I expand on the rationale, methodology and some of my findings from my review in this chapter. I conclude with further implications of my work and questions for future research, clinical practice, and policy.

3.2 Introduction

Global research has shown the prevalence for post-traumatic stress disorder (PTSD) in adults ranges from approximately 1-12% (NICE, 2018). PTSD is a psychiatric condition that develops following exposure to a traumatic event, with signature symptoms of PTSD including re-experiencing the traumatic event, cognitive disturbance, hyperarousal, and avoidance (American Psychiatric Association, 2022). The Adult Psychiatric Morbidity Survey in the United Kingdom (UK) reported higher rates of PTSD amongst Black British groups compared to White British adults (McManus et al., 2016). Similar findings have been reported in literature in the United States, suggesting higher rates of PTSD in African American and Hispanic adult populations compared to White groups (Alegría et al., 2013; Roberts et al., 2011; Sibrava et al., 2019; Asnaani et al., 2010).

Complex PTSD (CPTSD) was included as a diagnosis in the 11th revision of the International Classification of Diseases (World Health Organization, 2018). CPTSD encompasses the core features of PTSD as well as further disturbances in emotional regulation, self-concept, and interpersonal relationships. The introduction of CPTSD as a separate diagnostic classification to PTSD was built on extensive clinical observations that showed for those exposed to repetitive or prolonged traumas, such as childhood sexual abuse, often led to complex reactions that extended beyond reactions found in those who experienced trauma following a single event, such as a motor accident (Maercker et al., 2013). Experiences of adverse events such as racism, discrimination, and events related to fleeing persecution or war for refugee and asylum-seeking groups may render vulnerability to ongoing traumatic stressors and greater exposures to trauma among racialised minorities. Whilst this prompts valid enquiry

into prevalence and experiences of CPTSD among racialised minorities, studies exploring cultural variations among those with CPTSD remain limited (Heim et al., 2022).

And so, critically understanding the various cross-cultural factors that may shape or influence trauma experiences among racially and ethnically minoritised groups becomes important. This may include examining sociocultural explanatory models of illness and coping that may influence interpretation of trauma (Terheggen et al., 2001), as well as trauma disclosure (Long et al., 2007). For example, whilst those who are exposed to interpersonal abuse may report heightened sense of anger as a result of injustice following trauma (Goldner et al., 2019; Erzar et al., 2019), religious or spiritual models around forgiveness or revenge may impact this degree of anger, or how it is expressed through cultural norms (Hinton et al., 2003). Similarly, higher rates of mental illness stigma among Black and Asian groups (Alvidrez et al., 2008; Yang, 2007) may prevent help-seeking behaviour or disclosing trauma, through fear of backlash from local community members (Laban et al., 2008).

Currently, the National Institute for Health and Care Excellence (NICE) guidance for treating PTSD in the UK includes trauma-focused cognitive behavioural therapy, prolonged exposure therapy, eye movement desensitization and reprocessing therapy (EMDR) and narrative exposure therapy (NICE, 2018), and several published meta-analyses show positive outcomes of effectiveness for these interventions (Cusack et al., 2016; Powers et al., 2010; Seidler & Wagner, 2006; Lely et al., 2019). However, it is unclear if the effectiveness of such interventions can be fully generalised across racialised minorities due to low uptake of participating in clinical trials and research, thus remaining underrepresented at a global level (Brown et al., 2014). Further, clinical guidance on the management for CPTSD and associated difficulties remains outstanding, making it a challenge for clinicians working with individuals presenting with CPTSD or complex trauma presentations.

Critics have also cited that evidence-based interventions have mostly been developed in Western contexts (Bernal et al., 2009), arguing that proposed interventions may not be as acceptable to non-Western groups and societies who uphold diverse cultural practices and beliefs around health and illness. Worse, consistent stark racial disparities in outcomes and experiences exist for racially and ethnically minoritised groups engaging with current healthcare services (Das-Munshi et al., 2018; Hussain et al., 2022). There is therefore a pressing need for global research and services to ensure interventions designed to assess and

treat PTSD, CPTSD or trauma experiences are efficacious among diverse service user populations.

For racially and ethnically minoritised groups there is some evidence to suggest culturally-adapted interventions can increase intervention effectiveness in health services (Kohn et al., 2002, Kalibatseva & Leong, 2014), and that cultural groups are more likely to engage with services when they believe their cultural identities and beliefs are accurately reflected in the delivery of treatment (Bhui & Bhugra, 2004).

Cultural adaptation can be referred to as “the modification of an intervention protocol to acknowledge language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings, and values” (Bernal et al., 2009). Results from several meta-analyses on the effectiveness of culturally-adapted interventions in healthcare vary considerably (Rathod et al., 2018; Anik et al., 2021; Hall et al., 2016). Much of the evidence obtained from these reviews evaluated cultural adaptations across interventions designed to address a wide range of psychiatric disorders, notably depressive disorders. Many reviews also fall short of fully describing the nature of the adaptation process, making it hard to infer which components of the intervention approach was efficacious and the relative individual experiences of the adaptations.

Whilst research exploring cultural adaptations to trauma treatments among racially minoritised groups is growing (Ennis et al., 2020; Menon et al., 2023), the scope of reviews has often been limited to exploring adaptations to Cognitive Behavioural Therapy (CBT). Cross cultural research has questioned the application of CBT when working with diverse groups, citing CBT practices as individualistic and ignoring the wider social and cultural contexts that may influence distress (Hall et al., 2016). Whilst this may justify the need to explore adaptations to CBT when working with varied groups, a more expansive review of adaptations across several treatment modalities that extend beyond CBT is warranted. This strengthens the literature by exploring the effectiveness and appropriateness of the varied treatment modalities, making more informed recommendations for future practice and policy.

There is also a significant gap in our understanding on culturally adapted trauma assessments. This is troubling, as accurate assessments for mental health difficulties are a crucial part of a care pathway, ultimately shaping how trauma is to be understood, diagnosed, and subsequently treated. Without culturally adapted assessments, there is a clear risk of under

recognising trauma symptoms among racialised minorities, particularly when experiences may be routed through specific cultural idioms of distress or coping methods (Nichter, 2010). As highlighted in the work of Comas-Díaz (2016) and Williams et al (2022), cultural narratives of trauma in racialised minorities are often neglected in traditional care settings and require culturally responsive measures of assessment. Therefore, reviewing cultural adaptations to assessment practices for trauma is necessary to critically understand how trauma is being identified among racialised minority populations. Limited research has therefore been conducted on reviewing cultural adaptations to assessments *and* interventions for trauma experiences for these groups. Given the higher prevalence of trauma experiences among these groups, in addition to reported poor outcomes in accessing care, systematic exploration of the effectiveness and experiences of cultural adaptations to varied treatment interventions and assessments of trauma for these groups is warranted.

To address this gap, I conducted a systematic review of outcomes and experiences of culturally-adapted assessments and interventions for trauma experiences among racially and ethnically minoritised groups. The review aimed to (a) scope the adaptations and/or design features of assessment and interventions for trauma among racially and ethnically minoritised groups and (b) determine the experiences and effectiveness of adapted or specifically designed interventions for racially and ethnically minoritised groups with trauma.

3.3 Methodology

3.3.1 Search Strategy

The review protocol was registered prospectively on PROSPERO (Ref: CRD42022321884). Search terms in this comprehensive review included key words and identifiers related to my aims, such as “cultural adaptation”, “treatment”, “trauma”, “racial minority”, “CBT”, “EMDR”. A search of empirical studies was performed in six databases: MEDLINE, PsycINFO, Embase, CINAHL, Cochrane Central Register of Controlled Trials, Web of Science, from inception to May 2022.

3.3.2 Eligibility Criteria

Screening of primary studies was dependent on the following inclusion criteria: empirical studies using quantitative, qualitative or mixed-method designs, included adults aged 18 years or over from racially and ethnically minoritised groups, focused on target participants’ experiences and outcomes of culturally-adapted or specifically designed trauma assessments,

and/or psychological interventions for trauma experiences (e.g., PTSD, CPTSD, or related symptoms without diagnosis threshold met or specified) and related mental health symptoms (e.g., depression). I excluded papers that did not involve racially or ethnically minoritised groups, or which did not separate data for racially and ethnically minoritised participants in their analysis. I also excluded studies from the meta-analysis which were including existing or overlapping datasets from another study. I additionally excluded papers which did not include mental health populations or papers that exclusively focused on pharmacological intervention for mental health conditions. Non-pharmacological treatments such as community-based interventions or adapted psychotherapies offer greater insight into the social, cultural, and psychological needs of racialised groups, which is essential to understanding and addressing trauma in these groups.

3.3.3 Definition of Adaptation

For the purposes of this review, adaptations referred to a direct change, modification or adjustment to a standardised assessment or intervention to improve its acceptability for a targeted population (Bernal et al., 2009). Additionally, I was also interested in any assessment or intervention approaches that were uniquely designed for a targeted population (e.g., an approach that has been developed at the outset to capture the needs of the target audience rather than an adapted evidence-based treatment, such as CBT).

3.3.4 Screening and Study Selection

All titles and abstracts of papers identified from the searches, and full text papers of those met eligibility criteria were independently screened by myself and another peer student. Where discrepancies occurred, these were resolved through wider research team discussion with my supervisors.

3.3.5 Quality Assessment (risk of bias)

Quality assessment of included papers was independently rated by two reviewers (myself and a peer student) using The Mixed Methods Appraisal Tool v2018 (MMAT; Hong et al., 2018). The tool measures quality of studies against independent sets of criteria and measures bias across randomised controlled trials (RCT), non-randomised studies, descriptive studies, qualitative studies, and mixed methods studies. I then classified an overall strength of quality for each paper as follows: low quality (<40%); medium quality ($\geq 40\%$ and <80%); and high quality ($\geq 80\%$). I included a descriptive critique of the factors (e.g., clear research question,

rationale for methodology, analysis, etc.) that contributed to high, medium, or low-quality studies alongside their percentage scores and overall strength as per guidance (MMAT, Hong et al., 2018) to help infer a wider, comprehensive picture of study quality.

3.3.6 Data Extraction

Descriptive characteristics of eligible studies were recorded in a data extraction excel spreadsheet, including authors, year of publication, country, study design, target populations, trauma type, assessment / intervention and adaptation details, sample size, comparator (if applicable), results (including qualitative data from participants, means and standard deviations for symptom measure scores at several times points if applicable) and conclusions.

3.3.7 Data Analysis and Synthesis

Synthesis of data comprised three stages. The first stage involved a narrative synthesis of data pertaining to study designs and approaches used in the assessment and/or intervention for trauma.

The second stage of synthesis involved describing cultural adaptations used across intervention and assessment studies, using a narrative approach described by Popay and colleagues (Popay et al., 2006). Identified mechanisms of action were compared between these studies to find the commonalities and differences of certain adaptations and themes that emerged from the data. Any data that accounted for participant experiences of interventions or assessments was also explored.

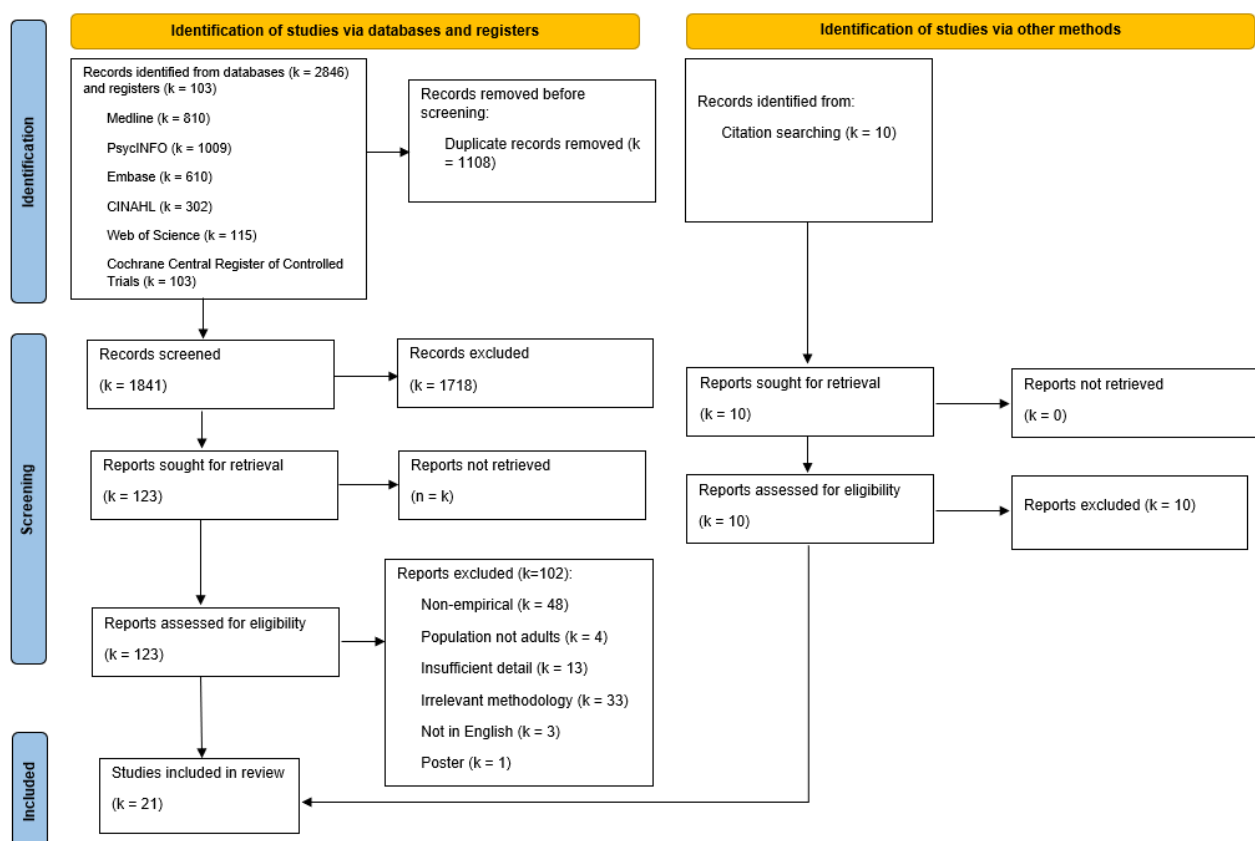
Third, meta-analyses were conducted to examine the intervention effects of culturally-adapted interventions on PTSD symptoms and common co-morbid difficulties (i.e., depression and anxiety symptoms). Only randomised controlled trials (RCTs) which reported symptom outcomes using validated measures were included in the meta-analyses (Concato et al., 2000). I was also interested in outcome measures that may capture complex trauma symptoms (e.g., negative self-concept), which may or may not include measurements of CPTSD. I conducted meta-analyses using the random effects model whenever there were four or more studies reporting usable data to capture any uncertainty resulting from heterogeneity among studies. When data were available from less than four studies, the fixed-effect model was used instead (Borenstein, 2010). No subgroup analyses to examine the extent of assessment and intervention effects across certain cultural groups were pre-specified

considering the limited volume of data to date. Review Manager software was used to conduct the meta-analyses (RevMan 5.4). Standardised mean differences with 95% confidence intervals were calculated for all comparisons with continuous measures. I^2 statistic depicted the heterogeneity (Borenstein et al., 2009): high heterogeneity was assumed if the I^2 value was $> 75\%$; moderate with I^2 between 25% and 75%; and low if $< 25\%$ (Higgins et al., 2003). Chi-square (χ^2) values were calculated to depict differences between observed and expected frequencies of outcomes and Tau-squared (τ^2) values were used to indicate estimates of between-study variance. Results of the remaining intervention studies which were not suitable for meta-analyses were narratively described.

3.4 Results

A total of 2,949 records were found following the search across databases and following removal of duplicate articles, a total of 1841 papers remained for title and abstract screening. After screening title and abstracts, this left 123 full-text papers to screen.

Figure 4. PRISMA flowchart. Overview of database searches and included studies



Full-text screening allowed for a total of 21 eligible papers included in the current review. Figure 2 describes a PRISMA flowchart (Page et al., 2021) and overview of the screening process.

3.4.1 Overview of Studies

A total of 21 studies with 3341 adult participants were included in this review. Sample sizes ranged from 7 to 1358. A detailed description of study characteristics is included in Table 1.

In reference to location of studies, the majority were conducted in the United States (Hinton et al., 2011; Galano et al., 2017; Pearson et al., 2019; Hahm et al., 2019; Hinton et al., 2004; Hinton et al., 2005; James & Noel., 2013; Hinton et al., 2013). Two studies were conducted in Australia (Gibson et al., 2021; Fernandes & Aiello., 2018), one in the Caribbean (Vera et al., 2022), one in Germany (Kananian et al., 2017), one in Pakistan (Latif et al., 2021), two in South Africa (Jalal et al., 2020; Madigoe et al., 2017), two in countries across Southeast Asia (Chhim, 2012; Eichfeld et al., 2019), one in Turkey (Eskici et al., 2021), one in Uganda (Goninon et al., 2021), and two in the United Kingdom (Hammad, 2020; Bahu, 2019).

Study populations were mixed; however, a notable number of studies focused on refugee or asylum-seeking populations from racially minoritised backgrounds (Eskici et al., 2021; Goninon et al., 2021; Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005; Hinton et al., 2013; Fernandes & Aiello., 2018; Bahu, 2019). In terms of study designs, nine studies used randomised controlled study designs (Vera et al., 2022; Hinton et al., 2011; Jalal et al., 2020; Eskici et al., 2021; Latif et al., 2021; Pearson et al., 2019; Hahm et al., 2019; Hinton et al., 2004; Hinton et al., 2005). One study used a qualitative design (Fernandes & Aiello., 2018), three were mixed methods studies (Hammad, 2020; Bahu, 2019; Chhim, 2012), three studies used pre-post evaluation designs (Eichfeld et al., 2019; James & Noel., 2013; Kananian et al., 2017), two studies used quasi-experimental designs (Goninon et al., 2021; Gibson et al., 2021), two studies were cross-sectional studies (Hinton et al., 2013; Madigoe et al., 2017), and one study used a controlled study design (Galano et al., 2017).

Table 1. *Overview and quality assessment of studies*

Assessment/ Intervention	Study author(s), year, country	Study design	Comparator	Population	Trauma type	Sample size, gender (% of sample)	Intervention details (modality, duration, delivery)	Mean age of sample (SD*)	MMAT* study quality
Intervention	Bahu (2019), United Kingdom	Mixed methods	None	Tamil refugees	Family or individual experience of imprisonment, torture, arrest, or death	16 Men: 10 (60%) Women: 6 (40%)	CA-CBT*, 12 group sessions	32 (NR*) Range: 23-55	High
Assessment	Chhim (2012), Cambodia	Mixed methods	N/A*	Cambodians	Development Group: victims of torture, healthcare and academic professionals, community leaders Validation Group: Stampede victims	Development Group: 53 Men: 34 (64.2%) Women: 19 (35.8%) Validation Group: 390 Men: 122 (31.2%) Women: 268 (68.8%)	N/A	Development Group: 56 (12.87) Validation Group: 53.40 (12.96)	Medium
Intervention	Eichfeld et al. (2019), Indonesia, Cambodia, and Thailand	Pre-post	Control group from another study	Southeast Asians	Natural disaster victims (Indian Ocean Tsunami), interpersonal violence victims, Khmer Rouge regime victims	1358 Men: 468 (34.5%) Women: 885(65.2%) Transgender: 5 (0.4%)	Individual and group focused trauma-focused therapy	31.69 (12.02)	High

Assessment/ Intervention	Study author(s), year, country	Study design	Comparator	Population	Trauma type	Sample size, gender (% of sample)	Intervention details (modality, duration, delivery)	Mean age of sample (SD*)	MMAT* study quality
Intervention	Eskici et al. (2021), Turkey	RCT*	TAU*	Syrian Refugees	NR	23 Women: 23 (100%)	CA-CBT 7 weekly group sessions, 1.5-2hrs	35.1 (8.3)	High
Intervention	Fernandes & Aiello (2018), Australia	Qualitative	None	Tamil refugees	Male survivors of torture and rape	42 Men: 42 (100%)	Narrative Exposure Therapy and Psychoeducation Group sessions: 10 weekly groups, 2.5hr Individual sessions: 1- 6	NR (NR) Range: 24-49	Low
Intervention	Galano et al. (2017), United States	Controlled study	Waitlist control	Latina immigrant women	Interpersonal violence victims	93 Women: 93 (100%)	Mixed modalities, 10- week group	35.66 (7.2)	High
Intervention	Gibson et al. (2021), Australia	Quasi- experimental controlled	UC*/TAU	Tuvaluans	Natural disaster	99 Funafuti sample: Men: 12 (24%) Women: 38 (76%) Nui sample: Men: 21 (43%) Women: 28 (57%)	Psychoeducation: 6 group sessions, across 5 days	Funafuti location: 34.12 (Range 18- 71) Nui location: 50.02 (Range 20-74)	High
Intervention	Goninon et al. (2021), Uganda	Quasi-exp	Immediate, delayed treatment	Congolese refugees	Refugees and victims of war	174 Men: 85 (49%) Women: 89 (51%)	Culturally-adapted trauma focused CBT, 9 group sessions, 1.5hr	33.4 (11.7)	Medium

Assessment/ Intervention	Study author(s), year, country	Study design	Comparator	Population	Trauma type	Sample size, gender (% of sample)	Intervention details (modality, duration, delivery)	Mean age of sample (SD*)	MMAT* study quality
Intervention	Hahm et al. (2019), United States	RCT	Waitlist control	Asian American women	Interpersonal trauma	63 Women: 63 (100%)	Mixed modalities 8-week group and SMS* messages	23.63 (NR)	High
Intervention	Hammad (2020), United Kingdom	Mixed methods	None	British MENA*-origin Muslim women	Victims of Grenfell fire tragedy	16 Women: 16 (100%)	Mixed modalities 1 st group: 8 weekly 2hr sessions 2 nd group: 9 weekly 1.5hr sessions	1 st group range: 36-83 (NR) 2 nd group range: 41-84 (NR)	High
Intervention	Hinton et al. (2004), United States	Pilot RCT	Immediate treatment, delayed treatment	Vietnamese refugees	Ex-political and non- ex-political detainees	12 Men: 6 (50%) Women: 6 (50%)	CBT, 11 weekly individual sessions	NR (NR)	Medium
Intervention	Hinton et al. (2005), United States	RCT	Initial, delayed	Cambodian refugees	Victims who 'passed through Cambodian genocide (1995- 1979)	40 Men: 16 (40%) Women: 24 (60%)	CBT, 12 weekly individual sessions	Initial: 50.90 (6.11) Delayed: 52.70 (7.43)	High
Intervention	Hinton et al. (2011), United States	Pilot RCT	Active treatment control (applied muscle relaxation)	Latina women	NR	24 Women: 24 (100%)	CA-CBT 14 weekly groups, 1hr	Intervention: 47.6 (8.2) Control: 51.4 (5.9)	High

Assessment/ Intervention	Study author(s), year, country	Study design	Comparator	Population	Trauma type	Sample size, gender (% of sample)	Intervention details (modality, duration, delivery)	Mean age of sample (SD*)	MMAT* study quality
Assessment	Hinton et al. (2013), United States	Cross- sectional	N/A	Cambodian refugees	All patients 'lived through Pol Pot genocide'	226 Men: NR Women: 149 (66%)	N/A	52.6 (9.5)	Medium
Intervention	Jalal et al. (2020), South Africa	Pilot RCT	Active treatment (applied muscle relaxation)	Indigenous South Africans	NR	20 Men: 5 (25%) Women: 15 (75%)	CA-CBT, 14 individual sessions, 7 weeks (2 sessions per week), 1hr	28.2 (NR)	High
Intervention	James & Noel (2013), United States	Pre-post	None	Haitians	Haiti earthquake survivors	113, NR	Psychoeducation; Lay worker group intervention: 1.5hr, 3x week for 2 months	Study 1: 35.44 (10.38) Study 2: 39.92 (.48) Study 3: NR (NR)	Low
Intervention	Kananian et al. (2017), Germany	Pre-post	N/A	Afghan and Iranian refugees	Imprisonment, torture	7 Men: 7 (100%)	CA-CBT, 12 group sessions, once a week, 1.5hr	25.6 (9.0)	Medium
Intervention	Latif et al. (2021), Pakistan	Feasibility RCT	Waitlist control	Pakistani women	Interpersonal trauma; 50 domestic violence victims	50 Women: 50 (100%)	CA-CBT & GSH*, 9 sessions over 12 weeks, 15-20min	Intervention 27.4 (4.6) Control 26.3 (3.7)	High

Assessment/ Intervention	Study author(s), year, country	Study design	Comparator	Population	Trauma type	Sample size, gender (% of sample)	Intervention details (modality, duration, delivery)	Mean age of sample (SD*)	MMAT* study quality
Assessment	Madigoe et al. (2017), South Africa	Cross- sectional	N/A	South African Zulu	NR	100 Men: 50 (50%) Women: 50 (50%)	N/A	NR (NR) Range: 18-61	Medium
Intervention	Pearson et al. (2019), United States	RCT	Waitlist control	Native American women	Interpersonal trauma	73 Women: 73 (100%)	CA-CPT*, 13 sessions	18-29: (n=16, 21.9%) 30-39: (n=21, 28.8%) 40-49: (n=23, 31.5%) 50-60: (n=13, 17.8%)	High
Intervention	Vera et al. (2022), Puerto Rico	RCT	Active treatment control (applied muscle relaxation)	Latino	Interpersonal violence, unexpected death, transportation accidents, war, and community violence	98 Total sample: Men: 18 (18.4) Women: 80 (81.6)	CA Prolonged exposure, 12-15 individual weekly sessions, 1.5hr	43.6 (NR*)	High

Key: **CA** – Culturally-Adapted. **CBT** – Cognitive Behavioural Therapy. **CPT** – Cognitive Processing Therapy. **GSH** – Guided Self Help. **MENA** - Middle East and Northern Africa. **MMAT** – Mixed Methods Appraisal Tool. **N/A** – Not Applicable. **NR** – Not Reported. **RCT** – Randomised Controlled Trial. **SMS** – Short Message Service. **SD** – Standard Deviation. **TAU** – Treatment as Usual. **UC** – Uncontrolled.

3.4.2 Quality Assessment of Studies

Most papers in the review (Vera et al., 2022; Hinton et al., 2011; Jalal et al., 2020; Eskici et al., 2021; Latif et al., 2021; Galano et al., 2017; Pearson et al., 2019; Goninon et al., 2021; Eichfeld et al., 2019; Hahm et al., 2019; Gibson et al., 2021; Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005; Hinton et al., 2013; Madigoe et al., 2017; Hammad, 2020; Bahu, 2019; Chhim, 2012) were assessed to have high or medium-high quality ($\geq 40\%$). Justifications for high quality rating included having complete outcome data, using appropriate sampling methods to address the research question(s), evaluating response rates, blinding of outcome assessors (and several more criteria set out in the MMAT). However, a small number of papers (Fernandes & Aiello., 2018; James & Noel., 2013) had low methodological quality ($\leq 40\%$). Common reasons for this included a lack of complete outcome data, groups not being comparable at baseline, or outcome assessors not being blinded to interventions in RCT studies. See Table 1 for quality ratings of each study.

3.4.3 Characteristics of Intervention Studies

Whilst studies often included multi-modal modalities in treatment approach, the most often modality incorporated amongst most studies was a form of culturally adapted cognitive behavioural approaches ($k=15$). Two papers (James & Noel., 2013; Gibson et al., 2021) solely focused on psychoeducation. Many studies delivered interventions through group formats ($k=12$). Duration of the interventions ranged from 7 weeks to 15 weeks with a mean of 11 weeks. A large proportion of intervention studies focused on experiences of refugee and asylum-seeking populations (Eskici et al., 2021; Goninon et al., 2021; Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005; Fernandes & Aiello., 2018; Bahu, 2019), which included traumas associated with war, forced displacement, imprisonment, torture, and rape.

3.4.4 Characteristics of Assessment Studies

Three studies focused on evaluating culturally specific assessments for trauma experiences (Hinton et al., 2013; Madigoe et al., 2017; Chhim, 2012). Assessment studies focused on the integration of culturally specific experiences, practices, and knowledge into the development of an assessment tool that assesses and screens for trauma. Two papers (Chhim, 2012; Hinton et al., 2013) focused on assessing trauma experiences among Cambodian populations and one paper (Madigoe et al., 2017) focused on the development of a culturally specific screening tool for trauma among South African Zulu groups. Trauma experiences that were investigated in assessments were therefore locally and culturally determined, which included integration

of culturally relevant somatic complaints into the acknowledgment of trauma (Hinton et al., 2013; Chhim, 2012) and an awareness of explanatory models and beliefs around illness (Hinton et al., 2013; Madigoe et al., 2017; Chhim, 2012). Two assessment studies reported the integration of spirituality into the assessment of trauma. Specifically, this included screening for trauma experiences or coping behaviours related to witchcraft or traditional rituals (e.g., interpretation of sleep paralysis and nightmares as spiritual attacks, Hinton et al., 2013). Assessment studies involved comparisons to Western diagnostic screening tools for trauma, with two papers (Hinton et al., 2013; Chhim, 2012) focusing on the PTSD checklist (Civilian Version; PCL-C) and one paper (Madigoe et al., 2017) focusing on the PTSD section of the Diagnostic and Statistical Manual - Structured Clinical Interview (SCID-I RV) to inform further validation and comparison of adapted measures.

3.4.5 Cultural Adaptations

Eight themes emerged on cultural adaptations, and these are depicted below. Further details of these themes are detailed in Table 2 as well as narratively below.

Table 2. *Summary of cultural adaptations*

Cultural Adaptation	Examples
Language	Adapting language within assessments or interventions to align with cultural nuances and meanings that are relative to groups. Avoiding Western concepts, terminology, and clinical jargon. Using cultural relevant metaphors, analogies, idioms, and practices to explain trauma. Facilitation of assessments or interventions in the preferred local language.
Sociocultural Considerations	Utilising methods that harness cultural context and identity and integrate this into practice (e.g., collective cooking/drumming to foster connection and belonging, assessing spirituality to understand meaning-making and coping mechanisms).
Training for Providers	Training for service providers that understands the cultural, social, and historical contexts of the communities they serve to best meet cultural needs.
Psychoeducation	Involves the use of education around trauma experiences in a way that is familiar or relative to the cultural background. Adaptations draw on cultural history and contextual examples to explain trauma experiences and the process of treatment.
Practical Considerations	Pragmatic and logistical adaptations to interventions to ensure they are accessible and retain engagement. Offering more trauma-sessions devoted to trust building. Offering care where appropriate within existent community networks and settings outside of medical and traditional services (e.g., faith-based places of worship).
Stigma	Reframing interventions to distance from Western concepts, such as “mental health intervention”. Harnessing group discussions that normalise trauma responses, behaviour and provide collective support.
Collaboration	Utilising the knowledge and experiences existent within community networks of racially and ethnically minoritised groups to develop and conduct assessments and interventions, such as input from traditional healers.
Cultural Matching	The choice for alignment between therapists’ and individuals’ cultural background, benefits often cited as enhancing a stronger therapeutic alliance or for rapport building.

Language

Language adaptations were reported across intervention and assessment studies. This included translation of an original intervention or assessment into the local language of participants, through either translated intervention materials (Galano et al., 2017; Pearson et al., 2019; Goninon et al., 2021; Hinton et al., 2004; Madigoe et al., 2017; Hammad, 2020; Bahu, 2019) and/or the intervention or assessment in the preferred local language delivered by the facilitator or use of an interpreter (Galano et al., 2017; Madigoe et al., 2017; Hammad, 2020; Fernandes & Aiello., 2018; Chhim, 2012). Changing jargon into more culturally specific and understood terminology to improve acceptability of interventions was also reported across several papers (Vera et al., 2022; Hinton et al., 2013; Hammad, 2020).

Cultural matching of the facilitator

Adaptations to the intervention through cultural matching of the facilitator to participants was present in over a third of all studies (k=8). Cultural matching of the facilitator included matching facilitators and participants for ethnicity as well as other characteristics such as gender or language as a way of improving acceptability of the intervention (Vera et al., 2022; Eskici et al., 2021; Goninon et al., 2021; Eichfeld et al., 2019; James & Noel., 2013; Hahm et al., 2019; Hammad, 2020; Bahu, 2019). Studies which included matching cultural backgrounds to participants discussed benefits in building therapeutic alliance (Hahm et al., 2019; Hammad, 2020), as well as rapport and trust (James & Noel., 2013; Hammad, 2020; Bahu., 2019). This was particularly notable in studies which included participants with histories of interpersonal traumas whereby participants and facilitators were matched on demographics such as ethnicity and gender. All papers which included cultural matching between facilitators and participants reported training and/or supervision of facilitators to ensure cultural competency is achieved as well as intervention fidelity.

Sociocultural considerations

Most studies included integration of sociocultural considerations into interventions or assessments (k=19). This included ensuring intervention activities were sensitive to participant cultural contexts (Vera et al., 2022; Hinton et al., 2011; Eskici et al., 2021; Pearson et al., 2019; Goninon et al., 2021; Eichfeld et al., 2019; James & Noel., 2013; Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005; Hammad, 2020; Fernandes & Aiello., 2018; Bahu, 2019) as well as the integration of cultural values, beliefs, experiences and practices into assessments or interventions (Vera et al., 2022; Hinton et al., 2011; Jalal et

al., 2002; Eskici et al., 2021; Latif et al., 2021; Goninon et al., 2021; Eichfeld et al., 2019; James & Noel., 2013; Hahm et al., 2019; Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005; Hinton et al., 2013; Madigoe et al., 2017; Hammad, 2020; Fernandes & Aiello., 2018; Bahu, 2019; Chhim, 2012). The integration of faith and spirituality was highlighted in nine papers (Hinton et al., 2011; Jalal et al., 2020; James & Noel., 2013; Kananian et al., 2017; Hinton et al., 2013; Eskici et al., 2021; Madigoe et al., 2017; Hammad, 2020; Bahu, 2019), with many incorporating prayer and/or religious rituals in interventions, or exploring beliefs held around spirituality in assessment. Culturally specific intervention activities were reported in papers which involved aspects of collective prayer (Hammad, 2020; Fernandes & Aiello., 2018), drumming and singing (e.g., darbuka drumming, Nasheed singing, Hammad, 2020), and pranayama breathing exercises (Bahu, 2019).

Most papers integrated culturally relevant metaphors, idioms, and concepts into intervention delivery (e.g., Buddha's arrow and the Chakra system, Bahu, 2019). Normalisation of symptoms was also reported using culturally resonant concepts (e.g., parables and vignettes from cultural texts of cultural heroes who experienced trauma, Fernandes & Aiello., 2018). Culturally relevant visualisations aided intervention exercises in many papers too (e.g., breathing and relaxation exercises, Hinton et al., 2011; Jalal et al., 2020; Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005; Hammad, 2020; Bahu, 2019).

Several adaptations were made to organise sessions to boost acceptability to cultural groups. Examples included groups set up to resemble social gatherings similar to participants' native countries, and restoring culturally familiar ways to participants through cooking traditional group meals with collective storytelling practices (Hammad, 2020).

Psychoeducation

Almost half of papers (k=8) involved psychoeducation on PTSD and trauma symptoms (Hinton et al., 2011; Eskici et al., 2021; Latif et al., 2021; Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005; Hammad, 2020; Bahu, 2020). Unsurprisingly, most of these papers involved adaptations to cognitive behavioural therapy (CBT), where psychoeducation is a key ingredient in CBT treatment. Culturally relevant games and activities were also described in papers to provide psychoeducation around somatic symptoms (e.g., "Kursi Karasi - musical chairs", Eskici et al., 2021). Traditional folklore or oral storytelling (e.g., 'Hikaya', Hammad., 2020; story of Mahatma Gandhi, Bahu., 2019; and Elephant and Six Blind Men to explain exposure, Latif et al., 2021) was integrated into psychoeducation in papers. Culturally

appropriate visualisations and imagery such as a lotus bloom to encode key Asian cultural values of flexibility (Kananian et al., 2017; Hinton et al., 2004; Hinton et al., 2005) were also utilised to promote discussion and psychoeducation amongst participant groups.

Collaboration

Another theme emerged from the findings was collaboration, where over half (k=11) of papers either involved community stakeholders in the delivery of interventions (Vera et al., 2022; Eskici et al., 2021; Galano et al., 2017; Pearson et al., 2019; Gibson et al., 2021; Kananian et al., 2017; Hammad, 2020; Bahu, 2019), and/or involved consultation with participants (Vera et al., 2022; Hahm et al., 2019; Kananian et al., 2017; Madigoe et al., 2017; Hammad, 2020; Bahu, 2019; Chhim, 2012). By understanding the social support structures of varied cultural groups, modifications were made to allow support through existing community networks in several papers. Specific examples included liaison with local faith-based community leaders to inform approaches (Hammad, 2020; Bahu, 2019; Chhim, 2012), collaborating with community leaders to host interventions outside of mental health settings such as in a community centre (Hammad, 2020) or local temple (Bahu, 2019), and providing consultation with community stakeholders to develop treatment manuals (Pearson et al., 2019). In one paper (Pearson et al., 2019) an additional pre-session dedicated to engagement and rapport building was added to the treatment manual based on community input and consultation between community stakeholders and participants. Similarly, another study (Vera et al., 2022) reported the opportunity for participants to attend a pre-session dedicated to building trust and offered opportunities for participants to bring along a trusted relative to aid support to partake in the intervention.

Practical considerations

A large proportion of intervention papers discussed making practical adaptations (k=12). Some included adapting the time or length of interventions (Vera et al., 2022; Eskici et al., 2021; Goninon et al., 2021; Kananian et al., 2017; Hammad, 2020), and/or location of treatment (Hinton et al., 2011; Latif et al., 2021; Hammad, 2020).

Modifications to treatment manuals included adapting content to acknowledge the beliefs and experiences of the relevant cultural group. This included content in manuals to refer to Afghan culture with visualisation exercises in one study (Kananian et al., 2017) or removing specific jargon and replacing content with relative cultural examples in others (Hinton et al., 2011; Eskici et al., 2021; Hammad, 2020). Of those reporting practical considerations, a high

proportion of studies referenced an emphasis on encompassing a sensorial or somatic element to interventions (Hinton et al., 2011; Pearson et al., 2019; James & Noel., 2013; Kananian et al., 2017; Hammad, 2020; Fernandes & Aiello., 2018; Bahu, 2019). A notable number of these papers included participants from Asian and Hispanic populations as well as with refugee and asylum-seeking populations.

Several papers which focused on trauma experienced by refugee and asylum-seeking groups (Eskici et al., 2021; Goninon et al., 2021; Kananian et al., 2017) referenced high dropout rate of refugees in treatments due to unsettlement in prior literature, and adapted sessions accordingly which included fewer sessions with longer time devoted to each session. Other studies (Vera et al., 2022; Hammad, 2020) reported longer period of engagement sessions to address mistrust of services.

Training for providers

A small number of papers (k=6) reported training for providers of interventions (Eskici et al., 2021; Goninon et al., 2021; Eichfeld et al., 2019; James & Noel., 2013; Gibson et al., 2021; Bahu, 2019). Papers discussed how training allowed facilitators to ascertain treatment fidelity and to understand the cultural needs of participants. Of these six papers, four studies (Eskici et al., 2021; Goninon et al., 2021; Eichfeld., 2019; Bahu, 2019) involved providers who were mental health professionals, and the remaining two studies involved ‘non-specialist’ peer lay workers (James & Noel., 2013; Gibson et al., 2021). Only two papers reported the time spent devoted to training providers (e.g., 1 week training course, Eskici et al., 2021; 3 months of training, Goninon et al., 2021) with the remaining papers not providing this information. It is also unclear what training included, details of any models or theories underpinning this, as well as who provided the training, as only one paper reported this detail (Eskici et al., 2021). This included training on basic helping skills, psychological first aid, mitigating challenges in group therapies and ensuring fidelity to the intervention protocol.

Stigma

Three papers explicitly referred to addressing stigma within interventions (Jalal et al., 2020; Hammad, 2020; Bahu, 2019). Examples of spirituality were referenced to address cultural stigma in one paper (e.g., trauma believed to be a sign of spirit possession, Jalal et al., 2020). Another paper details how labelling the intervention as a “non-mental health intervention” was important to tackle the stigma and shame often attached to trauma in Muslim communities (Hammad, 2020). Collective discussions between participants around

addressing stigma were also utilised (e.g., harnessing the knowledge of the community to overcome stigma, Bahu, 2019).

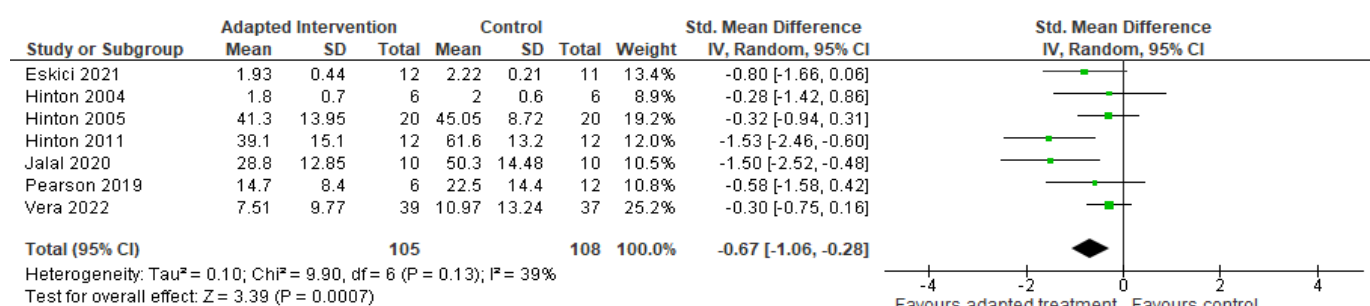
3.4.6 Intervention Effects

A total of seven RCTs (Vera et al., 2022; Hinton et al., 2011; Jalal et al., 2020; Eskici et al., 2021; Pearson et al., 2019; Hinton et al., 2004; Hinton et al., 2005) were included in the meta-analysis to evaluate the effectiveness of culturally-adapted trauma interventions on PTSD severity. Five trials looked at PTSD with co-morbid depression outcomes (Vera et al., 2022; Hinton et al., 2011; Jalal et al., 2020; Latif et al., 2021; Hahm et al., 2019). Co-morbid anxiety outcomes were also reported in five trials (Vera et al., 2022; Hinton et al., 2011; Jalal et al., 2020; Hinton et al., 2004; Hinton et al., 2005).

Of all the RCTs included in the meta-analyses, five RCTs utilised waitlist control comparisons (Latif et al., 2021; Pearson et al., 2019; Hahm et al., 2019; Hinton et al., 2004; Hinton et al., 2005), three used active treatment controls (Vera et al., 2022; Hinton et al., 2011; Jalal et al., 2020) and one study (Eskici et al., 2021) used treatment as usual as a comparator. It is worth noting that for the three trials that used active treatment controls all three utilised applied muscle relaxation. In the case of Eskici et al. (2021), the authors acknowledged that participants in the TAU condition may have received alternative psychosocial interventions, though these were not described in detail. This lack of clarity limits interpretability, as TAU conditions can differ considerably in content. Such variability could influence effect estimates and should be considered when drawing conclusions about the relative efficacy.

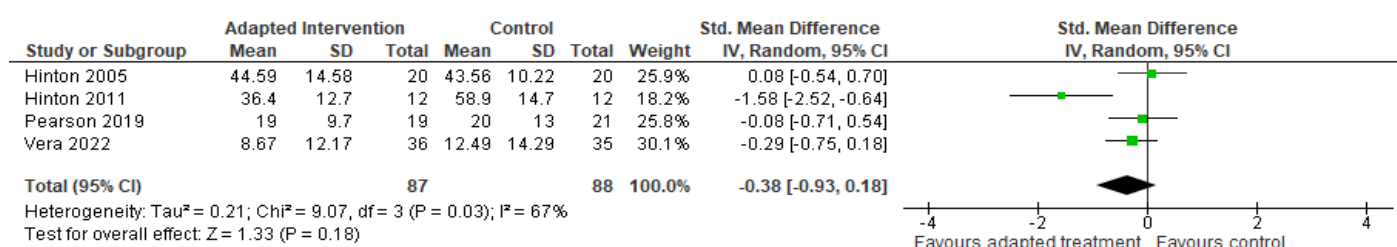
Meta-analyses results comparing culturally-adapted intervention groups with all controls for outcomes on PTSD severity showed the former more effective in ameliorating PTSD symptoms at post-intervention (7 RCTs, $n=213$, SMD -0.67, 95% CI -1.06 to -0.25, $I^2=39\%$). Figure 3 presents the forest plot on PTSD severity at post intervention.

Figure 7. Meta-analysis on participant's PTSD severity at post intervention



Less studies reported outcome results at a 3-month follow-up timepoint, and the meta-analysis results found the post-intervention effects on PTSD symptoms no longer sustained (4 RCTs, $n=175$, SMD -0.38, 95% CI -0.93 to 0.18, $I^2 = 67\%$) (see Figure 4).

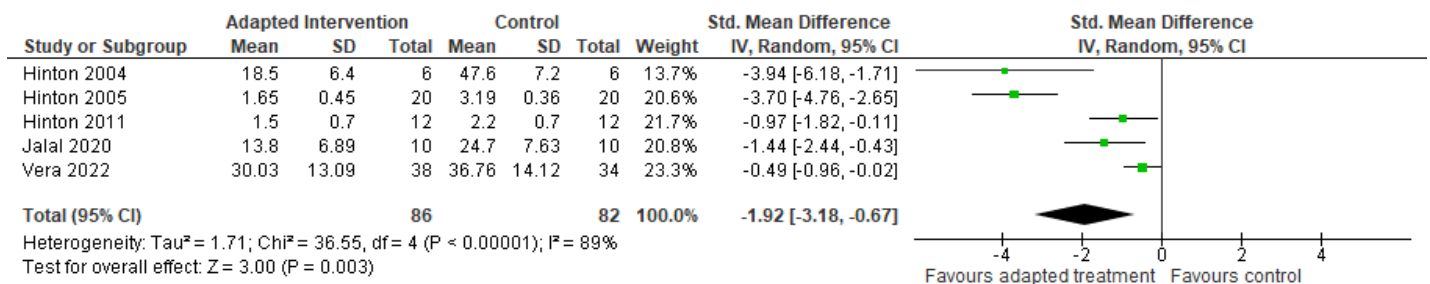
Figure 10. Meta-analysis on participants' PTSD severity at 3-month follow-up



Findings comparing culturally-adapted interventions targeting depression severity outcomes showed no significant effect at post intervention (5 RCTs, $n=206$, SMD -1.07, 95% CI -2.25 to 0.11, $I^2=92\%$). No follow-up data was available on depression outcomes.

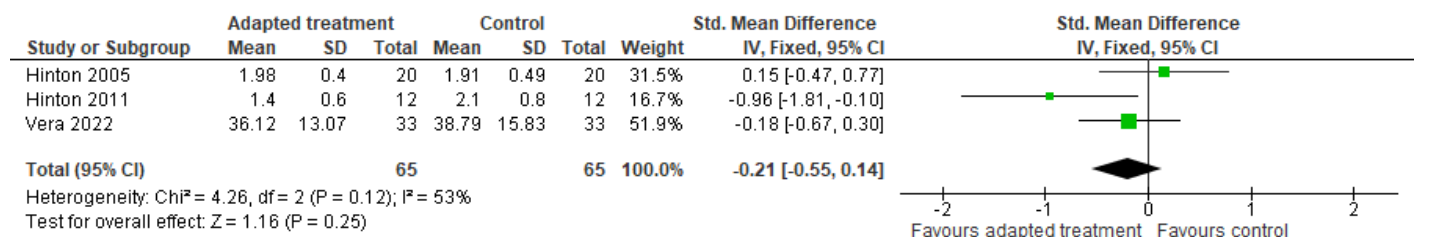
Figure 5 presents a forest plot on anxiety severity at post intervention. Culturally-adapted interventions were found to be superior in reducing anxiety symptoms when compared to control groups at post intervention (5 RCTs, $n=168$, SMD -1.92, 95% CI -3.18 to -0.67, $I^2 = 89\%$). A fixed effect meta-analysis was run for anxiety severity at 3 month follow up and no significant difference in effects on anxiety severity was found between culturally-adapted interventions and controls (3 RCTs, $n=130$, SMD -0.26, 95% CI -0.79 to 0.28, $I^2=53\%$) (see Figure 6).

Figure 13. Meta-analysis on participants' anxiety severity at post intervention



It is worth noting that high levels of heterogeneity were found in the comparisons on depression and anxiety symptom severity outcomes ($I^2 > 75\%$). High heterogeneity may be accounted for by differences in populations (e.g., some trials targeted same-gender participants), others included varied participants exposed to different trauma experiences. Intervention modalities between trials also differed, as detailed in intervention characteristics in Table 1.

Figure 16. Meta-analysis on anxiety severity at 3-month follow-up



3.4.7 Effectiveness Results from Non-RCTs

Six quantitative intervention papers and one mixed methods paper which measured PTSD severity did not use a RCT design (Galano et al., 2017; Goninon et al., 2021; Eichfeld et al., 2019; James & Noel., 2013; Gibson et al., 2021; Kananian et al., 2017) or included no comparable group (Bahu., 2019),

Consistent with the meta-analysis results, all these intervention papers ($k=7$) reported a reduction in PTSD symptoms immediately post-intervention for groups receiving culturally-adapted interventions. Four of these papers (Goninon et al., 2021; James & Noel., 2013; Gibson et al., 2021; Bahu., 2019) reported a statistically significant reduction in PTSD symptoms at post-intervention ($p < .05$). Little data was reported on co-morbid anxiety and depression severity or follow up data across non-RCT study designs.

3.4.8 Participant Experiences

While this review aimed to include both qualitative and quantitative data, only three studies reported qualitative findings on participant experiences, and these were limited in depth. Due to the small number and limited richness of qualitative studies, a formal qualitative synthesis was not feasible. Instead, qualitative data were narratively summarised and integrated descriptively into the second stage of synthesis to provide context around cultural adaptations and their perceived impact on engagement and outcomes.

In terms of participant experiences of adapted trauma interventions, two studies explored this using mixed methods (Hammad, 2020; Bahu, 2019) and one further study using a qualitative design (Fernandes & Aiello., 2018). The qualitative study involved reflective experiences in a therapy group. No papers explored experiences of adapted trauma assessments.

Two of the intervention papers included target populations from refugee groups; one paper (Fernandes & Aiello., 2018) focused on an adapted intervention to support male refugee survivors of rape and torture, and the other paper (Bahu, 2019) focused on trauma related to forced migration among Tamil refugee groups. Participants reported positive benefits from attending the interventions, particularly reporting reduced shame related to trauma following attendance, as well as more confidence navigating the refugee and immigration process. Qualitative data in studies highlighted how stigma and shame had previously impacted participants help-seeking behaviours as well as knowledge around trauma and mental health, and how adapted interventions had positively changed attitudes towards therapy and accessing support. Attendees of the interventions reported how these experiences helped retain engagement with the intervention, and one paper (Bahu, 2019) reported the potential influence on low dropout rates.

As the interventions were delivered in the local language held by participants either through translated materials or the use of language interpreters, participants reported benefits to this in helping engagement with interventions. In all three studies, group discussions encompassed spiritual and religious aspects to promote reflection amongst participants with references to prophetic stories or culturally understood parables. Qualitative data in one paper (Bahu, 2019) showed these techniques and approaches as beneficial in establishing a sense of cultural and collective identity following on from trauma, while the incorporation of faith and spirituality helped validate participants' experiences and manage shame effectively.

3.5 Discussion

This study to my knowledge is the first systematic review focusing on outcomes and experiences of culturally-adapted assessments and varied treatments for trauma experiences among racially and ethnically minoritised groups. Several adaptation methods were found in this review, which included integration of socio-cultural considerations, collaboration, psychoeducation, language, cultural matching, addressing stigma, training for providers and practical considerations. Little adaptations to assessments for trauma were found in the literature. Culturally-adapted interventions can reduce PTSD symptom severity immediately post-intervention among adults from racially and ethnically minoritised groups. Positive feedback was found among participants engaging in adapted interventions, and noted benefits were in help-seeking behaviours for trauma and mental health.

When considered through the lens of the four planes of social being (Bhaskar & Norrie, 2013), the cultural adaptations identified in this review can be understood as targeting different layers of social reality. At the ‘bodies in relation to nature’ plane, practical adaptations (such as accessible locations and flexible delivery formats) address the physical and logistical conditions of care. At the social structures/interpersonal plane, culturally sensitive collaboration or therapist-client cultural matching seek to enhance relational safety. At the social-structural plane, provider training initiatives reflect attempts to embed cultural competence and trauma awareness within organisational practice. Lastly, at the personal plane, adaptations such as psychoeducation, stigma reduction, and language tailoring aim to transform self-perceptions and internalised beliefs about trauma and help-seeking.

Mapping the findings in this way reveals that most adaptations found in this review operate at the individual and interpersonal levels, with comparatively fewer targeting systemic or structural factors. This suggests a need for future intervention development and evaluation to engage more explicitly with the social and institutional contexts that shape trauma experiences for racially and ethnically minoritised groups. For example, through organisational reform and anti-racist practice frameworks, which are being increasingly advocated for in mental health settings (Corneau & Stergiopoulos, 2012).

Results from the meta-analyses showed significant effects of a reduction of PTSD symptoms at post intervention for adapted interventions, however a lack of follow up data makes it difficult to know if results were sustained over longer periods of time. Meta-analysis results

suggest slightly beneficial effects on reducing anxiety severity more so than depression severity for adapted interventions.

Non-RCT papers which were not included in the meta-analyses mostly reported statistically significant reductions in PTSD severity among participants which looks promising. These interventions should be further tested in randomised controlled designs to offer more conclusive understandings of intervention effects for these adapted treatments. Indeed, further evaluation would be beneficial to test these interventions with greater sample sizes and controlled conditions. Future research should also report a more detailed exploration of participants' experiences of adapted interventions, given only a handful of papers exploring this in this review.

A number of papers in the review focused on targeted interventions to support refugee and asylum-seeking populations. In line with prior literature, targeted interventions that seek to address the psychosocial needs of populations impacted by war, conflict and persecution hold many benefits (Turrini et al., 2019). Whilst experiences of trauma among these populations is likely to vary (e.g., post displacement trauma, fear of persecution), this review shows adapting trauma interventions to focus on somatic and sensorial elements of trauma symptoms can cater to the diverse needs of refugee populations with trauma. Additionally, Western diagnostic labels, language, ideas, and beliefs are encouraged to be avoided. Health systems of care offered to refugees may also benefit from specialised treatments available and offered within existing community networks accessed by refugees (e.g., shelter homes). Indeed, health services and humanitarian agencies provisioned to support refugees and asylum-seeking populations would ideally involve collaborative, multi-agency input to account for the complex and varied needs of these populations as discussed (e.g., housing, health, legal support, etc.) (Butt et al., 2019). Whilst psychosocial interventions aimed to address trauma among refugee and asylum-seeking populations are necessary, simultaneously challenging oppressive systems and the socio-political contexts that often lead to trauma (e.g., systemic violence, ethnic conflict, or war) is also as important (Hammad & Tribe, 2020).

Integrating sociocultural considerations into the design and facilitation of interventions and assessments were the most reported adaptations found in this review. Several studies in prior literature have argued that Western centred beliefs can often dominate models of evidence-based psychotherapy and treatment (Rathod & Kingdon, 2009; Koç & Kafa, 2019). This

argument in theory justifies how culturally-adapted interventions should incorporate the local cultural and social experiences of populations into interventions in a way to understand, validate, and work alongside the cultural needs of those accessing mental health services.

In line with reviews that have adapted interventions to target depressive and anxiety disorders (Vally & Maggott, 2015; van Loon et al., 2013), this often includes reference to culturally understood metaphors, analogies, and imagery to support therapeutic intervention. In this review, parables, culturally understood stories or folklore, imagery and metaphors all had benefits in assisting with psychoeducation of trauma symptoms, to aid in treatment activities such as breathing or relaxation work, as well as to address mental health stigma and shame among these populations. Emotion regulation and distress tolerance skills were supported using local philosophy (e.g., drawing on Asian philosophy, Buddhism) and mindfulness practices to help ground participants with trauma. In addition, various cultures will hold specific beliefs and ideas about how and why trauma may occur in individuals which may be rooted through religious means. Framing interventions that capture the local explanatory models of illness could therefore be a way to culturally ground interventions and have practical use in facilitating interventions with religious groups. Further, different cultural groups will have varied methods of relieving distress associated with trauma. This review shows how treatment activities that include local cultural practices to promote coping strategies may be of therapeutic use here, such as addressing coping methods such as prayer, or collectivist cultures accessing supportive methods through community systems.

Several intervention papers in this review reported advantages to culturally matching participants with facilitators with regards to demographic characteristics, often ethnicity and gender. Prior research has produced mixed findings with regards to the utility of ethnic or racial matching of facilitators of interventions and service users, with two meta-analyses suggesting cultural matching does not impact treatment engagement or outcomes (Shin et al., 2005; Cabral & Smith, 2011), and some studies reporting clinical use of cultural matching (Flicker et al., 2008; Horst et al., 2012).

What is clear though amongst prior research, is that patient preferences for cultural matching are somewhat higher for some racial groups such as African Americans (Cabral & Smith, 2011). In this review, a large proportion of papers that involved cultural matching included target populations who had experienced interpersonal violences such as sexual assault and rape. Perhaps here on a contextual level, reported benefits in this review may relate to a sense

of rapport building through matching that captures the racialised and gendered elements of sexual trauma; whether elements of trust and safety following sexual harm may in fact be easier to build on through cultural matching. This becomes more apparent given the known impact experiencing interpersonal violence can have on trauma victims trusting others (Gobin & Freyd, 2014), and navigating relationships (Bell et al., 2019). This may not be as important in the prior literature which includes findings from varied service user populations who may or may not have been exposed to trauma or sexual violence.

Of note, all service providers which were culturally matched with service users in this review did report access to clinical or case management supervision for facilitators. Important factors that underpin this decision for service providers to culturally match groups therefore must include careful consideration to the nature of trauma, cultural group, patient choice, and access to effective, culturally relevant supervision for providers. On an organisational level, an argument can be made here to therefore increase racial diversity amongst staff offering care in trauma services to ensure cultural matching can be met or at least be considered should patients prefer and request this. This would indeed be on par with aims within global health systems to achieve racial equity by diversifying the healthcare workforce (Hussain et al., 2020; Rao et al., 2018).

Several interventions in the review were facilitated through group work by peer lay workers. NICE guidance does reference peer support to compliment treatments of PTSD (NICE, 2018). The empirical literature has cited many benefits of peer support in supporting service users with mental health needs and has become a rapidly growing area of interest for clinical services to implement peer support among services (Repper & Carter, 2011). Given that experiencing trauma can disconnect individuals from others (Dorahy et al., 2009) and additionally induce a lack of belonging felt amongst victims (Ellis et al., 2015), utilising group methods facilitated through peer support may be a strong therapeutic resource. It is possible that trained peer lay workers that were included in this review with lived experience of the needs of target populations who benefited from interventions, shows some support to the importance of group-based peer support in the therapeutic management of trauma.

It is difficult to explore potential mechanisms of change with such small relevant evidence and compare wider experiences of care in this review. It is therefore recommended that future research would benefit from inferring in greater detail the participant experiences of adapted interventions through further qualitative analysis methods, complemented with robust, RCT

designs over longer follow up periods. The lack of follow up data across most intervention papers in this review means it is difficult to explore whether intervention effects are sustained or extended to clinically meaningful differences (e.g., better quality of life, functioning) over time, a crucial factor to determining effectiveness of treatment interventions (Kendall, 2003). Only three papers included in this review focused on cultural adaptations to the assessment of trauma among racially and ethnically minoritised groups, and few studies explored CPTSD and complex trauma experiences among racially and ethnically minoritised groups.

Assessments for trauma that lack cultural sensitivity may inadvertently neglect or misinterpret the unique challenges racial groups face when addressing their trauma needs in services. As found in this review, assessment methods that capture culturally specific expressions for trauma, such as acknowledging spiritual explanations to trauma, may mitigate overlooking the needs of service users and instead contribute to feeling misunderstood by services, a common experience reported by racial groups accessing services (Taylan & Weber, 2023). This not only may strengthen mistrust towards healthcare providers, but inadequate assessments may also worsen the distress individuals are already facing, risking further iatrogenic harm from services (Faulkner et al., 2021). This largely justifies the vital research need for empirical work exploring adapted trauma assessments for racially and ethnically minoritised groups.

3.5.1 Implications for Future Research, Practice, and Policy

Whilst culturally adapted trauma interventions appear to be effective, greater research is needed to test interventions over longer follow up intervals. When developing and testing adapted trauma assessments collaborating throughout the research process with racially and ethnically minoritised groups is recommended to capture unique sets of preferences, experiences, and needs of these groups. Consultations and collaboration with service user groups and community stakeholders in the development of adapted interventions and assessments are recommended, which may include establishing connections with community leaders and cultural organisations to help practitioners deliver more culturally resonant care.

Addressing sub-group differences and the specific, tailored needs of various racial groups is an important aspect of the adaptation process and remains an important consideration for clinical practice. This may involve personalising assessments and interventions that integrate culturally relevant languages, practices, and values into the therapeutic process.

With regards to policy, national and regional health agencies may wish to revise guidelines for trauma care to review cultural adaptations for the assessment and treatment for trauma. Expanding efforts to fund and increase racial diversity in the mental health workforce may have both organisational and clinical benefits for mental health service providers and users. In addition, more research funding should be considered to develop adapted interventions, and to equally evaluate and explore the benefits of adapted interventions. Crucially, policies should support collaboration between mental health providers and community stakeholders to ensure that trauma care is accessible to diverse groups who may be seeking support through services

3.5.2 Limitations

Whilst there are many strengths to conducting this mixed methods review, limitations exist. Interventions and assessments included in the review were developed to address different target population groups. The depth and content of the cultural adaptation processes therefore may differ between groups, due to the commonalities and differences of cultural needs across varied populations groups. This additionally exposes potential challenges when comparing diverse cross-cultural studies in a meta-analysis. I also was only able to review papers published in peer-review journals, reducing the scope for finding suitable material in grey literature. It is possible that information existent within the grey literature may have included applications of adapted interventions which may have been useful for the review.

An additional consideration when interpreting these findings is the nature of the comparison condition used across studies. In several cases, the control group was treatment as usual (TAU) or a waitlist, while in others an active comparator intervention was employed. It is possible that effect sizes may be inflated when interventions are compared against non-active controls (TAU/waitlist), relative to when they are compared against another structured therapeutic approach. This introduces heterogeneity that cannot be fully accounted for in the present analysis. Although some meta-analyses address this issue by conducting subgroup or sensitivity analyses to separate studies with active versus non-active comparators, this was not undertaken here due to the small number of studies in each subgroup, which limited the feasibility and interpretability of such an analysis. Instead, this potential inflation of effect size estimates is acknowledged as a limitation of the present synthesis.

3.5.3 Conclusion

The evidence base showcasing the effectiveness and experiences of culturally-adapted trauma assessments and interventions remain small. This systematic review aims to add evidence to the empirical literature addressing prior gaps and methodological limitations. Results from this review highlight the importance of tailoring interventions and assessments of trauma for specific racially and ethnically minoritised groups. Future research should test intervention effects over longer follow up periods for further conclusive findings around the sustainability of interventions to address trauma outcomes. Research should ensure guidance on adaptation processes is detailed for greater reciprocity of findings, and further studies exploring experiences of interventions or assessments is recommended.

3.6 Chapter Summary

This chapter depicted the work conducted as part of my systematic review. The work set out to explore the current evidence base surrounding cultural adaptations to the assessment and treatment of trauma experiences among racially and ethnically minoritised groups. I immediately understood that the evidence base within this area remains scarce. The review identified several adaptations used across studies which I narratively described. I also was able to determine the effectiveness, and to some extent, the experiences of these adapted interventions among racially and ethnically minoritised groups. This preliminary work was foundational to having a greater understanding of the current evidence base in adapted trauma care for racialised minorities. It allowed me to remain curious about the findings and how they may relate to the real-time clinical practices, which I go on to explore and discuss in the next chapter through Phase 2 of my research focusing on electronic clinical records.

4 CHAPTER FOUR: CLINICAL RECORDS STUDY

4.1 Chapter Overview

In this chapter I present the clinical records study that explored demographic variations in the receipt of trauma care among mental health service users. This work was to understand the ways by which services are currently responding to the needs of service users, crucially understanding real time practices that assess and support trauma experiences. I outline further literature to illustrate a need for this work, the methods used, as well as interpreting the findings later in the chapter.

4.2 Introduction

Reducing ethnic inequalities in healthcare outcomes has been a top priority in government policy in the United Kingdom (UK) for over two decades (Marmot, 2020). One major area of healthcare where there are consistent ethnic disparities in access and experiences of services is within mental health care. In the UK there are known ethnic variations in pathways to specialist mental health services, with Black adults in particular experiencing more acute routes of entry to services, often involving police or detention under the Mental Health Act (Barnett et al., 2019). Potential explanations from prior systematic reviews suggests stigma towards mental illness and mistrust of care providers may deter Black adults from accessing support via traditional care pathways at earlier stages of illness and consequently entering services at points of crisis (Devonport et al., 2023).

Understanding the underlying causes of variations and disparities in healthcare is still complex, but a strong consensus has emerged on the importance of examining the wider social determinants of health, economic disadvantage, discrimination, and variations in help seeking behaviour as potential explanations for ethnic inequalities reported in healthcare (Alegria et al., 2018). In addition, explanatory beliefs around mental illness, what causes such, how this is experienced, and how illness should be addressed, will vary by cultural groups (e.g., distress being routed through spiritual means or coping mechanisms) which, in turn, may influence help-seeking behaviour and varied engagement with services (Maura & Weisman de Mamani, 2017).

Overlaying these challenges is another notable disparity, in that Black groups are more likely to be diagnosed with severe mental illnesses, such as schizophrenic disorders (Olbert et al.,

2018), disorders strongly associated with more intensive secondary care involvement (Fok et al., 2012; Jauhar et al., 2022). There is additional evidence from several meta-analyses that have published findings depicting high incidences of childhood trauma among individuals with severe mental health illnesses, including borderline personality disorder (Porter et al., 2020) and schizophrenia (Bonoldi et al., 2013). However, despite the role of trauma in the potential development and maintenance of severe mental illnesses, routine screening for trauma and trauma informed care is relatively absent within secondary care services (Sweeney et al., 2018). This creates a pressing gap, which I argue is maintaining a lot of racial injustices these groups face navigating services: Black adults are overrepresented in high-intensity care where trauma is common, and yet, often encounter care systems that do not routinely, nor appropriately, always recognise or assess their trauma histories.

This omission has far-reaching consequences. Without robust trauma assessments at service entry points (e.g., initial consultations), service users may receive inappropriate diagnoses and not access appropriate interventions to address their needs. Further, individuals with trauma may find services as invalidating as a result, or worse, harmful (Sweeney et al., 2018). For Black adults whose mental health difficulties may already be shaped by racial trauma and racism, the absence of culturally attuned mental health assessments can erode trust in care and contribute to feelings of being misunderstood (Snowden, 2003).

A culturally responsive approach within assessments therefore widens the ability for better formulation of presenting difficulties of service users from racialised backgrounds and mitigates against common invalidating experiences reported (Protocol, 2014). On an organisational level, inadequate assessments create subsequent delayed access to interventions for trauma-related difficulties, and the appropriate support service users need or desire become inaccessible. But I also argue trauma is not just a clinical and structural concern, it is a relational one. Asking the right questions, in the right way, and by the most appropriate person, is equally as important to ensure those with trauma feel understood and safe enough to embark on accessing trauma care offered within services, particularly for those from racialised backgrounds at risk of feeling misunderstood at the outset (Protocol, 2014).

Acknowledging this intersection between culture and mental health in assessments therefore has mutual benefits between service users and services, but importantly also opens the opportunity for sensitive, culturally informed enquiries of the needs of trauma service users

and what appropriate support may look like thereafter. With this in mind, this gives value to an exploration of ethnic variations in the receipt of mental health needs assessments at entry points to services, and whether there is any influence on outcomes by ethnic group among other demographic factors. Entry points were of specific interest in this study, partly because they are typically key moments in a care pathway that can crucially determine the trajectory of a service users' journey within services and their treatment planning. These entry points in this study refer to specific engagements where initial assessments or consultations, for example, are either conducted or missed. While these assessments are not *explicitly* designed to evaluate trauma experiences, this study focuses on whether these broader assessments are incorporating routine screening for trauma given the aforementioned factors above, and whether this differs by ethnicity.

The National Health Service (NHS) in the UK has a legal requirement to record clinical information onto secure databases as a means of reviewing healthcare provision across the UK, and to allow insight to potential inequalities in access to, and outcomes of, healthcare usage nationally. As part of this, ethnicity data (among other demographic data) inputted onto these systems provides real time data of experiences of care and a greater analysis of where disparities may be present to advocate changes in policy, practice, and preventative methods (Alderwick & Dixon, 2019). This is an explicit part of organisational strategy set out in the NHS Long Term Plan (NHS England, 2019), a national plan to improve healthcare service provisions and experiences of patients accessing them.

This study utilised NHS electronic healthcare records to explore ethnic variations in the receipt of trauma assessments and treatment referral among secondary and tertiary mental healthcare service users. Secondary care services within SLaM involve specialist services for those with moderate to severe mental health conditions, with care typically provided within the community. For example, secondary care services within SLaM involve community mental health teams (CMHTs), home treatment teams (HTTs) and A&E psychiatric liaison teams. Tertiary mental health care services within the trust provide services provisioned for those with complex and high-risk needs, such as specialist forensic secure units, or for individuals requiring long term-intensive care (e.g., neuropsychiatry services).

Specifically, the aims of the study were to:

1. Explore the sociodemographic characteristics of all new referrals to adult community mental health services, secondary care mental health services and tertiary mental health services in one borough in an inner London mental health NHS trust between February 2022 and March 2022
2. Describe demographic variations in completion rates for routine assessment and treatment referral for trauma at assessment points (including points of access).

To achieve these aims, the following research questions were developed:

1. What are the demographic variations among those accessing services and associated entries related to trauma?
2. What are the types of trauma entries being recorded on clinical records?
3. What are the referral outcomes following trauma entries and are there any variations by demographic groups?
4. What are the service use and medication outcomes among those accessing services?

4.3 Methodology

4.3.1 Study Setting and Population

This study utilised data from South London and Maudsley NHS Foundation Trust (SLaM). SLaM provides mental health services for approximately 1.3 million residents (Perera et al., 2016) across four South London boroughs (Southwark, Lambeth, Lewisham, and Croydon). This study focused on care among Southwark residents given it being a highly ethnically diverse borough, with half (51%) of residents identifying from a White ethnic background, a quarter (25%) identifying as 'Black, Black British, Caribbean, or African, one tenth (10%) identifying as Asian or Asian British, and just under one tenth (7%) reporting their ethnic group to be 'Mixed or having multiple ethnicities' (ONS, 2023). Having an ethnically diverse sample was important given the literature I have reported on inequalities in accessing healthcare among racialised minority populations.

This study focused on individuals referred to secondary and tertiary care mental health services within SLaM and did not include data from Improving Access to Psychological Therapies (IAPT) services, which operate at the primary care level. Eligible patients were

adults between 18-65 years old during the window period. Referrals made that were rejected were not eligible for this study. Given that there are specific and tailored provisions for children and adolescent mental health services (CAMHS) as well as for older adults (65+) in SLaM, this study only focused on adult mental health service data within SLaM. I captured data for all new referrals to Southwark adult secondary and tertiary care mental health services in SLaM within the window period of 1st February 2022 and 1st March 2022.

Information from patients in this study were identified using the Clinical Record Interactive Search system (CRIS NLP Service, 2020). CRIS uses a case register system that de-identifies electronic clinical records from secondary and tertiary mental health care services in several mental health NHS trusts nationally in England. Data pulled from the CRIS database includes data from both structured fields and unstructured fields (i.e., free text). Structured fields include clinical information such as method of clinical note (e.g., correspondence), diagnostic information using ICD-11 coding, date of birth, gender, ethnicity, and so forth. Unstructured free text includes information inputted by professionals into these notes, such as clinical formulations and assessment notes. Information from both structured and unstructured fields was used to ascertain relevant data was pulled from CRIS for the purposes of this study.

4.3.2 Data Extraction

For data extraction of structured text fields, the following categories were used: date of birth, ethnic group, gender, age, employment status, country of origin, marital status, deprivation quartile, the index date (first accepted date in window), index locations (team or ward name) and diagnosis (ICD-11 F codes).

Ethnicity data

Ethnicity data was pulled from the CRIS system which contained self-ascribed ethnicity information inputted onto clinical records by staff working in services. For the purposes of the analysis, I then collapsed these categories into five groups: Asian (including Asian British), Black (including Black British, Caribbean, African), Mixed or multiple ethnic groups, White or White other, and Other ethnic group. For missing data, free text entries were screened to see if any information pertaining to this was found and consequently added to the ethnicity data.

Service-related data

Mental health service division variables were aggregated from categorising the location or team where referrals and clinical entries were noted at the point of index date. Content analysis techniques (Drisko & Maschi, 2016) were employed to group healthcare teams into thematic categories based on their specialised functions and areas of care. These were then categorised into the following divisions of care that emerged from a content analysis of the available data, and included: acute and crisis care (e.g., A&E liaison psychiatry, home treatment teams, place of safety units); community mental health services (e.g., CMHTs); medical services and outpatients (e.g., general hospitals, outpatient clozapine clinics); and neuropsychiatry (e.g., specialist tertiary units).

Information on service-level eligibility criteria and pathway restrictions was not available. For example, within NHS secondary care, service users are typically not able to be active in multiple care pathways simultaneously (e.g., crisis services and specialist PTSD/trauma services), and some trauma services require abstinence from substance misuse before referral is accepted. These features of service delivery were not captured in the dataset and therefore could not be examined in the present study.

Diagnosis data

Structured text fields pulled from CRIS allowed for information relating to diagnosis to be explored. This meant that primary diagnoses on patient records were extracted by the electronic records system, which includes ICD-11 diagnoses (World Health Organisation, 2018) for mental, behavioural, and developmental disorders among service users. F Codes (F01-F99) from the ICD-11 were extracted and then aggregated into the following: anxiety disorders; behavioural and emotional disorders with onset usually occurring in childhood or adolescence; eating disorders; mental and behavioural disorders due to psychoactive substance use; mental disorders due to known physiological conditions; mood disorders; personality disorders; pervasive and specific developmental disorders; schizophrenic disorders and lastly unspecified mental disorder.

4.3.3 Data Analysis

All variables were analysed descriptively with summaries tailored to the data types. Categorical variables such as gender, ethnicity, deprivation decile, mental health service type, diagnosis, and trauma type were summarised using frequencies and proportions. Continuous

variables (e.g., age) were summarised using measures of central tendency (e.g., mean) and dispersion (standard deviation and range) to provide an overview of their distribution. The use of electronic healthcare data presented limitations in data completeness, and a large proportion of missing data limited the feasibility of conducting statistical comparisons, and thus no inferential statistics were performed. This descriptive analysis approach ensured that the data were presented in a manner consistent with their scale and characteristics and ensuring an accurate, transparent depiction of the demographic and clinical variations in trauma care.

Trauma data analysis

Notes were screened to identify relevant variables that could be included in the analysis relating to trauma experience. I used content analysis techniques (Drisko & Maschi, 2016) reviewing the overall free text data of those who had a trauma experience clinical record entry and then noting data of interest. These data were then coded defined by common and relevant themes in the data across entries using an iterative approach. In this study childhood trauma and in particular childhood sexual abuse (CSA) was categorised separately, this was primarily due to findings from systematic reviews and longitudinal studies illustrating significantly poorer mental health outcomes among CSA victims in adulthood, when compared to other childhood trauma experiences (Hailes et al., 2019; Fergusson et al., 2013).

The data does not include complete case formulations, detailed symptom profiles, or long-term care plans. Nor does it capture clinicians' reasoning about why trauma histories were not recorded or acted upon at particular encounters. This reflects the inherent structure of routinely collected electronic health records which are designed primarily for clinical and administrative purposes rather than research. As such, while this data provides valuable insight into what is documented in practice it cannot capture the full context of clinical decision-making.

Referral outcomes analysis

Binary variables were created to capture three key aspects of trauma-related care: (1) whether any trauma experiences were documented in clinical entries for each service user; (2) whether a trauma assessment or exploration of trauma-related needs was subsequently offered or considered following a recorded trauma entry; and, (3) whether a referral to, or consideration of, trauma-specific treatment was made after a trauma experience was documented.

Assessments or considerations of further trauma support had to explicitly centre on addressing or acknowledging the trauma in the clinical note, rather than generic support (e.g., a medical follow up in primary care). This distinction was necessary to ensure the analysis accurately captured instances where trauma was meaningfully engaged with, rather than instances of generic follow-up. Including only trauma-specific responses allowed for a more precise evaluation of how services are responding to trauma disclosures or recorded trauma entries. Information that pertained to trauma was then captured which included: how trauma was mentioned in clinical notes (e.g., from a psychiatric liaison note), method of trauma assessment (e.g., use of a trauma questionnaire), and any outcomes mentioned that were recorded following the entry of trauma (e.g., medical follow up, referral for trauma therapy). This was to ascertain greater insight into how clinicians and services are responding to trauma being reported, and as such, any other outcomes service users had within other entries whereby trauma was not mentioned were not coded.

I created categories for the method of assessment and outcomes by carefully reviewing the data and identifying common outcomes of interest using content analysis (Drisko & Maschi, 2016). After this, I grouped the data into these categories and combined them.

Of note, the dataset did not include information on the timing of referrals or delays between initial presentation and subsequent access to specialist trauma pathways. As such, it was not possible to determine whether trauma-related care occurred after the study observation window or following initial stabilisation in community or crisis services.

Medication and service use analysis

Natural language processing (NLP) methods were used to interrogate data in structured data fields and specific machine learning algorithms existent on the CRIS system (CRIS NLP Service, 2020) and allowed me to use structured algorithm applications to text-mine and identify data. This data pertained to service use and medication outcomes, such as admissions to an inpatient ward in Southwark within 6 months after the index date; if antipsychotics, antidepressants, or mood stabilisers were newly prescribed or renewed in those previously prescribed on a patient record within 6 months after the index date. These were selected a priori based on their clinical relevance among mental health service users rather than being chosen post hoc due to specific findings in the data.

The NLP algorithms identified all mentions of medications within these categories, regardless of dosage or indication. It is important to note that NLP tools do not reliably capture data on

psychosocial interventions (e.g., psychoeducation), and as such, concurrent psychosocial treatment alongside pharmacological interventions could not be examined through structured NLP algorithms. Data extracted by NLP methods were categorised into binary and categorical variables (e.g., inpatient admission, psychotropic medication type), and variations by demographic variables were then analysed and described.

4.3.4 Ethical Approval

Approval was made for CRIS to be used for the purposes of secondary data analysis by the Oxfordshire Research Ethics Committee (REC: 23/SC/0257). A letter of access was obtained in order to use the CRIS database (see Appendix B). Due to this study using data from de-identified data informed consent was not required (Stewart et al., 2009). This specific study was ethically approved within the CRIS Oversight Committee (Reference: 23-039; August 2023). An honorary contract with SLam was provided as well as training was provided by the Maudsley BRC on ethical data collection when using clinical records.

4.4 Results

Data from 702 SLam patients who met eligibility criteria were extracted from the CRIS database. After accounting for missing and unusable data (n=18), this resulted in 684 electronic healthcare records left for review. Reasons for unusable data were: patients within our index date had been accepted but not currently been seen and as such there is no recorded clinical information; if there were no clinical notes on presentation, assessment or referral; or electronic healthcare records were simply missing.

Clinical and sociodemographic characteristics of service users with and without trauma or childhood trauma are summarised in Table 3. The overall patient sample included all entries pulled from the CRIS system that matched the inclusion criteria, including those with or without an entry of trauma experience. The trauma sample made up those of the overall sample who had at least one entry of trauma experience recorded on clinical records, including both adulthood and childhood traumas. The childhood trauma sample included any clinical entries that explicitly recorded an experience of childhood trauma (e.g., history of childhood sexual abuse, childhood neglect). Categorical variables that detail variations in trauma experience type are depicted further below.

Table 3. *Sociodemographic characteristics of service users accessing SLaM services*

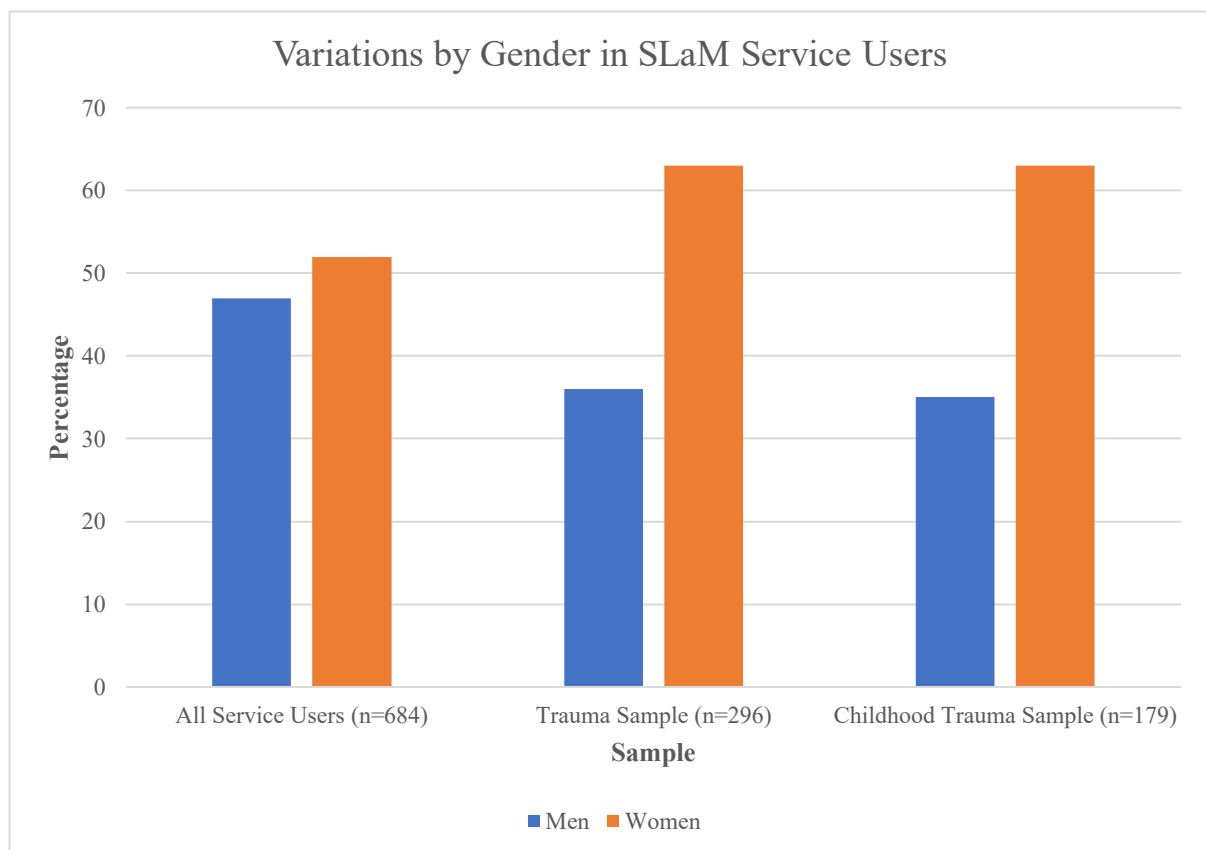
	Overall sample (N=684)	¹Trauma sample (N=296)	Childhood trauma sample (N=179)
Demographics	N (%)	N (%)	N (%)
Gender			
Men	322 (47)	106 (36)	63 (35)
Women	357 (52)	186 (63)	113 (63)
Other	5 (1)	4 (1)	3 (2)
Missing	0 (0)	0 (0)	0 (0)
Ethnicity			
White	297 (43)	143 (48)	91 (51)
Black (Black British, Black Caribbean, or Black African)	214 (31)	83 (28)	51 (28)
Mixed or multiple ethnic groups	26 (4)	16 (5)	9 (5)
Asian or Asian Other	31 (5)	9 (3)	2 (1)
Other ethnic group	37 (5)	20 (7)	11 (6)
Missing	79 (12)	25 (8)	15 (8)
Age			
18-25	161 (24)	90 (30)	64 (36)
26-35	184 (27)	77 (26)	51 (28)
36-45	140 (20)	57 (19)	29 (16)
46-55	124 (18)	52 (18)	26 (15)
56-64	75 (11)	20 (7)	9 (5)
Missing	0 (0)	0 (0)	0 (0)
Service Division			
Acute and crisis care	414 (61)	198 (67)	125 (70)
Community mental health services	195 (29)	71 (24)	46 (27)
Medical services and outpatients	65 (10)	24 (8)	7 (4)
Neuropsychiatry	10 (1)	3 (1)	1 (1)
Missing	0 (0)	(0)	0 (0)
Diagnosis			
Anxiety disorders	40 (6)	19 (6)	11 (6)
Behavioural and emotional disorders with onset usually occurring in childhood	13 (2)	0 (0)	0 (0)
Eating disorders	5 (1)	1 (0.3)	0 (0)
Mental and behavioural disorders due to psychoactive substance use	37 (5)	17 (6)	8 (4)
Mental disorders due to known physiological conditions	4 (1)	2 (1)	1 (1)
Mood disorders	84 (12)	40 (14)	21 (12)
Personality disorders	62 (9)	39 (13)	27 (15)
Pervasive and specific developmental disorders	6 (1)	2 (1)	2 (1)
Schizophrenic disorders	140 (20)	46 (16)	24 (13)
Missing	293 (43)	130 (44)	85 (47)
Deprivation decile			
1 (most deprived)	169 (29)	76 (26)	49 (27)
2	250 (43)	104 (35)	66 (37)
3	131 (22)	61 (21)	38 (21)
4	25 (4)	12 (4)	7 (4)
5 (least deprived)	11 (2)	7 (2)	3 (2)
Missing	98 (14)	36 (12)	16 (9)

¹Includes those with childhood trauma. Percentages may not total exactly 100% due to rounding.

Overall demographic service user data

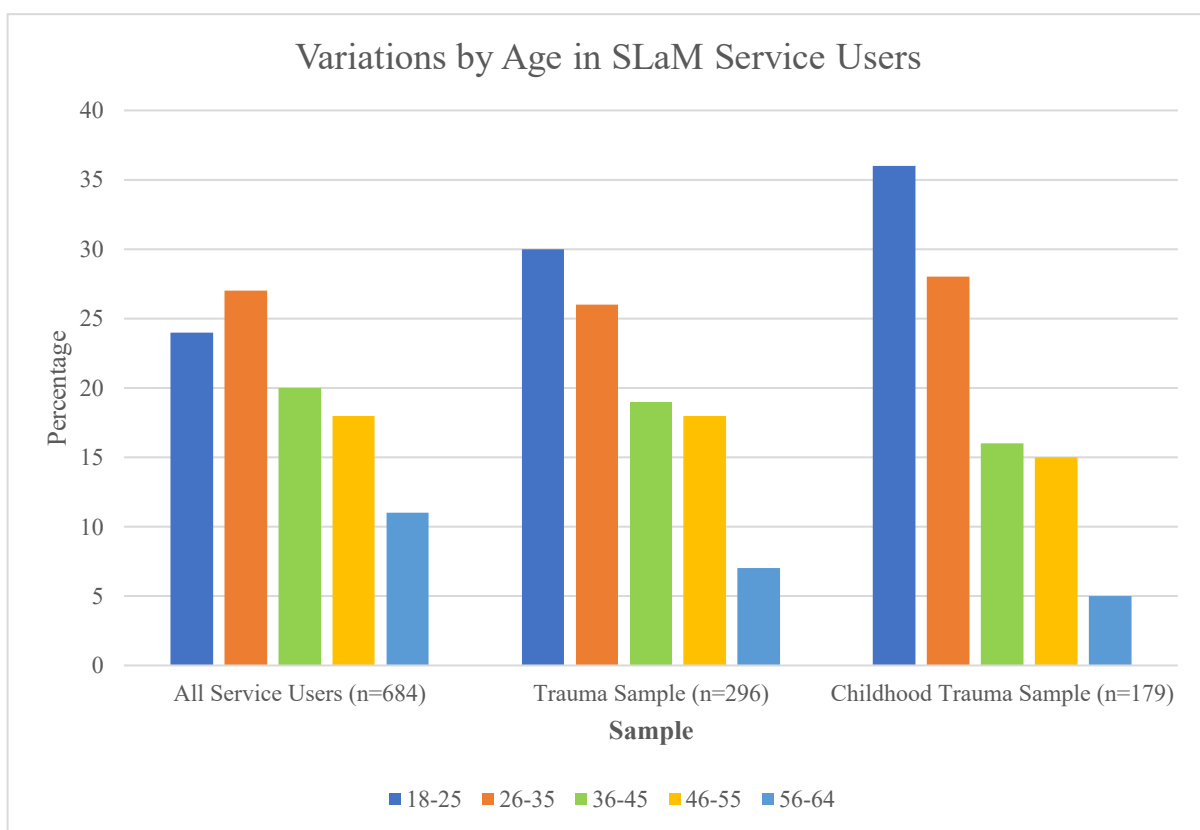
Data were extracted from the CRIS system from a total of 684 service users. Of all those accessing services (n=684), 296 (43%) had at least one entry of trauma experience recorded on clinical records. When uniquely exploring those with these trauma entries, childhood trauma records made up most experiences (n=179). There were no missing data across gender, age, and service-type domains. However, missing data were present across ethnicity (n=79, 12%), diagnoses (n=293, 43%) and deprivation level (n=98, 14%) domains, when describing the overall sample. Just over half those accessing services in the sample, regardless of trauma entry, were women (n=357, 52%) and this is depicted in Figure 7. This proportion rises when factoring for trauma entries (63%) and childhood trauma entries (63%) entries among women.

Figure 19. *Gender variations across service user sample*



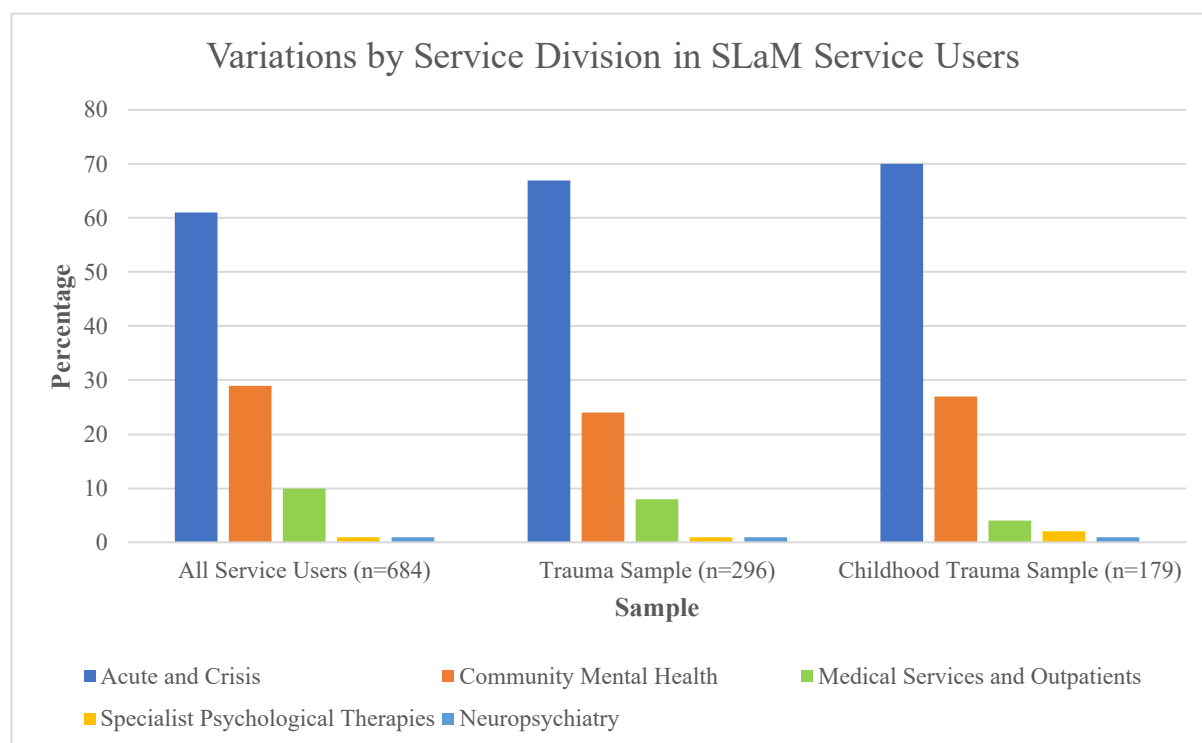
Most of those accessing services, regardless of trauma entry, also had younger ages: 18-25 (n=161, 24%) and 26-35 (n=184, 27%), when compared with older age groups (36-45, n=140, 20%, 46-55, n=124, 18%, 56-64, n=75, 11%), with a detailed breakdown of this shown in Figure 8. The mean age of those accessing services was 37.28 (SD = 12.86, Range = 46).

Figure 22. *Age variations across service user sample*



In addition to the above findings, most service users were accessing acute and crisis care services (n=414, 61%) when compared to other service divisions (community mental health services, n=195, 29%, medical services and outpatients, n=65, 10%, neuropsychiatry, n=10, 1%). Figure 9 shows variations of service use across the sample.

Figure 25. *Service division variations across service user sample*

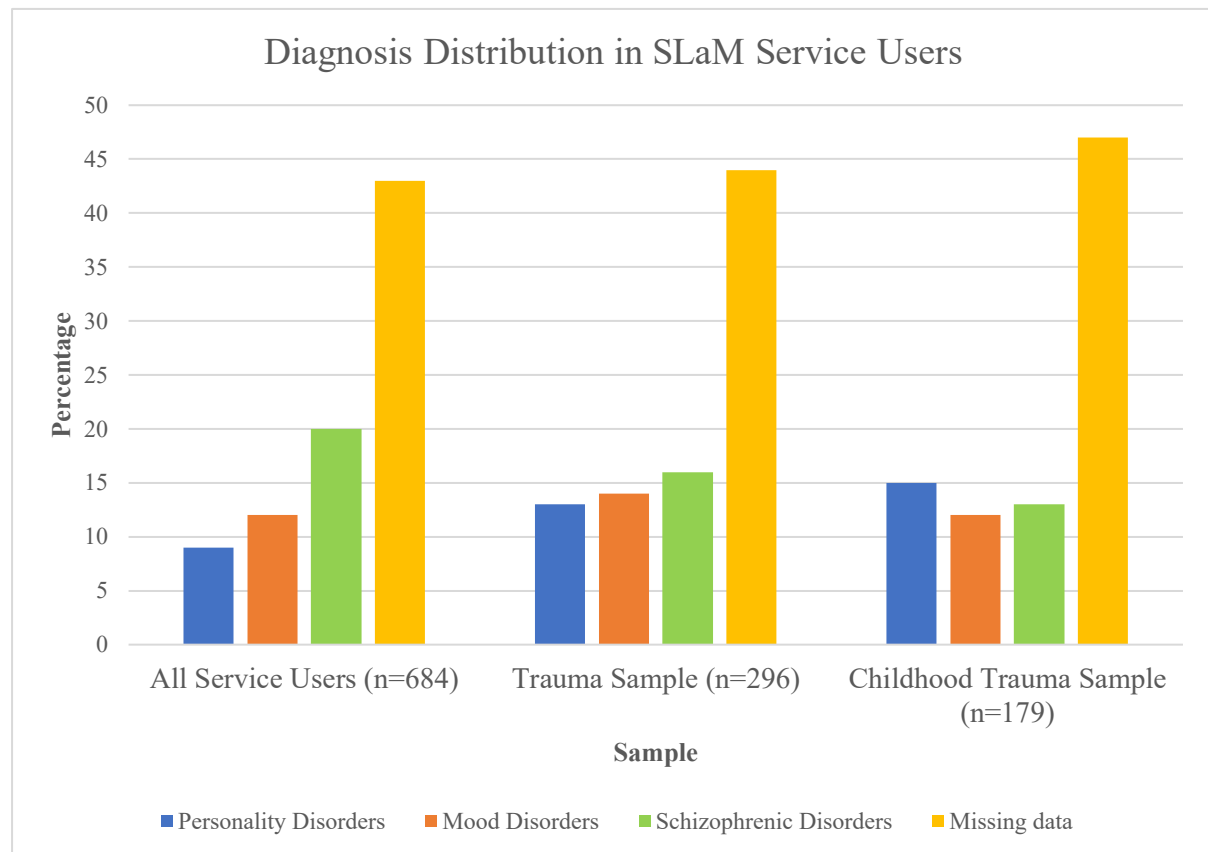


For the domain of diagnoses, the following data was recorded on entries within the total service user sample: anxiety disorders (n=40, 6%), behavioural and emotional disorders with onset usually occurring in childhood (n=13, 2%), mental and behavioural disorders due to psychoactive substance misuse (n=37, 5%), mental disorders due to known physiological conditions (n=4, 1%), mood disorders (n=84, 12%), personality disorders (n=62, 9%), pervasive and specific developmental disorders (n=6, 1%), schizophrenic disorders (n=140, 20%), although a large proportion of diagnosis data was missing (n=293, 43%).

The majority of service users were thus diagnosed with a severe mental illness (SMI) entering services, including schizophrenic spectrum disorders, bipolar disorder, and personality disorders. This aligns with the focus outlined in the introduction of this chapter, where individuals with SMI are noted to have more frequent contact with secondary care mental health services due to the complexity and severity of their presentations. While other diagnostic categories (e.g., eating disorders, anxiety disorders) were present in the dataset, they represented a very small proportion of the sample (e.g., $\leq 1\%$), and were therefore not included in the visualisation below due to limitations in interpretability and visual clarity. To maintain transparency, these diagnostic groups are acknowledged (see Table 3), but the

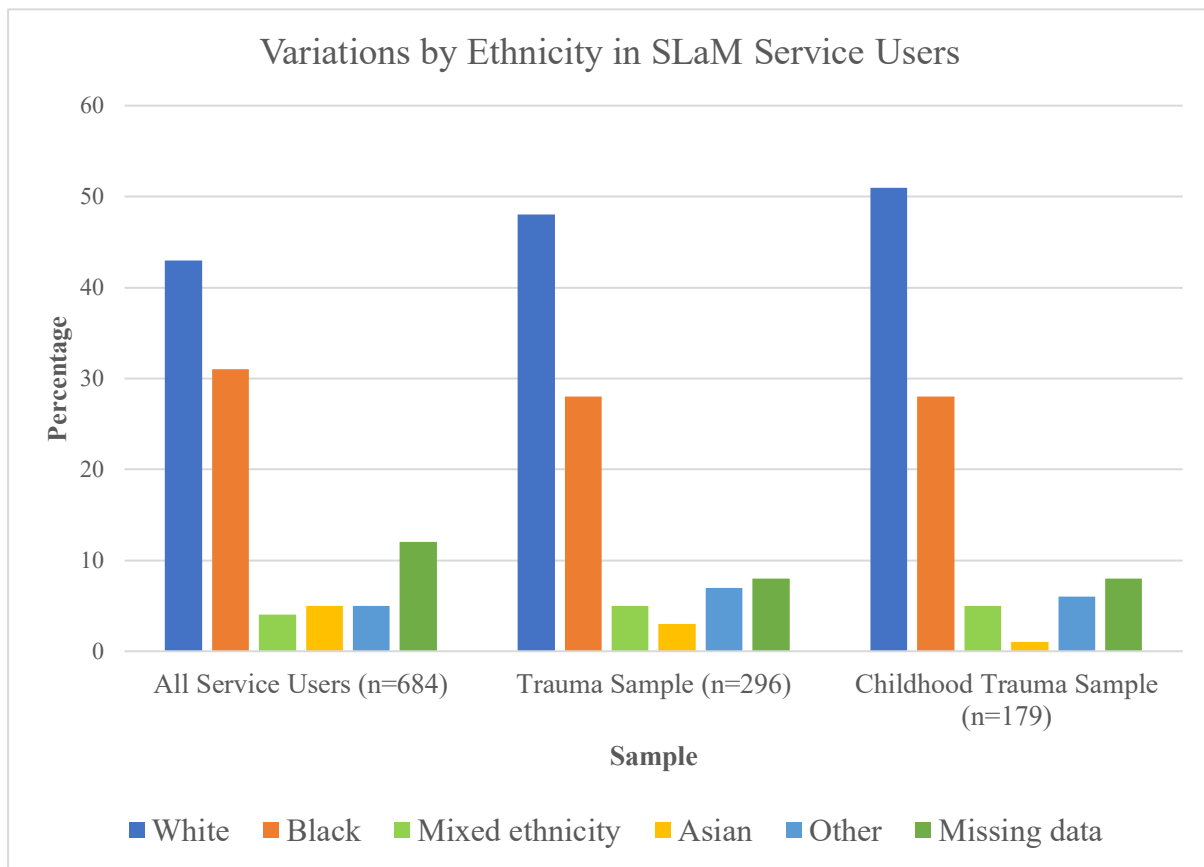
decision to graphically represent only SMI categories was made to ensure analytical focus on the population most relevant to the study's aims. Figure 10 depicts diagnosis distributions across the sample below.

Figure 28. *Diagnoses variations across service user sample*



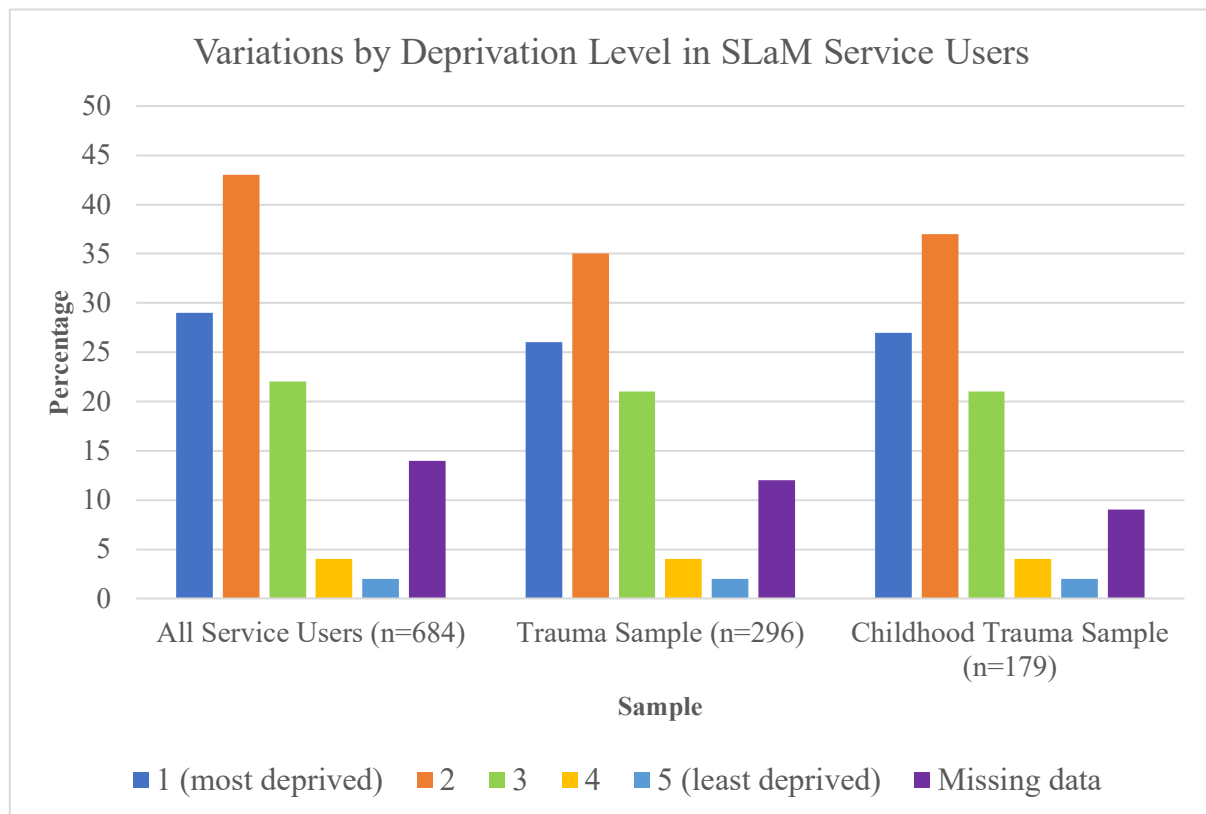
White ethnic groups (n=297, 43%) made up the largest proportion of the sample, followed by Black ethnic groups (n=214, 31%) with missing data accounting for 12% (n=79), nearing the total of the three remaining ethnic groups (Mixed ethnic groups, n=26, 4%, Asian ethnic groups, n=31, 5%, Other ethnic groups, n=37, 5%). Ethnic variations within the sample are depicted below in Figure 11.

Figure 31. *Ethnic variations across service user sample*



Deprivation levels indicated those living in more disadvantaged areas of the borough (IMD deciles 1, n=169, 29%, and deciles 2, n=250, 43%) were accessing services at higher rates when compared with deciles 3 (n=131, 22%), 4 (n=25, 4%), and 5 (n=11, 2%), with missing data accounting for 14% (n=98). These variations are reported in Figure 12.

Figure 34. *Deprivation level variations across service user sample*



Trauma data

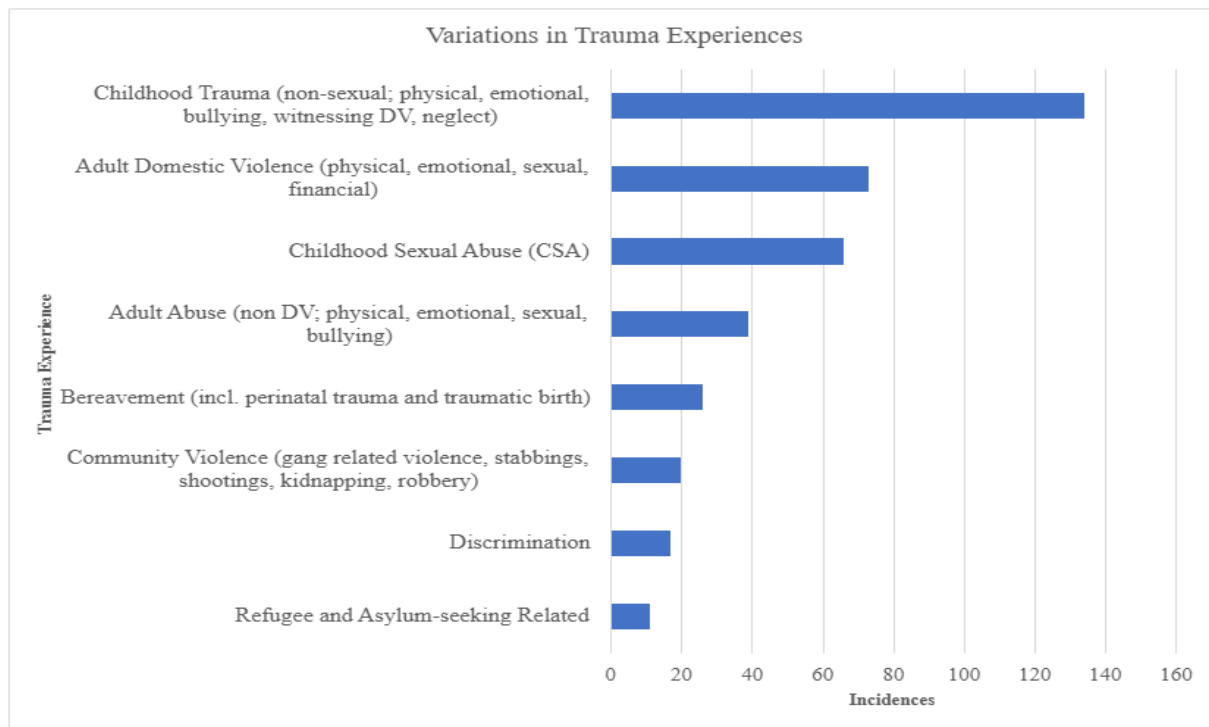
Types of trauma entries

Variations in trauma experiences reported on clinical notes were recorded and depicted in Figure 13. Following content analysis of the data, the categorical variables that depicted these variations were: childhood abuse (non-sexual; physical, emotional, bullying, witnessing domestic violence and neglect); childhood sexual abuse; adulthood domestic violence (physical, emotional, sexual and financial); adulthood abuse (non-domestic violence; physical, sexual, emotional and bullying); discrimination (racism, homophobia, transphobia, ableism and biphobia); bereavement related (including perinatal trauma and traumatic birth); refugee or asylum seeker related (including war, imprisonment, and torture); community violence (gang-related violence, police brutality, stabbings, shootings, kidnapping or robbery) and unknown reported trauma type (e.g., generic reference without trauma detail).

Overall, 386 adulthood and childhood traumas were reported in clinical entries from 296 service users with trauma. The reason why the number is higher is due to several service users having more than one entry on clinical records pertaining to trauma experience. The most commonly reported trauma on clinical records were childhood traumas (non-sexual,

n=134), followed by adulthood domestic violence (n=73), childhood sexual abuse (n=66), adulthood abuse (non-domestic violence, n=39), bereavement trauma (n=26), community violence (n=20), discrimination (n=17), and refugee and asylum seeking related traumas (n=11).

Figure 37. *Variations in trauma experiences recorded on entries*



Referral outcomes

From this point onward, I report my findings when exploring outcomes for those with at least one trauma entry (n=296), not overall sample which looked at all those accessing services with or without trauma entries (n=684).

Table 4 depicts aspects of trauma assessment, referral for trauma treatments and variations in receipt of this by demographic groups. For those that had trauma recorded on notes (n=296), only 35 (12%) were considered or referred for trauma treatments. Treatment examples within notes included referrals to interventions to specifically address the trauma that was recorded within clinical entries (e.g., to refer for an intervention to address trauma, such as a PTSD intervention group).

Notably, the number of service users referred to trauma-focused treatment (n=35) exceeds those recorded as having been offered or considered for a trauma assessment (n=32). This discrepancy is likely due to some clinical entries bypassing the formal assessment stage, with direct referrals made based on clinical judgment with no formal assessment with a service user (e.g., a case instead discussed in a triage multidisciplinary team meeting without a service user). Additionally, as the data collection window spanned only one month, it was not always possible to determine whether assessed individuals were subsequently offered treatment, hence the variable 'trauma assessment offered *or* considered'. Though, among those referred for trauma-focused treatment (n=35), 66% had been previously offered or considered for a trauma assessment. Due to the relatively small numbers, it was possible to manually identify overlap between individuals across variables, allowing this linkage to be determined.

Table 4. *Overview of service users with trauma entries and corresponding outcomes*

	Trauma experience recorded (N=296)	¹Trauma assessment offered or considered (N=32)	Trauma treatment referral offered or considered (N=35)
Demographics	N (%)	N (%)	N (%)
Gender			
Men	106 (36)	9 (28)	9 (26)
Women	186 (63)	23 (72)	26 (74)
Other	4 (1)	0 (0)	0 (0)
Missing	0 (0)	0 (0)	0 (0)
Ethnicity			
White	143 (48)	15 (47)	17 (49)
Black (Black African, Black Caribbean or Black British)	83 (28)	7 (22)	8 (23)
Mixed or multiple ethnic groups	16 (5)	1 (3)	1 (3)
Asian or Asian British	9 (3)	2 (6)	1 (3)
Other	20 (7)	3 (9)	4 (11)
Missing	25 (8)	4 (13)	4 (11)
Age			
18-25	90 (30)	8 (25)	7 (20)
26-35	77 (26)	13 (41)	15 (43)
36-45	57 (19)	4 (13)	6 (17)
46-55	52 (18)	7 (22)	7 (20)
56-64	20 (7)	0 (0)	0 (0)
Missing	0 (0)	0 (0)	0 (0)

¹Data is captured from the same population and so experiences of assessment and treatment referral may overlap. Some service users were offered or considered for treatment without evidence of a formal assessment being offered or considered. Percentages may not total exactly 100% due to rounding.

There were more women (n=186) in the sample of service users who had trauma entries reported than there were men (n=106). Women were more likely to be considered or referred for trauma support (n=26) when compared with men with trauma entries (n=9). Those aged 18-25 were the largest demographic group who had entries related to trauma compared to other ages (n=90) and only 7 (8%) went on to receive or be considered for a referral for trauma support. Whilst adults aged 56-64 made up the lowest proportion of trauma entries (n=20), they also received zero referrals or considerations for trauma support. There did not

appear to be large variations by ethnic group in the receipt of trauma assessment or trauma treatment referrals.

Table 5 describes broader outcomes on entries following a record entry of trauma experience (n=296). These outcomes were common themes that emerged within the data following content analysis methods, and included: medical review (e.g., discharge to general practices for health reviews, alterations to medications), referral to acute and crisis care (e.g., inpatient units), referral for community mental health services, and referral for treatment to address identified trauma within clinical entries.

Table 5. *Demographic variations in service outcome following trauma entries*

	Medical follow up (N=176)	Referral to acute and crisis care (N=106)	Referral for community mental health services (N=113)	Referral for trauma treatment (N=35)
Demographics	N (%)	N (%)	N (%)	N (%)
Gender				
Men	71 (40)	33 (31)	45 (40)	9 (26)
Women	102 (58)	72 (68)	66 (58)	26 (74)
Other	3 (2)	1 (1)	2 (2)	0 (0)
Missing	0 (0)	0 (0)	0 (0)	0 (0)
Ethnicity				
White	90 (51)	48 (45)	53 (47)	17 (49)
Black (Black African, Black Caribbean or Black British)	45 (26)	32 (30)	28 (25)	8 (23)
Mixed or multiple ethnic groups	9 (5)	9 (8)	7 (6)	1 (3)
Asian or Asian British	6 (3)	4 (3)	3 (3)	1 (3)
Other	13 (7)	7 (7)	10 (9)	4 (11)
Missing	13 (7)	6 (6)	12 (11)	4 (11)
Age				
16-25	46 (26)	32 (30)	39 (35)	7 (20)
26-35	49 (28)	28 (26)	25 (22)	15 (43)
36-45	36 (20)	23 (22)	18 (16)	6 (17)
46-55	30 (17)	17 (16)	23 (20)	7 (20)
56-64	15 (9)	6 (6)	8 (7)	0 (0)
Missing	0 (0)	0 (0)	0 (0)	0 (0)

The more probable outcome for all those who had trauma experiences recorded (n=296) was a form of medical review or follow up (n=176, 59%). Exclusively reviewing those with medical follow ups following a trauma entry being recorded, women (n=102), and those from White ethnic groups (n=90), were more likely to receive medical follow ups. There did not appear to be large variations by age across all outcome data.

Service use and medication outcomes

From this point on, I discuss inpatient admissions and medical outcomes data that was derived from natural language processing (NLP) methods. NLP data was drawn from all SLaM service users in the study sample (n=684), yet explored structured text data within 6 months of the index date (date of service use access) and was not isolated between 1st February 2022 and 1st March 2022 like above data.

Inpatient admissions

Of all those accessing services (n=684) with and without trauma, just under one quarter (n=153 service users, 22%) had an inpatient admission within 6 months of the index date, which is depicted in Table 6. More men (54%) were admitted to an inpatient ward when compared to women (45%). Black ethnic groups were most likely to be admitted (44%) when compared to other ethnic groups (White ethnic groups 37%, Mixed and Asian ethnic groups, 6%, and Other ethnic groups 4%, missing data, 3%). Young adults aged 26-35 were most likely to have an inpatient admission (31%), when compared to other age groups (18-25, 19%; 36-45, 21%; 46-55, 18%; 56-64, 10%).

Of all those admitted (n=153), half had reports of trauma documented on entries (n=77, 50%), and there were slight demographic variations in trauma entries. More women had trauma entries when compared with men (56% vs 43%). White ethnic groups had greater trauma entries (43%) compared to other ethnic groups (Black ethnic groups, 36%; Mixed ethnic groups, 9%; Asian ethnic groups 4%, Other ethnic groups, 6%, missing data, 1%). Younger groups still had greater trauma entries (18-25, 27%; 26-35, 31%) compared to other age groups (36-45, 17%; 46-55, 19%; 56-64, 5%).

Table 6. *Admission outcomes within 6 months of index date*

	Admission sample (n=153)	Admission sample with trauma (n=77)
% with Trauma	—	77/153 (50%)
Demographics	N (*%)	N (%)
Gender		
Men	82 (54)	33 (43)
Women	70 (45)	43 (56)
Other	1 (1)	1 (1)
Missing	0 (0)	0 (0)
Ethnicity		
White	57 (37)	33 (43)
Black (Black African, Black Caribbean or Black British)	68 (44)	28 (36)
Mixed or multiple ethnic groups	9 (6)	7 (9)
Other	9 (6)	3 (4)
Asian or Asian British	6 (4)	5 (6)
Missing	4 (3)	1 (1)
Age		
18-25	29 (19)	21 (27)
26-35	48 (31)	24 (31)
36-45	32 (21)	13 (17)
46-55	28 (18)	15 (19)
56-64	16 (10)	4 (5)
Missing	0 (0)	0 (0)

*All percentages within demographic rows are column based. Trauma prevalence row (%) is calculated against the full admission sample. Percentages may not total exactly 100% due to rounding.

Medication outcomes

Table 7 summarises medication outcomes of SLAM service users. This data is derived from natural language processing approaches used within the study that explores outcome data within 6 months of index date of service access for all service users (n=684).

Table 7. Medication outcomes within 6 months after index date

	Antipsychotic use (N=337)	Trauma among antipsychotics sample (N=142)	Antidepressant use (N=279)	Trauma among antidepressants sample (N=151)	Mood stabiliser use (N=121)	Trauma among mood stabiliser sample (N=66)
% with Trauma	—	142/337 (42%)	—	151/279 (54%)	—	66/121 (55%)
Demographics	N (*%)	N (%)	N (%)	N (%)	N (%)	N (%)
Gender						
Men	165 (49)	51 (36)	121 (43)	53 (35)	41 (34)	18 (27)
Women	171 (51)	90 (63)	156 (56)	96 (64)	79 (65)	47 (71)
Other	1 (0.3)	1 (1)	2 (1)	2 (1)	1 (1)	1 (2)
Missing	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Ethnicity						
White	122 (37)	56 (39)	146 (59)	8 (56)	67 (55)	39 (59)
Black (Black African, Black Caribbean or Black British)	146 (45)	52 (37)	69 (28)	3 (23)	29 (24)	14 (21)
Mixed or multiple ethnic groups	15 (5)	10 (7)	9 (4)	7 (5)	6 (5)	3 (5)
Other	22 (7)	5 (4)	10 (4)	4 (3)	6 (5)	1 (2)
Asian or Asian British	23 (7)	14 (9)	12 (5)	10 (7)	8 (7)	7 (11)
Missing	9 (3)	9 (6)	33 (13)	12 (8)	5 (4)	2 (3)
Age						
18-25	63 (19)	37 (26)	72 (26)	47 (31)	22 (18)	13 (20)
26-35	88 (26)	35 (25)	70 (25)	38 (25)	38 (31)	21 (32)
36-45	79 (23)	34 (24)	62 (22)	30 (20)	26 (21)	15 (23)
46-55	64 (19)	28 (20)	48 (17)	26 (17)	24 (20)	15 (23)
56-64	43 (13)	8 (6)	27 (10)	10 (7)	11 (9)	2 (3)
Missing	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	(0)

*All percentages within demographic rows are column based. Trauma prevalence row (%) is calculated against the full medication samples. Percentages may not total exactly 100% due to rounding.

Antipsychotic usage

Of all those accessing services (n=684) with and without trauma, there was antipsychotics prescribed for 337 (49%) service users within 6 months of index date of access. There did not appear to be major variations across gender among men (49%) and women (51%). However, there were notable variations across ethnic groups, with Black ethnic groups (45%) having greater antipsychotic documentation on records compared to other ethnic groups (White ethnic groups, 37%, Mixed ethnic groups, 5%, Asian ethnic groups, 7%, Other ethnic groups, 7%, missing data, 3%). Those aged 26-35 were more likely to be prescribed anti-psychotics (26%) when compared to other age groups (18-25, 19%, 36-45, 23%, 46-55, 19%, 56-64, 13%).

Of all those prescribed antipsychotics (n=337), under half had trauma entries (n=142, 42%). Women with trauma entries were more likely to be prescribed antipsychotics (63%) compared to men with trauma entries (36%). White and Black ethnic groups with trauma entries were more likely to be prescribed antipsychotics (White ethnic groups, 39%, Black ethnic groups, 37%), followed by Other ethnic groups (9%), Mixed ethnic groups (7%), and Asian ethnic groups (4%). Missing data accounted for 6%. There were smaller variations by age when exploring antipsychotic usage among those with trauma entries (18-25, 26%, 26-35, 25%, 36-45, 24%, 46-55, 20%, 56-64, 6%).

Antidepressant usage

Of all those accessing services (n=684) with and without trauma entries, there was antidepressant prescribed among 279 service users (41%) within 6 months of index date of access. Women were more likely to be prescribed antidepressants (56%) when compared with men (43%). White groups were more likely to be prescribed antidepressants (59%) when compared with other ethnic groups (Black, 28%, Mixed ethnic groups, 4%, Asian ethnic groups, 4%, Other ethnic groups 5%, missing data, 13%). Smaller variations were found among age groups (18-25, 26%, 26-35, 25%, 36-45, 22%, 46-55, 17%, 56-64, 10%).

Of all those prescribed anti-depressants (n=246), over half had trauma entries (n=151, 54%). Women with trauma entries were far more likely to be prescribed antidepressants (64%) when compared with men with trauma entries (35%). White ethnic groups with trauma entries were more likely to be prescribed antidepressants (56%) when compared with other ethnic groups with trauma entries (Black ethnic groups, 23%, Mixed ethnic groups, 5%, Asian ethnic groups, 3%, Other ethnic groups, 7%, missing data, 8%). Younger age groups

with trauma entries were more likely to be prescribed antidepressants (18-25, 31%, 26-35, 25%) when compared with older age groups (36-45, 20%, 46-55, 17%, 56-64, 7%).

Mood stabiliser usage

Of all those accessing services with or without trauma entries (n=684), there was mood stabilisers prescribed for 121 service users (17%) within 6 months of the index date. Women were more likely to be prescribed mood stabilisers (65%) when compared with men (34%). White ethnic groups were more likely to be prescribed mood stabilisers (58%), when compared with other ethnic groups (Black ethnic groups, 25%, Mixed ethnic groups, 5%, Asian ethnic groups, 5%, Other ethnic groups, 7%, missing data, 4%). Those aged 26-35 were more likely to be prescribed mood stabilisers (31%) when compared with other age groups (18-25, 18%, 36-45, 21%, 46-55, 20%, 56-64, 9%).

Of all those prescribed mood stabilisers (n=121), over half had trauma entries (n=66, 55%). Women with trauma entries were far more likely to be prescribed mood stabilisers (71%) when compared with men with trauma entries (27%). White ethnic groups with trauma entries were more likely to be prescribed mood stabilisers (59%) when compared with other ethnic groups (Black ethnic groups, 21%, Mixed ethnic groups, 5%, Asian ethnic groups, 2%, Other ethnic groups, 11%, missing data, 3%). Those aged 26-25 with trauma entries were more likely to be prescribed mood stabilisers (32%), compared to other age groups (18-25, 20%, 36-45, 23%, 46-55, 23%, 56-65, 3%).

4.5 Discussion

Identifying practice related to assessing trauma histories and supporting those with trauma within current clinical service provisions and subsequent demographic differences in the clinical process is vital for ensuing access and provision of tailored care for service user groups. This study aimed to describe current routine clinical practice for trauma care among secondary and tertiary care mental health service users, and whether there were any demographic variations, particularly ethnicity, in the receipt of this. As this was a descriptive study no inferential statistical analyses were conducted, meaning associations between variables cannot be confirmed. However, findings depict important trends in trauma identification and management within services to which I explain below.

The findings show that many of those with trauma recorded on clinical entries had records of childhood trauma experiences. This aligns with broader literature, which shows adverse

childhood experiences are strong predictors of poorer adulthood mental health outcomes (Mandelli et al., 2015; McKay et al., 2021). This relatively higher documentation of childhood trauma entries among all those with trauma, depicts the vitality of early identification screening and structured trauma referral pathways within current routine practices.

A key aim of this study was to identify ethnic variations in the receipt of trauma assessments and care. Unfortunately, the dataset was too limited to draw robust conclusions. This limitation is replicable to wider literature citing poor ethnicity demographic data quality in electronic healthcare records (Polubriaginof et al., 2019), limiting the ability to draw robust conclusions in healthcare disparities. This is of concern, as literature has consistently shown clear ethnic inequalities in accessing mental health services (Bansal et al., 2022). Without robust ethnicity data in this study, it is difficult to explore disparities at the point of access to care within NHS services.

One observed pattern was the relatively low number of psychological therapy interventions documented following trauma disclosures. However, this finding must be interpreted with caution. The dataset did not include primary care services such as IAPT, where many psychological therapies occur. Importantly, even within secondary care, therapies may have been delivered but were not explicitly documented as trauma-focused in structured fields or free-text notes. Therefore, it is not possible to ascertain whether service users in secondary care received psychological therapies in practice; the study can only describe what was recorded and coded. The apparent low numbers of therapy interventions may thus reflect limitations in data capture and coding rather than true absence of provision. Consequently, the study cannot determine whether trauma disclosures were followed by support in practice, only whether such support was explicitly documented in the available data.

For the small minority of cases of trauma disclosures were followed by documented trauma assessments, referrals for trauma-specific support were also recorded. In most other cases, however, disclosures did not lead to further documented trauma assessment or support. While this may point to gaps in systemic follow up, it is equally possible that some support was provided but not documented. Thus, findings should not be taken as evidence that service users “did not receive” care, but rather that the available records do not allow confirmation either way.

The analysis also highlighted demographic variations in service use. Women were more likely to be prescribed medications than men, whereas men were more likely to be admitted to inpatient care. Younger adults (aged 26–35) were more likely to be prescribed psychotropic medication and recorded inpatient admissions, consistent with this age group being at higher risk for severe mental illnesses (Miettunen et al., 2019; Solmi et al., 2022). These findings point to important trends, though again the appropriateness of clinical decisions cannot be assessed without symptom-level data.

Black adults are more frequently diagnosed with psychotic disorders and more likely to be prescribed antipsychotics (Halvorsrud et al., 2019; Kuno & Rothbard, 2002), which the dataset from this study appears to replicate. However, this dataset did not link diagnoses or symptom profiles to prescribing decisions. As such, it cannot be determined whether treatments were clinically appropriate or not. These patterns should therefore be interpreted descriptively, as evidence of what is recorded, rather than evaluatively.

Experiences of racism and discrimination were rarely documented as trauma despite evidence that they are associated with poorer mental health outcomes (Hatch et al., 2016). This likely reflects under-recording rather than absence. Because routine data collection does not include systematic enquiry about racism and discrimination, their true prevalence in trauma histories is likely underestimated. This represents an opportunity for services to develop more culturally sensitive trauma assessment practices with enquiry on these experiences.

Overall, this study highlights descriptive trends in how trauma is recorded and followed up in secondary care. However, given the limitations of the dataset, findings should be interpreted as evidence of documentation practices rather than direct evidence of care provision or its appropriateness.

4.5.1 Implications for Future Research, Practice and Policy

This work was descriptive and cross-sectional making it not possible to explore causality in the observed outcomes. This presents as an opportunity for future research which could apply longitudinal designs with inferential statistical analyses to examine whether demographic disparities exist after controlling for confounding factors. Future research should also utilise evaluating larger healthcare study datasets which may have greater availability of ethnicity

demographic information, in order to comprehensively examine disparities in healthcare access which may be achieved with inferential statistical analyses.

Future work would also benefit from linking trauma disclosures more explicitly with symptom profiles, diagnoses, and severity indicators (e.g., HoNOS scores). This would allow clearer assessment of whether interventions were clinically appropriate, something this study could not establish. Without such data, prescribing and referral patterns can only be interpreted descriptively.

The apparent underrepresentation of psychological therapies following trauma disclosures highlights a potential area for future investigation. However, this study cannot determine whether therapies were delivered but not documented. Future research should therefore explore how psychological therapies are coded and captured in secondary care records, and whether current systems adequately reflect service provision. A more detailed mapping of therapy delivery, including both primary and secondary care pathways, would be valuable in understanding how trauma needs are addressed across the wider NHS system.

Qualitative research could also play an important role in exploring barriers to accessing assessment for trauma exposure and for trauma-focused therapies, including service user and healthcare professional's perspectives. Questions could probe healthcare professionals on how service models can be adapted to improve access to interventions, complimented with rich qualitative data from service users around what may be needed to mitigate barriers in accessing them.

At a practice level, these findings reinforce the importance of more systematic and routine trauma enquiry within assessments. While not all service users will have trauma-related needs, greater consistency in documentation could improve care planning and referral decisions. However, caution is warranted in interpreting apparent gaps in trauma follow-up: the absence of a record in this study, does not necessarily indicate absence of care. Nevertheless, staff training in both trauma-informed care and culturally sensitive enquiry may support more accurate and meaningful documentation.

From a policy perspective, the findings highlight the need for improved routine data capture, particularly around ethnicity, trauma, and culturally relevant experiences such as racism and discrimination. Strengthening data quality would enable better monitoring of potential inequalities in trauma care. Policymakers may also wish to consider supporting the

integration of structured fields for trauma and therapy pathways into routine records, in order to provide clearer visibility of care processes without overburdening clinicians.

Finally, demographic trends observed in this study, such as higher inpatient admissions among men and younger adults, warrant further exploration. Services may wish to strengthen outreach and early intervention approaches for groups at risk of later crisis-driven service use. However, these findings should be interpreted as descriptive trends. Further research is needed to establish whether these patterns represent true inequities, differences in help-seeking or other contextual factors.

4.5.2 Strengths and Limitations

Data used in this study was pulled from a large service provider of mental health care in the UK, with known rich ethnic and cultural diversity among service users. A strength here allowed for exploration of relationships varied demographic groups have with services and their experiences of care using real-world data. However, limitations of the study do exist.

First, psychological therapies for trauma may have been delivered within secondary care but were not identifiable unless explicitly documented as trauma focused. The study therefore cannot determine whether service users did or did not receive therapy, only whether it was coded in records. Apparent underrepresentation of therapy pathways must be interpreted as a limitation of documentation, not evidence of absence of care. It is also plausible that some individuals were appropriately offered therapy within CMHTs or other teams, but the sessions were not coded in ways that allowed identification. In other cases, therapy may have been delayed due to long waiting times, prioritisation of immediate crises, or service-level requirements such as substance-use stabilisation before referral to trauma-focused interventions.

Second, the dataset did not include symptom-level data or consistent diagnostic linkage to interventions. As such, it was not possible to determine whether particular treatments (e.g., prescribing antipsychotics) were clinically appropriate. The dataset did not include information on long-term care plans, or in some cases, the rationale for treatment decisions. For example, an encounter leading to antipsychotic prescribing may have been driven by acute psychotic symptoms or a relapse crisis, where addressing trauma was not immediately prioritised. Similarly, trauma histories may have been explored at a later stage once stability was achieved, but such sequencing is not visible in the dataset. It is therefore not fully possible to determine whether trauma histories were deprioritised due to acute presenting

needs (e.g., crisis management) or service-level restrictions (e.g., being ineligible for referral to specialist trauma services while engaged with crisis or substance misuse support). Findings about interventions should therefore be interpreted descriptively, rather than as evaluative statements about appropriateness.

Third, reliance on clinician documentation introduces further constraints. Trauma may have been disclosed but not recorded, or recorded without detail. Similarly, experiences of racism and discrimination may be under-documented, meaning their apparent low prevalence in this study should not be taken as evidence that they were absent.

It is therefore important to recognise that the absence of documented trauma referrals within the dataset does not necessarily mean such referrals never occurred. Specialist trauma pathways within the NHS often require service users to first stabilise in community teams or resolve acute crises, and waiting times for referral acceptance can be prolonged. Eligibility criteria, such as abstinence from substance use or not currently relying on crisis services, may also delay or prevent referral to specialist trauma teams. These service-level constraints cannot be observed in the dataset but represent another important limitation: the study cannot rule out that some service users did eventually receive trauma-focused care beyond the timeframe or coding structures captured here.

When thinking more broadly, survivor-led research has detailed extensively the sensitive, relational aspects that should be considered when working with trauma service users (Forkey et al., 2021; Butler et al., 2011). For example, aspects of disclosure around trauma may very much rely on the organisational and relational dynamics between service users and providers themselves. In this instance, it is important to be mindful again that just because trauma is not self-disclosed or documented on entries in this study, it does not mean service users have not experienced trauma. This may be more pertinent when considering the role of mistrust of healthcare among trauma survivors (Garg et al., 2020), as well as mistrust or stigma among racialised minority groups (Misra et al., 2021). Staff training on trauma-informed care only strengthens the potential for more efficient screening for trauma and embed sensitive relational approaches to support disclosures.

One of the notable limitations of this study was within the study design being descriptive. This meant that it was not possible to draw casual inferences or establish directionality between variables. As no inferential statistical analysis were performed due to the availability of the data, associations between data variables could not be established. Another limitation

pertains to missing data which was substantial for some variables. Given the reliance on electronic clinical records not all information was routinely implemented across records. This poses as a limitation as I was not able to obtain complete datasets to test and explore variations or disparities.

Despite the limitations, I still believe this study provides valuable exploratory insights into current clinical practices and variations in service user access. While the findings should be interpreted with cation, they depict important areas for future investigations.

4.5.3 Conclusions

To conclude, this study emphasises a need for more targeted efforts of developing more systematic and proactive approaches to trauma enquiry and documentation in routine NHS care. These approaches, alongside continued efforts to improve data quality and further research, may help address inequalities in access to trauma support and enhance the overall quality of mental health service provision.

4.6 Chapter Summary

This chapter presented work from the clinical records study depicting demographic variations in the receipt of trauma care. It exposed a prime finding: the recognition and assessment of trauma among service users is alarmingly inadequate. I also expanded on some of the strengths and limitations of this study, given a vast proportion of electronic healthcare records data were missing or unavailable. I discuss some of the implications of this in my discussion, as well as some of the consequences of under-recognition of trauma among service users, according to the data that was available.

5 CHAPTER FIVE: QUALITATIVE STUDY

5.1 Chapter Overview

In this chapter I discuss the qualitative segment of the research. I describe the rationale behind qualitative work to platform lived experiences and voices into academic literature, crucial within this study context for Black adults. I expand on the approaches that inform my methodology as well as the results and interpreting these findings through an expanded discussion.

5.2 Introduction

Complex trauma, a condition originally defined by Herman (1992), is characterised by chronic, cumulative, and prolonged exposure to trauma often stemming from childhood. Experiences of complex trauma, such as childhood abuse and neglect, are frequently associated with poorer adulthood mental health outcomes (Copeland et al., 2018) and can disrupt a person's sense of safety, identity, and worldview (Cook et al., 2005). Elevated rates of traumatic life events have been well documented among Black and racialised minority groups (Hatch & Dohrenwend, 2007). These patterns reflect more than individual vulnerability as they emerge in the context of structural inequalities that shape exposure to adversity. Experiences of racism and discrimination, in particular, contribute to the burden of trauma and deepen its psychological impacts (Comas-Díaz et al., 2019). These intersecting harms accumulate over time, shaping how complex trauma is experienced and how racialised minority groups interact with systems of care.

In the United Kingdom (UK), mental health services are primarily delivered through the National Health Service (NHS) with care organised through primary, secondary, and tertiary care levels. Secondary care includes specialist services such as community mental health teams, crisis services, as well as inpatient psychiatric care, services that typically become involved with service users with more acute and complex needs. There is substantial evidence that many individuals accessing these services have disproportionately high rates of complex trauma (Mauritz et al., 2013). Yet, paradoxically, these services also have great potential to become sites of re-traumatisation for service users due to the use of restrictive practices (e.g., restraint and seclusion), which may emulate prior traumatic experiences (Cusack et al., 2018).

Service utilisation data has frequently depicted an overrepresentation of Black adults within acute and secondary care mental health services (Bignall et al., 2019). Evidence shows Black individuals are more likely to be compulsorily admitted to mental health services as well as receive more coercive and adversarial treatments relative to other ethnic groups (Barnett et al., 2019; Singh et al., 2007). These trends highlight the influence of institutional harms in shaping access to care and mental health outcomes. For Black adults with complex trauma though, repeated encounters with coercive services may deepen feelings of powerlessness and mistrust, compounding rather than alleviating trauma.

While complex trauma is a key contributor to distress, it is often overlooked within mental health settings, particularly in acute and secondary care settings. For instance, symptoms of trauma can overlap with those seen in acute psychiatric conditions, including schizophrenia-spectrum disorders (Varese et al., 2012). When trauma is not adequately recognised, care may focus narrowly on symptom management rather than addressing underlying or root causes. This lack of awareness of trauma can contribute to fragmented or misaligned care and elevates the potential for re-traumatisation, particularly where coercive measures are employed. As such, a crucial need for trauma-informed approaches embedded within these settings and beyond is therefore warranted to sensitively respond to the needs of service users (Sweeney & Taggart, 2018).

Over the years, efforts to establish more trauma-informed care within routine healthcare practice have grown (Menschner & Maul, 2016). Despite an evolving awareness of the impact of trauma on service users, prior literature has often overlooked the interplay of race and culture when supporting those with complex trauma. There is a small but growing evidence base exploring cultural adaptations to trauma care for racialised minority groups (Ennis et al., 2020; Naseh et al., 2020), with recent meta-analytic evidence showing that adaptations in trauma care are effective in reducing trauma symptoms (Benjamin et al., 2025). However, little evidence exists exploring adaptations tailored specifically to Black adults with complex trauma, leaving a gap in understanding how such adaptations might support recovery for these groups.

Overlooking the cultural needs of Black service users sustains ongoing cycles of inadequate care and upholds structural harm within services. Crucially, understanding what culturally competent, trauma informed care may look like for Black adults with complex trauma therefore has great potential to address some of these inequities. Cultural competency, for

instance, can operate at multiple levels within services, such as (1) at the organisational level of services which may refer to institutional policies of equity and anti-racism, (2) at the relational level through culturally attuned practitioner-service user interactions and (3) at an intervention level, culturally adapting treatments and methods (Kirmayer, 2012). Without such shifts, services risk continuing to offer care that is poorly aligned with the needs of Black groups and may unintentionally reproduce racial injustices and harms through everyday practice.

This qualitative component of the research aims to tackle the current gap in literature by understanding the lived experiences of Black adults with complex trauma in seeking support, examining their journeys in services to address complex trauma, as well as their experiences and views of mental healthcare. Critically, the research aimed to expose how mental health services are responding to the specific needs of Black adults with complex trauma. The research questions were:

- 1) What were the journeys Black adults had when seeking support for complex trauma?
- 2) What were the experiences and views of mental health services and support shared among Black adults with complex trauma?

5.3 Methodology

5.3.1 Study Context

This qualitative study formed part of a broader NIHR funded project titled PATHWAY (NIHR Award: 203947). PATHWAY utilised mixed methods to explore the development of a trauma informed care pathway for service users with complex trauma in UK mental health services. I was also embedded within the PATHWAY programme, however led a standalone qualitative sub-study as part of my doctoral research project, exploring the experiences of Black adults with complex trauma who had sought support from statutory and voluntary mental health services. While the overarching infrastructure and ethical approval were provided through PATHWAY (IRAS: 314403), the recruitment, interviews, analysis, and interpretation presented within this study were independently designed and conducted by myself as part of a separate line of inquiry and contributing to my doctoral thesis.

Recognising the influence of researcher identity in qualitative work, especially work that explores race and trauma, the research process was designed to centre trust and reduce power imbalances in line with trauma informed research values (Alessi & Kahn, 2023). The

positionality therefore of myself both as a researcher but also holding lived experience as a Black male with experiences of complex trauma, informed relational approaches to recruitment and interviewing as well as analytic sensitivities to the racialised dynamics within participants narratives. This orientation was complemented and challenged through collaboration with a lived experience advisory group (LEAG) of Black adults with lived experiences of complex trauma and accessing services.

Building on the critical realist framework outlined in Chapter Two, this study operationalised critical realism concepts in the qualitative design and analysis. Critical realism provided a way to bridge participants' subjective narratives with the broader structural forces shaping their experiences (Fletcher, 2017).

In particular, I drew on the four planes of social being (Bhaskar & Norrie, 2013), a framework which positions experiences across four planes, those being (1) natural "bodies in relation to nature" plane (e.g., embodied trauma), (2) interpersonal relations plane (e.g., relational dynamics with clinicians), (3) larger social relations and structures (e.g., service design, institutions) and (4) inner human being in the mental-social-embodied personality (e.g., self-concept). This framework was particularly appropriate for a study exploring Black adults' experiences navigating mental health services for complex trauma. It enabled me to examine both the narratives participants shared and also the broader conditions within which experiences were embedded. By drawing on this multi-layered understanding of being, the study could attend to both the depth of individual stories and the structural forces that shape them, a key strength of critical realism in applied, social research (Alderson, 2021).

5.3.2 Participants and Recruitment

Black adults (including of mixed ethnicity) residing in the United Kingdom, aged between 18-65 who had experienced complex trauma and attempted to seek support through statutory formal mental health services, or voluntary (not-for-profit) sector mental health services were eligible for the study. The age limit was based on the study's focus on adult mental health services which typically operate under different models of care from those for older adults (65+). Participants were eligible to take part if they self-identified as having experiences complex trauma and had engaged with mental health services in an attempt to seek support.

Complex trauma was defined using Herman's (1992) framework, which encompasses trauma that was prolonged, chronic, and/or involving multiple experiences. To ensure inclusivity, I also acknowledged both social and cultural aspects of trauma extend beyond Western medical

labels (Ray, 2008) and thus no formal diagnosis of post-traumatic stress disorder (PTSD) or complex PTSD was an obligation to take part. This definition and inclusive approach were communicated within the study's recruitment materials and in participant information sheets. Participants were invited to take part if they recognised their experiences as prolonged, chronic, or involving multiple traumatic events that negatively impacted their wellbeing, acknowledging the principle that trauma survivors are experts of their own experiences (Isobel, 2021).

Targeted recruitment was used to recruit a diverse sample of Black adults to take part, with particular attention to recruit those underrepresented in research. I cultivated relationships with local Black-led community organisations across different UK localities, some of which had a direct focus on mental health, while others focused on celebrating cultural identity or supporting specific communities such as Black LGBTQIA+ networks or Black disability advocacy groups. These partnerships supported recruitment efforts and helped build trust with communities historically marginalised within the research landscape. Recruitment strategies and approaches were further refined and shaped by support from the LEAG.

The target sample size was between 8-15 participants. Due to the exploratory nature of this study the focus was on achieving depth and richness of participants' experiences. Sample size adequacy was assessed through ongoing discussions with my supervisory team and the LEAG to establish when thematic saturation was reached (Hennink & Kaiser, 2022).

5.3.3 Data Collection

Sociodemographic data were collected using an optional self-reported form which asked participants for their ethnic group, gender, age, sexual orientation, and disability status. Interviews were conducted by myself and split into two parts, with participants having the opportunity to do them together or over separate dates, though all participants opted to complete in one sitting. The first interview part used narrative techniques (Ricoeur, 1991) lasting up to 60 minutes to understand journeys in seeking support for trauma within statutory mental health services and the voluntary sector. As trauma may disrupt a person's sense of chronology, optional creative aids such as visual mapping were used to support narrative-telling (e.g., depicting a visual timeline with prompts of experiences of each stage of the participants' journey). The second interview part involved a semi-structured interview lasting up to 60 minutes exploring experiences and outcomes of mental health services. Informed consent was obtained through a two-step process, first by reading participant information

sheets that outlined the aims of the study, what participation involved, as well as their rights to withdraw and confidentiality. After reading these materials, participants provided written informed consent (in person or signed via email) prior to commencing interviews.

The LEAG provided significant input towards data collection methods. This included informing recruitment strategies and materials as mentioned, as well as supporting the development of interview topic guides, questions, visual aids (see Appendix C), and to inform a sensitive approach to interviewing those with lived experiences of trauma. Interview questions were designed to capture Black adult's experiences of services, any barriers to accessing care, and acceptability of current clinical practices. Interviews were conducted either in person or via Zoom online platforms in line with participants' preference. Participants were compensated £25 for each interview part completed.

5.3.4 Data Analysis

The analytical process was led by myself and involved several iterative and reflexive phases, underpinned by a thematic analysis approach (Clarke & Braun, 2017). The approach was also situated within critical realism, and in particular, using the four planes of social being framework (Bhaskar & Norrie, 2013). The first stage involved transcribing the audio-recorded interviews verbatim and anonymising the data. I immersed myself in the transcripts through repeated readings and making initial reflective notes on language and narrative content.

Data were then coded inductively to identify features relevant to my research aims, with particular attention to emotional expression, identity positioning, content, and narrative structure. In practice, this involved close attention not only to what participants said, but how they said it. For instance, noticing emotional shifts when recounting experiences of not being believed by clinicians. Codes captured both explicit references to racism (for example) and more implicit forms of racialised experiences (e.g., “being treated differently” or “they just don’t get people like me”), as well as structural and interpersonal dynamics, such as power imbalances in therapeutic relationships or repeated service disengagement following dismissive experiences. These were interpreted as pointing to broader mechanisms like institutional mistrust or systemic barriers to care access. As part of the analysis, I critically considered how such dynamics manifested across accounts. For example, where participants

described having to ‘prove’ their distress to receive support, or where their trauma was minimised due to racialised stereotypes.

Codes were then organised into initial thematic patterns across the dataset. In line with critical realist assumptions, as mentioned, this process aimed to move beyond surface-level descriptions to identify underlying generative mechanisms and social structures (e.g., such as systemic racism and institutional mistrust) that influenced Black adult’s experiences. The four planes of social being (Bhaskar & Norrie, 2013) were conceptually useful here for examining how Black adults’ narratives reflected each plane, such as (1) the natural plan (“bodies in relation to nature”) (e.g., embodied trauma), (2) interpersonal relations plane (e.g., relational dynamics with clinicians), (3) larger social relations and institutional structures (e.g., service design) and (4) inner human being in the mental-social-embodied personality (e.g., identity). These planes informed the way I theorised the relationship between subjective experience and broader conditions.

Themes were refined through constant comparison with the data and iterative peer debriefing with members of a LEAG of Black adults with histories of complex trauma. Their contributions provided culturally grounded interpretations of subtext and meaning, enhancing the credibility and contextual validity of the analysis.

Finally, themes were defined and contextualised in relation to broader socio-structural dynamics and presented in the findings chapter to reflect the multifaceted experiences of Black adults navigating mental health services. Participant quotes were used throughout to illustrate each theme and honour the richness and integrity of individual narratives.

5.3.5 Ethical Considerations

This qualitative study was conducted as part of a larger existing study titled PATHWAY. PATHWAY was funded by an NIHR grant (REC: NIHR203947) which aimed to develop a novel complex trauma care pathway for trauma survivors. It was deemed appropriate given the similarities between PATHWAY and my doctoral work to support much of this work as it had already obtained ethical approval (IRAS ID 314403), however, to centre more explicitly on Black adult’s experiences. To support the cultural relevance and ethical design of the study, I collaborated with a lived experience advisory group (LEAG). The LEAG comprised Black adults with lived experiences of complex trauma and using mental health services, with the group contributing to the development and delivery of the study. For example,

recruitment materials were co-developed with the LEAG and ethical approval was obtained for these adaptations as part of an amendment under the broader PATHWAY study ethics (REC Reference: 23/EM/0024). These adaptations aimed to enhance the cultural relevance of the materials for the sub study as well as the wider PATHWAY project (see Appendix E for targeted recruitment flyer). Throughout the qualitative study, I adhered strictly to the ethical guidelines established by the PATHWAY including obtaining informed consent, participant confidentiality, and securely managing sensitive data (see Appendix D for ethical documents).

5.4 Results

A total of ten Black adults with complex trauma took part in the study. A summary of demographic characteristics is provided in Table 8 below. Pseudonym names are provided in the results to protect participants' confidentiality.

Table 8. *Overview of socio-demographic characteristics of participants*

Pseudonym	Ethnicity	Gender	Age	Sexual and Gender identity	Disability declared
Amir	Mixed Ethnicity	Male	40s	Heterosexual	Yes
Maureen	Black Caribbean	Female	40s	LGBTQ+	No
Amani	Black African	Female	40s	Heterosexual	Yes
Tony	Black Caribbean	Male	50s	Heterosexual	No
Ava	Black African	Female	20s	LGBTQ+	No
Dominique	Black Caribbean	Female	20s	Heterosexual	Yes
Jamila	Black African	Female	30s	LGBTQ+	Yes
Elliott	Mixed Ethnicity	Male	20s	Heterosexual	No
Deborah	Black African	Female	30s	Heterosexual	Yes
Audrey	Black African	Female	50s	Heterosexual	Yes

Note. LGBTQ+ category includes individuals identifying as lesbian, gay, bisexual, transgender, queer, or other sexual/gender minority identities.

A total of six themes emerged from the data and are listed in Table 9 alongside subthemes and descriptive summaries. To deepen the critical realist interpretation of the findings, Table 10 summarises how the themes and subthemes identified in this study map onto Bhaskar's 'four planes of social being' (Bhaskar & Norrie, 2013). This mapping situates participants' experiences across natural, interpersonal, social-institutional, and personal dimensions of social life, illustrating how trauma and care experiences are embedded within wider social structures. While the results are presented thematically, the table below demonstrates how each subtheme aligns with the corresponding plane of social being.

Table 9. *Summary of themes, sub themes, and descriptive examples from the data*

Themes	Sub themes	Description
A fragmented mental health system	Continuity of care	Depleted resources in statutory services hinder consistent long-term support. For Black adults, this lack of continuity compounds existing distrust in services that have historically failed their communities, reinforcing a sense of invisibility.
	Iatrogenic harm	Barriers to accessing trauma support frequently result in unmet, leaving Black adults feeling abandoned during critical periods. This exacerbates distress and perpetuates wider systemic neglect.
	Forced self-reliance	Religion and spirituality as protective factors to mental health. Interventions of value having an interconnected ‘mind-body-spirit’ focus to address holistic needs of those with trauma. What was offered from statutory services felt incomplete or inadequate, forcing self-reliance or to disengage entirely from services.
Alternative support systems	Religion and spirituality	Religion and spirituality offer culturally grounded coping strategies that frequently compensate for services failing to acknowledge spiritual and holistic dimensions of healing. These systems also provide validation for trauma experiences in ways that statutory services often do not.
	Peer support	Peer spaces foster authenticity and belonging often missing in statutory settings. Peer support can also buffer experiences of racism and harms within services, providing both validation and a sense of community safety.

Themes	Sub themes	Description
Inadequate or inappropriate assessments	Impersonal practices	Assessments lack depth and curiosity. Assessments ignore the role of culture, such as coping mechanisms through religion, or how culture may influence experiences and management of trauma.
	Experiences with questionnaires	Long, standardised tools feel rigid and alienating. However, questionnaires may be helpful to conceptualise the extent of distress.
Overly clinical and medical focus	Disempowerment and agency over own care	Minimal say and control over care planning with desires or insights ignored. A lack of collaborative approaches exacerbates disempowerment and frustrations navigating the healthcare system.
	“Quick fixes” and medicalised treatments	Defaulting to medication overlooks the social and cultural dimensions of trauma. A notable preference for relational and community-based interventions, but systemic barriers limit access to these alternatives in statutory care, deepening feelings of neglect.
Cultural matching	Preferences and choice	Having the option of working with a practitioner from a shared cultural background plays an important role on building rapport and meaningful therapeutic work. Lack of choice often replicates broader power imbalances and alienation in services.
Improving person centred care	Experiences of Cognitive Behavioural Therapy (CBT)	Experiencing CBT as too rigid with little room for collaboration, exploration, and partnership working which is desired.
	Task-focused mentality	Feeling like “just a number” is particularly pronounced when racialised service users are already navigating invisibility and marginalisation in healthcare, reinforcing alienation and disengagement.

Themes	Sub themes	Description
	Environment	Standard clinical environments and hospitals may feel unsafe or hostile to those with trauma. Alternatives that centre comfort, cultural safety, and relational engagement foster better access and trust in healthcare.

Table 10: *Mapping of themes and subthemes onto the Four Planes of Social Being*

Plane of Social Being	Themes/subthemes	Interpretation
Plane 1 – Natural (“bodies in relation to nature”) <i>(embodied, physical, natural conditions)</i>	Environment	Participants described clinical environments as sterile or unsafe, reinforcing trauma responses. Physical settings that lacked warmth heightened distress, whereas community or faith-based settings felt more grounding.
Plane 2 – Interpersonal <i>(social interactions, relationships)</i>	Peer support Preferences and Choice	Relational safety was central to healing and feeling supported. Cultural matching and peer spaces fostered belonging and trust often absent in statutory settings.
Plane 3 – Institutional <i>(structures, systems, and organisational practices)</i>	Continuity of Care Iatrogenic Harm Impersonal Practices Experiences with Questionnaires Quick Fixes and Medicalised Treatments Experiences with CBT Task-Focused Mentality	Structural features of the mental health system (fragmentation, resource depletion, risk orientation, and bureaucratic practices) produced alienating experiences. Clinical frameworks prioritised efficiency over relational depth, compounding racialised marginalisation.

Plane of Social Being	Themes/subthemes	Interpretation
Plane 4 – Personal (inner human being in the mental-social-embodied personality”) (identity, agency)	Forced Reliance Disempowerment and Agency Over Own Care Religion and Spirituality	Participants’ sense-making processes reflected both resistance and adaptation. Spirituality and cultural beliefs provided protective meaning while disempowerment reflected constrained agency under systemic pressures.

As shown in Table 10, participants' narratives spanned all four planes of being, with the greatest concentration of difficulties located within the institutional (Plane 3) domain. This exposes how structural conditions, such as service fragmentation and limited choice, shape these personal and relational experiences of care for Black adults. I now go on to discuss and present the themes in depth below.

5.4.1 Theme 1: A Fragmented Mental Health System

The first theme identified from the data exposed the consequences of a fragmented mental health system and highlighted systemic barriers and inconsistencies Black adults experienced when seeking support for trauma. While some of the systemic issues described may impact many service user populations, participants' narratives made clear that for Black adults, these challenges were often amplified by racialisation. The consequences and shortfalls reflected a deeper sense of not being seen, nor understood, ultimately excluded by the system when navigating support for complex trauma.

Participants described care journeys marked by frequent referrals and repeated assessments, often leading nowhere. Amir described a demoralising 18-month journey:

Continuity of care. It's so important, and the amount of people I've seen and then you get to the end of the process and one person will say, 'This person will help sort you out and redirect you', and then you go to the next person, and they say, 'Yeah, I'll signpost you and do that, I refer you to the next one.' And, then what happened at the very end was like, 'Oh, no, we can't do anything.' You just accept that it's just so under resourced. – Amir

For others, long waitlists and surface level interventions further eroded trust in the mental health system. Ava described reaching a point of disengagement after multiple failed attempts to access meaningful care:

I just thought... you've had a lot of trauma, trying to get help. I just think we need to manage this internally. And I just felt like, until I can afford to consistently fund privately - I just have a lot of, I guess, PTSD regarding accessing health just because it just hasn't been a streamlined process at all. – Ava

Beyond frustration, the instability of service provisions sometimes caused emotional and iatrogenic harm. The sense of being re-traumatised by the very system expected to support them emerged across accounts and how this undermined confidence in the system. Maureen reflected on this disruption and how it ultimately led her to withdraw:

:

The care coordinator kept changing. I found it really destabilising. I just find it sometimes with the mental health system ... you're vulnerable anyway and you take a chance to get help. And it can leave you in a worse state than before. I know with the mental health system two years ago I just discharged myself because I just think it wasn't helping ... My GP spoke to me recently and said, 'Oh, let me refer you to the mental health team again.' And I just said to her, I always feel misunderstood when I go there. – Maureen

While not explicitly referenced in terms of race, this sense of being misunderstood by services was echoed across participants' narratives and may be understood, particularly for Black adults, as connected to feeling culturally misrecognised. This repeated sense of being misread, even subtly, adds to the psychological burden placed on Black adults navigating services.

The culmination of these systemic failures, from discontinuity to iatrogenic harm, was a pattern by which Black adults reported being forced to become self-reliant. However, this self-reliance was not always framed as an empowered choice, but rather as a reluctant and exhausting outcome. For example, Elliott shared a sense of resignation after services failed to provide a meaningful resolution:

But last thing I remember, is to me it still felt incomplete. So, it's more like from that point on, it was more like trying to figure out the rest myself - Elliott

Others shared similar accounts of withdrawing or becoming self-reliant out of necessity. This pattern of self-reliance is rooted within a long history of racial exclusion from care, forcing Black adults to navigate their healing without adequate support.

Within this theme, participants' accounts illustrate more than just service inefficiency. For Black adults with trauma, systemic barriers were experienced as gaps in service that also created deeply personal ruptures in care, reinforcing feelings of marginalisation. The recurring sense of being misunderstood within care may not always have been framed explicitly in terms of race, yet it was felt in ways that were *racialised*, shaped by broader histories of racial exclusion and unequal treatment.

5.4.2 Theme 2: Alternative Support Systems

In response to failures of statutory services, Black adults turned to more informal spaces that felt more affirming. One notable commonality between participants was expressing value

around peer support in managing trauma. In some cases, this related to informal peer support such as through the community (e.g., social gatherings, local neighbourhood events) accessible to anyone. Peer spaces in the community allowed for mutual connections to be made and instilled a sense of belonging:

And so there's a lot of isolation around that and connecting with other people who've been through similar things, and you know, how they're managing was quite helpful to understand ways of, you know, ok, so I'm struggling, but it's ok because they did that, you know? That kind of thing. So I think the difference is that it made me feel connected and also felt cared about and supported at times when I felt particularly low or isolated. – Maureen

When people attended peer group spaces and shared experiences this often led to positive impacts on wellbeing for participants as it allowed them to feel validated and seen. For example, Amir shared the impact of this on their mental health:

I only attend one class a week that's it, right, but it's a regular group. You get to know each other. People take an interest in your life and how you're doing and whatnot. And, yeah, that has massively lifted my spirits for sure ... people get their comfort, and it becomes a safe space where you trust each other. And just being part of that community and support does make a big difference. – Amir

These spaces operated outside of formal services, yet they provided the relational safety Black adults felt was needed to heal. Whilst these spaces had benefits for many Black adults, several participants expressed a further need to seek out more direct culturally resonant support networks, ones where religious and spiritual backgrounds were acknowledged. Maureen talked about their experiences of peer support finding an LGBTQIA + group for racially minoritised groups in the voluntary sector, which offered space where her cultural background was recognised, not overlooked:

But ... with this therapy group, there was a lot more things I can explore. Because my background is from Jamaica, and there's a lot of spirituality within Jamaica itself. And I think, I've seen ghosts in the past, and when I mention it I always feel awkward about it. Whereas if I mention it to people in Jamaica, it's a normalised thing. So there's all that kind of translation that might get a bit lost. – Maureen

Common experiences within these more culturally affirming peer networks allowed Black adults to express greater authenticity and vulnerability when discussing mental health, and ‘fully show up’ as themselves, rather than concealing important aspects of their identity or experiences due to fears of being judged from statutory services. Maureen reflected on this:

It was a short space, but we spoke about spirituality. And there's just a wealth of experience that I have in terms of my mental health and life in general that I've never really gone into with, you know, sort of westernised therapy. So that just said to me that there's something here, because it wasn't only just about spirituality it was more as well about people's experience of being isolated, that sense of not belonging. – Maureen

Beyond cultural spaces, participants described how creative and somatic approaches also supported healing. These included acting groups, art spaces, and somatic practices that offered non-verbal ways of processing trauma. For instance, Elliott shared the impact of attending a community-based acting group:

But I went to a place ... it was essentially like a little acting place. Because I wasn't really good at using my voice then. I was very quiet. It taught me, how to speak up and like talk to people, and not always be so silent when it comes to things like this. And even though it was mainly, just primarily just like acting out scenes, it did teach me like there are always people who do want to talk to you and who do want to hear your own opinion on things and matters. And it did help me to open up a little bit more. – Elliott

For Elliott, acting was more than a creative outlet, it became a form of emotional expression, a space for interpersonal connection, and a catalyst for confidence. His story, along with others, demonstrated the importance of spaces that affirm one's voice and identity, offering both healing and community. These spaces and approaches were particularly valuable for those who had felt silenced or dismissed by traditional talk therapy models offered within statutory services.

5.4.3 Theme 3: Inappropriate or Inadequate Assessments

Black adults often reflected on the inappropriateness and inadequacy of assessments when accessing mental health services. Assessments often felt too short or were too generic. In particular, participants noted a lack of curiosity toward the racialised dimensions of their experiences, such as coping strategies informed by culture (e.g., collective prayer), which left them feeling overlooked or devalued. Assessments were often the first point of contact with

services and participants felt they set the tone for a care journey that overlooked their lived realities as Black adults navigating complex trauma.

Ava explained how their negative interactions with the assessor who made a culturally insensitive remark led to disengagement with the service and mental health system entirely:

It's just been so frustrating because understanding the generics or understanding the genesis of my culture will help you to understand the genesis of my problem.

INTERVIEWER: *And what was the impact of that experience when they said that to you?*

Well, I didn't continue. I dropped out. And this is a person that has come to you with trauma, saying 'I need support.' But no one is understanding of me. So it constantly feels like it's a vicious cycle of being penalised.

In reflecting on what she needed, they shared a simple but powerful suggestion:

I guess just a better understanding of me, maybe assessment should begin with: 'Introduce yourself before you introduce your trauma because you are not your trauma. – Ava

Rather than a reaction to the structure of the assessment itself, Ava's disengagement was prompted by a lack of cultural understanding and a sense that her background and identity were being overlooked. Amani also expressed their thoughts on cultural awareness among assessors:

It would have made a huge difference ... I think it would be very helpful because they would obviously have an idea or have some experience of some of the experiences [of what] it's like to be an ethnic minority, and that's helpful. – Amani

Some participants criticised assessment methods such as the extensive reliance on questionnaires. Black adults shared that administering assessment tools *before* any human connection felt impersonal and inappropriate, particularly during vulnerable periods of accessing support:

*I like the fact that somebody has to contact you before you do like your questionnaires. It's like, 'How have you felt in the last three months?' It's the *GAD-7 score and all of that. And I like the fact that, that's not flung in your face, you have to speak to a professional first. That doesn't always happen. Sometimes you literally call and you're like 'I'm depressed' and they're like, 'Really? Answer 50 questions on how depressed you **really** are.' It's like, this is inappropriate. – Ava*

*GAD-7: Generalised Anxiety Disorder Questionnaire.

While the impersonal nature of these tools was a concern for many, not all participants dismissed their usefulness entirely. For Jamila, questionnaires helped her contextualise the severity of her experiences, even though it initially seemed reductive:

I think for me, it was more - kind of really put into words like how serious this was in terms of low scores. And I think at the time I kind of saw it as, like, 'Wow, it's just a questionnaire, like, doesn't really mean anything.' Um, but because of the scores that I had, it was kind of - it made me realize, OK, this is more serious. And the doctor was taking it quite seriously as well. – Jamila

And so, while questionnaires may help articulate distress, they are no substitute for relational, sensitive engagement in the context of trauma. When deployed without care or cultural sensitivity, they risk reinforcing feelings of invisibility and mistrust that Black adults may already hold at such a pivotal moment in their care journey, potentially leading some to disengage entirely from the system. When assessments became inadequate here, they often acted as barriers rather than gateways to healing. These early experiences often ushered Black adults into an overly medicalised and standardised mental health system that prioritised symptoms over stories, a dynamic explored in the following theme.

5.4.4 Theme 4: Overly Clinical and Medical Focus

Beyond the initial point of access to services, many Black adults shared how the ongoing delivery of care remained dominated by narrow medical models. Rather than progressing into

more relational and holistic forms of support, desired by many, Black adults encountered systems that continued to prioritise diagnosis and symptom monitoring. Maureen shared:

And sometimes when I go and I talk about my mental health in terms of, I don't know, the bipolar, and I know that's not the true picture of everything, it's just an aspect of me. But then I'm seen through this lens of, 'How are you sleeping?' And that's not the full picture that they're getting, but that's the picture that they take and accept. – Maureen

This sense of disempowerment led to some participants feeling service providers generally lacking genuine interest in them, or even not wanting to listen nor trust service users' perspectives or desires. The emotional toll on participants of not feeling listened to caused frustrations navigating what was deemed an already unjust system with their needs feeling ignored:

When I try and, I'm unwell and I need to seek the services ... I feel disempowered. Sometimes like psychiatrists, they don't listen to you. It's almost like you're an unreliable narrator of your own story and your own needs ... And I always find that in terms of the mental health system ... there's just no investigations or curiosity about me or my life. It's this kind of tick list of symptoms, ok so you're going through this, here is the medication and then get on, you know, are you looking for therapy – Maureen

Others spoke to a desire for alternative or complementary approaches that were more in tune with their values and ways of healing:

You know, medication ... I don't take them all the time. Now, I've moved into more natural therapies, which I really like ... they ground you. It's a mind, body, and soul treatment option – Amani

However, participants shared how these more integrative and meaningful approaches were absent from their treatment pathways. What they encountered instead was the dominance of a biomedical framework throughout the care pathway, one that focuses on pharmacological treatment and diagnosis, which was often seen as misaligned with the needs of Black adults.

5.4.5 Theme 5: Cultural Matching

Participants described how access to practitioners who shared similar cultural backgrounds deeply influenced their ability to engage with services. For Black adults, cultural matching was not simply a preference, but a factor that shaped their sense of being understood and emotionally safe, especially when disclosing racialised trauma and racism.

A common frustration though was the lack of availability of diverse practitioners within statutory services. This often left Black adults feeling disillusioned or forced to accept care that didn't align with their needs or identities. Tony reflected on this after inquiring about cultural representation in one service:

That was one of the early questions is ... What cultural backgrounds are your therapists coming from? And it was very clear that it was, primarily white and primarily women, and I said, "well, you know, if I wanted a black therapist. Ideally male, you know, 40 to 50 with some life experience from London. How long would I need to wait? And the answer was, well, we don't really have anybody like that in our system at the moment. So, would you like to take what we've got? I never asked the question again after that because I then started to read and learn about that service and I realised that in order to get that type of profile, you'd need to be very lucky or wait a very long time. – Tony

Tony, like many others, attempted to seek support elsewhere when realising their preferences were unlikely going to be met through statutory services. This created additional emotional and logistical burdens, with Black adults describing the need to research and navigate services independently while unwell. However, when eventually finding practitioners who they deemed relatable in other sectors, cultural matching fostered a deeper sense of feeling understood and valued. For example, Tony shared their experiences of finding a suitable practitioner through a community organisation after disengaging from statutory services:

I've signed up with an organization called BMM. Black Minds Matter. They have just gone out to market with a free service, which I still can't believe. Offering 10 1 to 1 sessions with a counsellor, a practitioner of colour ... they've just connected me with my therapist, and I've checked her out online on LinkedIn and her profile looks absolute bang on match for me. And I couldn't be happier. – Tony

Ava shared a similar journey and their experiences of eventually finding another Black woman through the same organisation who they could choose to work with and the profound emotional shift:

It was everything. Because at that time, that was the help I needed ... And I just remember, 'I don't know what to do.' I needed a Black woman to come and say, 'This isn't your job. This isn't your fight to fight, you know?' And that she did say. So, it was so important. It was everything in that particular season of my life.

INTERVIEWER: *What was the impact of having that choice and being able to make that choice?*

The impact on me was just - I feel like it honestly, improved my overall wellbeing. I wholeheartedly believe that because it just felt like I'm really being heard. And it's like healing me from the inside out. Yeah, it boosted my self-esteem. It boosted my morale, increased my self-worth. It was amazing, you know, just to be honoured by being listened to. – Ava

Participants also described how working with practitioners who did not share similar cultural backgrounds could limit the depth of therapeutic engagement, particularly when it came to discussing experiences of racism or discrimination. Maureen shared:

So at the time when I went to see the therapist that I was seeing, some of the things I brought up ... it just fell short. It wasn't explored in a way that I was doing with my friends. There wasn't any depth as much as I would have liked to have gone into ... there was stuff happening at work as well at the time. You know, I think that was racial discrimination ... when I spoke to my friends, they would give me more information about what I could do about it or, you know, understand. But I felt that wasn't really an avenue that I could sort of explore with my therapist. – Maureen

For those seeking cultural matching who had financial barriers to affording therapy elsewhere, often support was sought through existing informal networks (e.g., friends and family). These informal networks had great value in acknowledging shared understandings of some of the racialised difficulties that exist for Black adults, such as managing racism, which led to more practical advice and support. However, these networks lacked the necessary clinical intervention needed to manage psychological aspects of trauma (e.g., nightmares) which many Black adults were seeking to manage as part of their distress:

It's more of a kind of an understanding that when you do explore a sense of connection, belonging, spirituality, those elements as a black woman living in Europe, it's just ... there's more of an understanding with my friends, but there's some things that I don't tend to go into with my friends, because, they're not mental health professionals – Maureen

While most participants (notably all Black women) viewed cultural matching as critical, a few male participants held a more neutral position. Amir, for example, acknowledged its importance for others, even if it wasn't essential for him:

I know some people have the whole thing of what's it called, a cultural ... culturally appropriate therapy ... Me personally, I don't really care for that, but I know it does have an effect. – Amir

Findings within this theme ultimately emphasise how cultural matching between Black adults and practitioners shaped both access to and quality of therapeutic engagement. While not universally prioritised, for many, the option to choose a practitioner with a shared cultural background was central to feeling understood, particularly navigating the impacts of racism and trauma.

5.4.6 Theme 6: Improving Person-centred Care

This theme highlights how participants experienced care that often felt rigidly standardised and inattentive to their lived experiences as Black adults with complex trauma. While person-centred care is widely upheld as best practice, Black adults described a common disconnect between this ideal and the realities of statutory care. Rather than feeling recognised as individuals, Black adults spoke to being treated as data points within a system structured around efficiency and targets, that left little room for relational and cultural understanding.

This sense of detachment was most expressed during experiences of Cognitive Behavioural Therapy (CBT). Black adults felt that care was reduced to pre-set tasks where relational engagement was minimal. Deborah explained:

Sometimes she will finish the session early, and like she just didn't seem like she cared. It was just like a checklist ... it was like I was just another number, and I am not that important. – Deborah

This structured model left participants feeling like passive recipients rather than active participants with agency in their own care. This often reflected a pattern of feeling unseen or undervalued within therapeutic spaces. Tony shared a similar sentiment:

I had never, ever had felt any level of partnership throughout any of my CBT sessions. For me, it was just a tick box exercise. And it was just a matter of statistics and data. You know, you're just another number. – Tony

Participants' accounts expanded beyond critiques of therapeutic style to highlight the institutional logic underpinning these interactions. For some, this repetitive emphasis on targets and outcome measures came to symbolise care that failed to treat them as full people with lived experiences. Ava expands on this:

We really downplay the power of communication, the power of interest, you know, like genuinely just being interested and just caring, not being so task focused. Because I don't think when it comes to the lives of people we should be saying, 'Oh, obviously KPIs matter and that, but you're making your boxes green on Excel but making people's actual life red.'*

**KPI – Key Performance Indicators*

In this context, person-centred care was actively displaced by service cultures that continued to prioritise procedural compliance over connection. Ava went on to discuss the importance of person-centred care which is purpose-driven, not task-driven, with them critiquing the systemic structures in mental health services that prioritises 'tick boxes' at the expense of understanding people's unique needs:

You can't be task focused with people's life in your hands. You can't tick boxes and assume you've done a good job. That's not how it works. So, we have to change the structure and the systems in place because nobody's life is an Excel document. It's a lot more intricate than that. - Ava

In contrast to the rigidity of task-focused care, participants expressed a desire for more collaborative, flexible approaches. They offered practical suggestions, such as greater use of whiteboards and visual tools that could enhance engagement. Tony elaborated on this:

One thing that absolutely surprises me is that in these therapy rooms, there isn't a white board. I'm about facilitating ... I want to be able to engage. Those 45 minutes might be the only 45 minutes I'm going to be with a professional for the next 14 days. So, I want to be able to go in there with some ideas, and I want to be able to talk through those ideas. This is what's happened to me. This is how I dealt with it. Let's brainstorm. – Tony

Tony expanded further on the role of collaborative treatment practices, and the impact when such tools are missing:

We have got to be more creative here. You have got to be able to use the technology, use the whiteboard, get up, put a pen in your hand, talk, get your thoughts out. Because when I come out of those sessions with this guy, unless I'm doing the same as he is, which is writing down stuff, then what do you get? You get two guys who are writing but not communicating ... and then 6 sessions later, I'm coming out thinking, "actually, what did I accomplish?" Not a heck of a lot really. – Tony

Without opportunities for collaboration, participants described therapy as something that was done *to* them, not *with* them, a dynamic that mirrored wider disempowerment experiences Black adults shared across care pathways.

Beyond the structure of care, the physical environment also emerged as a key component of person-centred care. Participants discussed how traditional clinical spaces, such as hospitals, often felt impersonal, and ill-suited to the needs of those with trauma. In contrast, more community-oriented, informal spaces were perceived as healing environments. Maureen shared their experiences of a community-based crisis house, and how these spaces were deemed more supportive. They discussed the impact of the surrounding area, the comfort of the space, as well as the absence of rigid professional roles:

*This house in, somewhere in Bristol where they've got charity shops nearby and cafes. And then the house is actually big. It's comfortable, there's a garden and they have like, carers who, I mean, some of them have had experience working in the NHS, and some of them haven't. So they don't have you know ... if you're in hospital somebody would say to me, 'Oh, I'm the *HCA or 'I'm the nurse ... There's nothing like that within the crisis house. It's everyone is kind of equal in a way ... it's more of a community. – Maureen*

*HCA – Healthcare Assistant

Their experiences highlight how informal environments with fewer visible hierarchies can create a stronger sense of emotional safety and belonging when navigating trauma. Maureen contrasted this to nature of hospital environments, sharing how they felt 'cold' and clinical:

"I think at the time, I think I just definitely needed warmth. I didn't want to go into a clinical space, you know, with all the kind of no windows situation and uncomfortable chairs. It just, yeah, it just felt very cold and clinical. – Maureen

For Black adults with complex trauma, these interactions and spaces discussed in this theme held particular emotional weight. Many adults, as shared, had already navigated systems where their distress and identities have been overlooked or misinterpreted. When entering services that offered minimal connection and environments deemed unwelcoming, participants felt like past harms were being repeated. Person-centred care, in this context, was missing the integral elements that were needed to respond and acknowledge the full complexity of Black adults' lives and support needs, something rarely experienced in

practice. As a result, many Black adults were left feeling marginalised within their own care, deepening feelings of exclusion.

5.5 Discussion

This study provided insight into the unique experiences Black adults with complex trauma have when accessing and navigating mental health services. I explored through qualitative interviews the journeys Black adults had when seeking support for complex trauma, including their experiences and views of mental health services. Several themes emerged from the data which included a fragmented mental health system, alternative support systems, inadequate or inappropriate assessments, overly clinical and medical focuses in care, cultural matching, and improving person-centred care.

When interpreted through the ‘four planes of social being’ (Bhaskar & Norrie, 2013), participants’ accounts illuminate how experiences of trauma care are distributed across multiple levels of reality. Natural and relational dimensions (Planes 1-2) shaped the immediate sense of safety, belonging, and trust, while institutional processes (Plane 3) often constrained opportunities for continuity and cultural responsiveness. At the personal level (Plane 4), participants drew on spirituality and self-reliance as protective responses to systemic failures.

Notably, the preponderance of difficulties described at the structural plane aligns with the findings of my systematic review, which showed that existing culturally adapted interventions predominantly target individual and relational levels but rarely engage with structural determinants. Together, the mixed-methods findings highlight the need for trauma-informed models that extend beyond individual adaptation to include institutional reform and racial equity work at structural levels.

Another recurring thread across Black adults' accounts was a sense of invisibility within mental health services. An experience that, while not coded as a discrete theme, powerfully illustrated how statutory services often failed to acknowledge or validate their identities and needs. This reflects wider work on epistemic injustice in healthcare, where the voices and experiential knowledge of marginalised groups are routinely dismissed or devalued (Carel and Kidd, 2014). Such systemic disregard has serious consequences for both the quality of care and the erosion of trust between marginalised groups and the healthcare system.

These findings also highlight that whilst some challenges may be shared with other service user populations, complex trauma among Black adults is often layered and racialised, shaped by both interpersonal and systemic harms. These intersecting dynamics help explain why statutory services were so often experienced as culturally incongruent, and thus, emotionally unsafe and unhelpful. These findings closely align with the work of Thema Bryant-Davis (2019) who argues for trauma recovery models that are culturally grounded and responsive to spiritual, communal, and embodied dimensions of healing. When these dimensions are ignored, and when care remains narrowly clinical, it widens the risks of further harms placed on Black adults and alienating those in need, as found in this study.

Black adults frequently experienced fragmented and disrupted care journeys and often faced ‘closed doors’ whilst in times of need. The trauma support they sought, such as relational, comprehensive, and culturally grounded practices, was generally considered beyond scope of what was available in statutory services. These systemic shortcomings placed a disproportionate burden on Black adults to co-ordinate their own care, often through informal support or self-reliance. While these alternative strategies reflect resilience among Black adults, they also expose structural neglect. As a result, Black adults commonly reported experiences of iatrogenic harm: often re-telling traumatic histories to several clinicians, receiving impersonal short-term interventions, inappropriate assessments, and ‘bounced’ between services, often without meaningful support. These fragmented encounters and disruptions eroded trust, further distancing them from systems that already felt unwelcoming or unsafe. These findings together echo evidence that discontinuity in care disproportionately harms those with complex trauma (Adair et al., 2005), and the urgent need for trauma-informed systems that are capable of sustaining meaningful therapeutic relationships (Courtois and Ford, 2012; Slade and Holmes, 2019). Crucially, such systems must be culturally attuned and responsive to socio-cultural needs of service users in order to not inflict further iatrogenic harm (Sweeney et al., 2022).

In response to fragmented and impersonal care, many Black adults turned to alternative systems of support which were more validating and affirming. Black adults' signalling value towards creative arts-based approaches, peer networks, as well as spiritual and community practices may reflect a desire for trauma healing that is relational and expressive by nature. Such approaches may be particularly important in the context of complex trauma which often disrupts agency and emotional expression (Shepherd & Wild, 2014). Further, spirituality and religious practices have been long documented as protective factors to mental-ill health for

racialised groups (Nguyen, 2020). Religious and spiritual gatherings provide spaces where communities can collectively discuss their experiences with others who may share similar struggles. And so, these collective spaces may shield experiences of isolation that are often manifested in complex trauma experiences (Dagan & Yager, 2019). This level of cultural understanding and solidarity provided by others who follow similar values and customs may extend beyond what is typically offered within statutory mental health services (e.g., individual talking therapy).

A critical finding from this study was that many participants felt their care was centred too explicitly on clinical and medical management with little room for exploring alternative solutions. This may speak to larger criticisms of Western psychiatry and medical practices which centre a biomedical model (Deacon, 2013). Cross-cultural studies have cited concerns that Western psychiatry and medical models of illness tend to individualise and pathologize distress without factoring wider socio-cultural and political manifestations of distress, such as racism or systemic oppression (Morrow & Weisser, 2012). It is therefore important for practitioners to engage meaningfully with the sociopolitical realities and structural harms that shape Black adult's experiences, including an awareness of potential prior experiences of silencing or discrimination Black adults may have had in healthcare. Efforts made here may help combat medical distrust and the ongoing sense among Black adults that their needs are routinely overlooked (Brown et al., 2024).

Preferences for cultural matching were also nuanced. While all Black women in this study expressed a desire for practitioners who shared their cultural background, this was less evident among all Black male participants. This suggests the importance of considering how racialised and gendered experiences of trauma intersect (Collins and Bilge, 2020), and how these intersections inform care preferences. The findings support institutional efforts to diversify the mental health workforce, providing greater *choice* for service users, which becomes particularly important for trauma survivors whose histories are often marked by disempowerment (Sweeney et al., 2018). Indeed, expanding and retaining a racially diverse workforce remains a key global priority in health services (Hussain et al., 2020; Rao et al., 2018).

Black adults in this study found great therapeutic value in collaborative and partnership work between themselves and providers. These participatory approaches in care may work favourably with Black adults, particularly when factoring for the disempowering nature of

racism and systemic oppression (Corneau & Stergiopoulos, 2012). In contrast, CBT was often experienced as too structured and rigid and left little room for the collaboration Black adults wanted. And so, while CBT has established evidence in reducing trauma symptoms for many (Lewis et al., 2020; Bisson et al., 2007), more research is needed to explore experiences of unmet needs in treatment, particularly for Black adults with complex trauma where the evidence base remains scarce. Additionally, those exposed to complex trauma may have had prior experiences of chronic invalidation (Cook et al., 2005). Therefore, it is crucial that services do not maintain these experiences and instead pay particular attention to collaborative, validating approaches within assessments and treatments.

The preferences for less clinical spaces to do therapeutic trauma work as shared by Black adults in this study is in line with trauma-informed approaches that emphasise the need for comfort and safety (Sweeney et al., 2018). Black adults reported having assessments and interventions often in busy and loud general practices or outpatient hospitals, which were sometimes considered unsuitable places to access trauma support. Empirical work also questions the suitability of these environments when factoring for historical and cultural concerns, whereby Black adults may find traditional clinical environments (e.g., general hospitals) stigmatising due to historical marginalisation and medical racism (Feagin & Bennefield, 2014). Taken together, service providers should remain aware of the environment and therapeutic spaces that are available to service users to avoid re-traumatising those who access care.

Rather than proposing these adapted practices replace statutory services entirely, findings suggest an opportunity for integration and collaboration. Mental health services would benefit from moving beyond narrow biomedical models by working alongside culturally congruent services or existing community networks valued by Black communities. This includes developing referral pathways to trusted, community-based support and funding culturally adapted interventions. Integrating statutory and community responses could improve both the accessibility and acceptability of care for Black adults with complex trauma.

The findings further highlight the need for trauma-informed care that is both culturally attuned and responsive to the racialised dimensions of trauma. A truly effective model of care must centre clinical expertise alongside an active responsiveness to the lived realities of those it serves, especially Black adults navigating the impacts of complex trauma. This requires embedded anti-racist, healing-centred frameworks in clinical training programmes ensuring

practitioners are equipped with relational and reflective skills, cultural awareness, and a critical understanding of the systemic forces that shape how trauma is experienced and expressed among Black groups. Ultimately, improving outcomes for Black adults with complex trauma requires systemic reform that aligns care and training practices with principles of dignity and cultural belonging, and are consequently grounded in a sustained commitment to ethical, culturally responsive care. These reforms are crucial for ensuring timely access to effective trauma-informed support that honours Black adults' cultural identities and lived experiences, while reducing the racial disparities they face in accessing care.

5.5.1 Limitations

Whilst this study offered rich and valuable insights into the experiences of mental health services Black adults with complex trauma had, several limitations in the study exist. Firstly, the study focused on experiences accessing statutory mental health services and the voluntary sector in the United Kingdom. NHS mental health services have specific structured pathways to care and policies that may limit transferability of findings to other global health systems. Another limitation of the study was that the study focus was not on exploring previous or ongoing traumas Black adults had, but more on how mental health services can best support this population. It felt important to adhere to trauma informed principles (Reeves., 2015) and create safe and supportive environments for participants to not risk re-traumatisation by probing on trauma histories. This though may have limited understanding on how specific traumas may have influenced experiences, and how they may relate to specific needs of Black adults navigating services.

Conducting this study as part of a doctoral project also had many logistical constraints worth mentioning. Time, funding, and capacity, imposed challenges to how extensively co-analysis or fully democratic processes could be implemented. For example, whilst the LEAG shaped many elements of the study design and validating emerging interpretations, the final analysis was independently conducted by me. This dynamic, while pragmatic, meant that power could not equally be shared across all phases of this study. These tensions reflect broader realities within participatory and survivor led research where ideals of power-sharing must often contend within institutional structures and resource limitations (Cargo & Mercer, 2008).

5.5.2 Conclusion

Significant challenges exist for Black adults with complex trauma in accessing and receiving trauma support. This study highlights the pressing need for trauma-informed care that is tailored and adapted to the unique cultural needs of Black adults. By addressing these challenges, services become more inclusive and responsive to the needs of Black adults with complex trauma and strengthens the potential for improved experiences and outcomes for this population. The findings reinforce the imperative for structural reform within services, reform that dismantles existing barriers and expands access to culturally informed, appropriate pathways of care.

5.6 Chapter Summary

Significant challenges exist for Black adults with complex trauma in accessing and receiving trauma support. This chapter highlights the pressing need for trauma-informed care that is tailored to the cultural needs of Black adults to improve experiences accessing trauma support based off the findings emerged from the qualitative study. Adaptations to current practices may lead to improved experiences of Black adults on their journeys to accessing services and ultimately equitable access to services too.

6 CHAPTER SIX: DISCUSSION

6.1 Chapter Overview

This discussion chapter synthesises the findings from all three studies conducted and explores how best to support Black adults with complex trauma who access mental health services.

The systematic review provided valuable data on the benefits of culturally adapted assessments and interventions for trauma and depicted their effectiveness when working with racialised populations, however more research is needed to explore longer-term outcomes of interventions as well as qualitative experiences of undergoing assessments or treatments.

Findings from the descriptive clinical records study explored current clinical practice approaches when assessing and supporting adults with trauma and highlighted the need for better screening and referrals made for complex trauma support. Lastly, the qualitative interview study allowed for narratives and experiences of Black adults with complex trauma to be platformed, and allowed rich insights into how Black adults experience current trauma support within mental health services. Taken together, I discuss the implications of the studies for reducing inequalities and poorer outcomes within the mental health landscape for Black adults, and I make recommendations for informing future research, clinical practice, and policy.

6.2 Interpretation of Key Findings – Synthesis

In this section I discuss the outcomes of the interpretation phase of the concordant triangulation strategy, informed by Plano Clark (2017), detailed in Chapter Two. Based on this interpretation phase of study findings, six main conclusions were drawn from the synthesis: 1) lack of routine assessments for complex trauma, 2) inadequate care pathways, 3) partnerships and collaborative working, 4) culturally adapted treatments and interventions, 5) medicalised language and concepts, and 6) practical and environmental considerations. I discuss in detail each key finding below.

6.2.1 Lack of Routine Assessments for Complex Trauma

The systematic review highlighted that amongst the current literature very limited empirical evidence exists understanding culturally adapted trauma assessments for racialised minorities, particularly for Black groups. In addition, both the clinical records study and qualitative studies depicted significant neglect towards assessing for complex trauma among Black adults.

When factoring for the needs of Black adults, experiences of complex trauma may be compounded by experiences of racism and discrimination. As Cénat (2023) details in a recent review, racism operates as a chronic and cumulative stressor that profoundly impacts trauma experiences. Yet routine mental health assessments fail to investigate these dimensions, despite evidence depicting racism as a contributor to psychological distress (Paradies et al., 2015) and contributing to worse physical health outcomes (Williams et al., 2019). Inadequacy here only risks not identifying levels of needs of these groups accessing services, potentially leading to inappropriate care pathways and support, or worse, contribute to poorer experiences within services.

Valuable findings from my qualitative work directly expose the impact of these consequences. Participants reported how current assessment practices too often fall short at capturing the lived racialised experiences of Black adults into formulations. Participants detailed how culture influenced how they managed their traumas (e.g., through faith-based means, or accessing tailored community support), yet assessments neglected enquiry around these areas. Consequently, assessments that did not explore experiences of racism or aspects of their cultural identities led to some Black adults ‘not feeling seen’ or feeling misunderstood. As in, by failing to explore the lived realities of navigating the world as Black adults, efforts to understand their identities and traumas became insufficient. Their concerns raise a valid question. How can services even begin to understand trauma among Black adults should they fail to understand Black adults themselves? The two are not mutually exclusive.

To be fully understood and be offered less impersonal care, Black adults were seeking validation and acknowledgment of their cultural identities and how they influence the management of their trauma, to then determine how best they could be supported. As argued by Laher and Cockcroft (2017), culturally responsive assessments are crucial for effective

person-centred care and improved outcomes. Current assessment practices experienced by Black adults in the qualitative work exposes significant limitations in this area.

6.2.2 Inadequate Trauma Care Pathways

Findings from the clinical records study showcased streamlined and effective pathways to trauma support (i.e., from assessment, referral, to treatment) were rarely documented. It was therefore not possible to determine whether such pathways were truly absent or whether they were provided but not coded. Nonetheless, the available records point to an apparent lack of systematic follow-up after trauma disclosures. This finding was further re-iterated within the qualitative component, whereby Black adults also reported journeys on inappropriate care pathways with no participants reporting being referred to desired trauma-specific interventions within NHS services.

These findings may speak to a wider systemic challenge in the current national health system in the UK without factoring uniquely for the needs of Black adults, and speaking more generally. Both the clinical records and qualitative studies point to the absence of routine and integrated trauma assessments, which seems to be a critical shortfall in care pathways. My study findings from the systematic review and qualitative study showcased significant value in community-based services or networks, faith-based groups, as well as peer support systems, as these alternative support systems were deemed influential in managing trauma experiences. Yet, even beyond the issues on assessment, both studies showed that such support systems were rarely acknowledged nor incorporated into formal care pathways, despite their central role in supporting those with complex trauma.

A growing evidence base does exist showing the efficacy of these alternative support systems in the recovery of trauma. For example, Harper and Paragament (2015) argue that spirituality and religion become reliable supportive methods of addressing trauma, specifically in helping individuals make sense of their distress and developing coping mechanisms. There is additional supporting evidence by Bryant-Davis's work (2012) that again shows spirituality being a strong protective measure against traumatic distress and being a reliable coping mechanism. Despite the advantageous roles religion and spirituality may play in managing trauma, my current work exposes that there is significant neglect for integrating these support systems within current pathways.

Black adults in my qualitative study reported the journeys following assessments to seeking support for complex trauma were often prolonged and exhaustive with many failing to

eventually access the trauma support they desired. This lack of streamlined care following assessments exacerbated feelings of alienation and mistrust Black adults had, forcing many to become self-reliant. Black adults shared they often found they were referred to inappropriate services that offered short-term, surface level interventions that did not tackle the root causes of their trauma. Others reported feeling disempowered by a lack of choice and decision making in their own care planning, feeling they were offered medicalised treatments rather than the support they desired.

These qualitative accounts resonate with the descriptive findings from the clinical records study, which showed that many individuals with documented trauma histories had records of pharmacological interventions or general follow-up, though the data did not allow assessment of whether these were appropriate or sufficient. Taken together, the evidence from both studies suggests systemic challenges in how trauma is recognised and supported within services. While these challenges appear to affect service users broadly, the qualitative findings demonstrate that the consequences for Black adults can be especially profound, showcasing the need for more culturally informed trauma pathways.

6.2.3 Partnerships and Collaborative Working

Another key finding from my work is around the role of collaboration and partnership between service providers and users. Picked up in my systematic review, valuable adaptations to assessments and treatments often included collaboration. Collaboration involved the development of culturally adapted assessments or interventions, intervention delivery, as well as embedding community experts and those with lived experiences in these processes too.

Findings showed credit to the knowledge and experiences community services or systems had when supporting those with trauma. Community leaders such as faith-based leaders, grass-root organisations, and community networks (e.g., social support in local community centres and neighbourhoods) were commonly expressed to obtain influential knowledge and skills in supporting their communities, which was picked up as a key adaptation method in the systematic review.

The reliance and comfort these community systems provided were seen as valuable to managing the holistic needs of those with trauma. These networks allowed many to connect and obtain mutual support when facing distress and combat isolative experiences. Research supports these findings, with evidence showing clear value of community resources in trauma recovery, particularly for racialised populations (Schultz et al., 2016). For Black adults in the

qualitative work, their communities were a space to feel empowered and ‘heard’, thus holding significant value to them whilst managing their trauma.

Whilst the review data precluded the possibility to explicitly explore how partnership work and collaborations implicated experiences of those undertaking the adapted interventions despite it being a key adaptation, the impact of limited collaborative efforts was detailed in my qualitative work. Black adults discussed how a lack of partnership approaches led to missed opportunities for meaningful engagement or empowerment, directly impeding positive outcomes of approaches administered to them. Key though, was also how this impacted the role of trust between Black adults with trauma and service providers.

Collaborative partnership approaches in healthcare may signify value and credibility due to an established measure of equal partnership (Lake & Turner, 2017). And so, when this is not adhered to or even offered, understandably many Black adults shared disappointment. Involving mental health service users in their own care planning and establishing collaborative practices has indeed been demonstrated in prior literature to have clear value (Clark, 2015). Suggested adaptations that include partnership and collaborative work emerged from the qualitative findings. These included the use of whiteboards and co-creation tools within sessions, visual aids, greater agency, and greater decision making. These methods directly value the role of service user’s voices in shaping the care they would be receiving. They also bridge any gaps in communication between service providers and service users and allow care to be more person-centred or tailored around individual and culture-specific needs.

Lastly, concluding much of the above, the lack of collaborative approaches itself acts as a significant barrier to efficient care. As directly detailed in my qualitative work, when the voices and experiences of those accessing care become neglected, so do opportunities to allow these groups to have positive experiences and outcomes of care. Both the systematic review and qualitative components platform the impacts of culturally adapted interventions that acknowledge the role of spirituality or alternative approaches to healing outside of mainstream approaches (e.g., somatic or drama focused approaches).

However, as picked up in the qualitative component further, a lack of collaboration within care planning leads to these preferences becoming overlooked, ignored, or even offered within current services. As a result, care becomes misaligned between what Black adults deem valuable and what is available to them. And as depicted in the qualitative work, these

painful experiences force many adults to disengage entirely from mental health services, rather than risk continued efforts to be understood and receive desired support.

6.2.4 Culturally Adapted Treatments and Interventions

Culturally adapted interventions or treatments were reported as advantageous in both my review and qualitative work, yet accessing these interventions within current care pathways was less notable in the clinical records and qualitative work. This is of particular concern given the meta-analysis conducted as part of my review also detailed that adaptations to treatments yield statistically significant reductions in trauma symptoms (Benjamin et al., 2025).

Black adults found transformative potential in interventions that go beyond conventional talking therapy and instead incorporate sensory, creative, somatic, and spiritual approaches. Drama-based therapies, somatic interventions, and expressive arts were particularly valued as they engage the body and emotions in ways that traditional methods (e.g., individual therapy) do not. In the systematic review conducted as part of this work, somatic and sensorial focused adaptations to interventions were cited as particularly beneficial in supporting refugee or asylum-seeking populations with trauma. Somatic therapies provide ways to process trauma through movement and body awareness (Scaer, 2014), routes that may feel safer or intuitive for groups who struggle to verbalise their trauma, due to factors like language barriers or even the overwhelming nature of trauma itself.

These approaches may also align better with community-based healing traditions often found in racialised minorities, including many refugee communities. For example, collective practices such as dance and drumming, have historically played important roles in healing across many cultures (Bennet Leighton, 2018). They also offer alternative models of care against Western models that prioritise ‘thinking and talking’ (Kuhfuß et al., 2021), which may be less familiar to these populations. As found in my review, incorporating these approaches into trauma care respects cultural differences and can enhance treatment engagement and efficacy.

Alongside this, spirituality also emerged as a central dimension of culturally adapted care across the systematic review and qualitative work. Findings of the review showed support to adapted trauma assessments to explore spirituality among adults and whether adults may conceptualise their trauma or distress as being routed through spiritual means. The review also showed how using religious coping mechanisms like collective prayer was also a

beneficial asset to adapted interventions (Benjamin et al., 2025). Many Black adults in the qualitative segment depicted faith and spiritual practices as key sources of resilience, and were particularly supportive when mainstream services were not helpful. Interventions that incorporate these elements (e.g., meditation, rituals, spiritual gatherings) fostered a deeper sense of connection or purpose in the trauma healing process.

These adaptations are important, as these practices were grounded in ways that affirmed Black adult's cultural identities and thus strengthened their engagements with adapted interventions. And further evidence in the literature does support this, in that better therapeutic engagement and outcomes in services can be achieved when service users feel services reflect their lived experiences and cultural identities (Vasquez, 2007; Asnaani & Hofmann, 2012).

6.2.5 Medicalised Language and Concepts

A major finding from this work also highlights the limitations of medicalised concepts and language. Black adults often felt their care was seen through fixed and rigid Western diagnostic frameworks that failed to capture the lived realities of their trauma. This was notably highlighted when services failed to explore experiences of racism. This disconnection was apparent in my qualitative work with many feeling alienated within services. The clinical records research component also showed a significant neglect to screening for racism and discrimination within routine clinical practices.

Medicalised language that is grounded through Western concepts and psychiatric paradigms often conflicts with the idioms of distress used by racialised minority groups (Antić, 2021). As an example, in both the systematic review and qualitative work, trauma experiences such as nightmares may have been seen through spirituality, such as 'spiritual attacks'; rather than as a symptom of a disorder such as PTSD. This has implications when it comes to assessing for trauma, as Black adults may find screening measures either inappropriate, potentially not disclose experiences, or may misunderstand what is being asked from services. Whilst these experiences and expressions may be culturally understood through spiritual or ancestral frameworks for some cultural groups, they may also be misinterpreted as symptoms of psychosis within Western psychiatric frameworks (Phillips III et al., 2009; Hecker et al., 2016). And so, these cultural expressions and understandings towards trauma offer crucial insights into the spiritual or emotional dimensions of trauma, yet, become commonly

dismissed, overlooked, or even pathologized, within services should they not be enquired sensitively and appropriately through assessments.

Such misunderstandings may contribute to the longstanding mistrust racialised minorities may have towards services when seeking support for their mental health (Whaley, 2001; Suite et al., 2007). My findings also suggest a transition away from deficit-oriented models of care that pathologize and individualise distress is warranted. Alternative approaches may instead centre on either collective or strength-oriented approaches that acknowledge cultural pride or community networks that contribute towards trauma healing (Schrader et al., 2013). For example, in the qualitative work some Black adults spoke about feeling accepted within intersectional peer spaces, such as LGBTQIA+ groups, groups specifically oriented around the unique needs of racialised minorities. The implications of these collective spaces allowed affirmative, validating experiences of those attending, and contributed to a greater sense of belonging. Providing affirming environments that centre on cultural identity among marginalised communities thus has potential to facilitate healing in ways formal clinical settings may not (Kirmayer et al., 2003).

Lastly, a consistent narrative I have reported throughout my work is around the vitality of producing spaces where service users feel heard and understood. Services should be prepared to alter their relational and communication practices, pay attention to the cultural narratives of Black adults, and avoid from enlisting Westernised concepts or language that may not resonate to service users. This aversion offers greater opportunities for racialised minorities to feel respected, significantly weakening chances of disengagement within their care (Memon et al., 2016).

6.2.6 Practical and Environmental Accommodations

Practical and environmental adaptations were crucial elements to establishing trauma care that feels safe and welcoming for Black adults. Within my review this was cited to improving accessibility of care, as some successful adapted treatments were delivered outside of hospital settings and within a community environment to address stigma. In my qualitative findings, participants shared in a similar vein how current care delivered within clinical hospitals and spaces felt inappropriate to do trauma work, and at times even intimidating. These settings may be compounded in institutional power (Verbeke et al., 2019), which may additionally emulate prior disempowering experiences of Black adults with trauma, or even act as a barrier to some seeking care if it was to be delivered in their local general or psychiatric hospital due to stigma.

Insights from the qualitative segment of my work discussed how averting from clinical and sterile-like environments would feel safer and more inviting to those seeking care. Black adults discussed how delivering services within the local community would feel more appropriate for trauma care. These environments may directly tackle the stigma that may be associated with accessing services through clinical hospitals. Instead, services that operate within the local community, means that care is embedded within the very fabric of their own communities and environments they are used to. These findings align with work by Sweeney and colleagues (2018), that show environments that support those with trauma must consider environments that feel psychological safe and relevant to service users. It is therefore with no surprise that community spaces and networks were reported as crucial elements to healing trauma for Black adults in my findings too, given the familiarity or relevancy of these spaces to Black adults themselves.

Other practical adaptations that were apparent within my findings related to the structure of trauma treatments themselves. This related to the duration and length of treatment. In my review, adapted trauma treatments included longer sessions for engagement or to build trust for those attending. This was cited as important given the contextual nature of trauma and mistrust, and so longer sessions can be devoted for building safer relationships with those who attend treatment (Hammad et al., 2020; Vera et al., 2022).

Unsurprisingly, in my qualitative findings, many Black adults shared how the traditional interventions that were on offer to them were often felt as too limited or too short, and thus insufficient. On top of this, shorter interventions also led to Black adults feeling interventions

were merely tackling surface level layers to their trauma rather than addressing deeper root causes. Rather than being supported through a coherent and sustained care pathway, many Black adults cycled through fragmented services often repeating their histories without meaningful interventions. Over time, Black adults questioned whether genuine recovery was possible within statutory services. This led to feeling they were forced to be self-reliant, with many seeking alternatives in community-led initiatives or the private sector. While this may point to the resilience and resourcefulness of marginalised groups in proactively addressing their own struggles (Silverman et al., 2023), it also exposes the failings, and unfairness, navigating a system not built with their needs in mind.

Finally, flexibility within approaches and interventions was another positive adaptation found in my work. Interventions that accommodated the varied physical, social, and logistical realities of those with complex trauma were favourable. This may have related to delivering care within accessible venues, outside of traditional working hours such as in the evening, as well as within community or familiar spaces as mentioned.

These adaptations were reported to mitigate against logistical or practical barriers to accessing interventions or services and resultantly improving engagement. A further important consideration in designing flexible trauma care is crucially understanding the physical toll trauma can have on the body (D'Andrea et al., 2011). A strong evidence base shows many individuals with complex trauma have co-morbidities with long term chronic health conditions, such as autoimmune disorders, digestive disorders, chronic pain, and fatigue (Goodwin & Stein, 2004; Van Houdenhove & Patrick, 2008; Noteboom et al., 2021). In my review and qualitative work, it may have been possible that offering care within local community spaces within reach, having flexible length of sessions, or offering care in the evening, may have attended to these intersecting health needs and promoted accessibility, and thus were reported advantageously.

Black adults in my qualitative work depicted the consequences when these adaptations failed to be included. When care was inflexible, Black adults felt they were navigating a punitive system. For example, Black adults reported being discharged from services should they miss two consecutive appointments. In a rather cruel irony, missed appointments were often grounded in the manifestations of the complex trauma they were seeking to address. Such as, attending other healthcare appointments for chronic health issues, mistrust around intervention approaches or practitioners, or even fear and being overwhelmed. This narrow

and rather structured way of working demanded service users to meet the needs of services rather than the other way round. As a result, those most in need of support were often the same ones unable to access it, resulting in them being discharged or forced to withdraw from services entirely. There is a growing body of literature reflecting on this issue, calling for a more compassionate mental health system, particularly one that adopts more flexible discharge policies for individuals with complex mental health challenges (Carusone et al., 2017).

6.3 Implications for Future Research

In the below section I discuss implications for future research based on the findings detailed above. Key implications for future research based on the findings were: developing and testing adapted trauma treatments, assessments, and the need for longitudinal research.

6.3.1 Developing and Testing Adapted Trauma Treatments

Whilst the systematic review component of this work provided rich data on the effectiveness of adapted trauma interventions for varied global racialised groups, data was too limited to perform thorough sensitivity analyses that explicitly analyses the effectiveness of interventions solely for Black adults. Future research would benefit testing and evaluating large scale randomised controlled trials of adapted interventions for trauma for Black adults explicitly, and assess the effectiveness over longer follow up periods. In addition, interventions typically reported outcomes relating to PTSD, depression, and anxiety symptoms. It would be beneficial for future research to explore wider symptoms given the complex presentations often manifesting in complex trauma. This may look like extending exploration to co-existing mental health challenges including substance misuse difficulties.

Building on this, in general, more research is needed to evaluate more adapted trauma interventions explicitly for Black adults with complex trauma. Mainstream treatments (e.g., CBT, EMDR) may be too limited to fully address the cultural and social manifestations of complex trauma among Black adults. While CBT and EMDR are widely used in trauma treatments (Korn, 2009), these approaches emphasise individual pathology and cognitive restructuring with little emphasis on the collective and historical dimensions of trauma that may be experienced by Black adults. In other words, these therapies may typically focus on the micro-level experience of trauma and neglect the broader systemic or structure factors that contribute to the distress itself.

It is important to understand that the realities of Black adults involve exposures to racism and racial discrimination which perpetuate trauma beyond the individual level (Bryant-Davis & Ocampo, 2005). To develop more appropriate interventions, future research needs to investigate how trauma treatments can acknowledge these wider structural and systemic factors that contribute to trauma within healing frameworks.

With this in mind, it is imperative to explore alternative paradigms that are holistic or community-centred to meet the needs of Black adults, something that emerged as favourable among those taking part in the qualitative component. An example derived from the systematic review may be group therapy models that are rooted in collective storytelling, as these have been documented as beneficial interventions and enhance resilience and a sense of belonging, particularly for racialised minorities (Mannell et al., 2018). Future research should consider how these models can be adapted and empirically tested in the context of trauma support.

As picked up within my work, developing and evaluating somatic-based interventions would also be advantageous. Somatic-based interventions recognise the role of the body in trauma processing. Research highlights how interventions involving movement or ritual (e.g., dance, drumming, and yoga) are effective in addressing trauma among racially minoritised groups (Chang, 2015; Williams et al., 2022). Future research should examine the efficacy of these approaches, particularly when compared to Western treatments that may typically offered within services (e.g., talking therapies).

Liberation psychology may offer culturally congruent intervention alternatives. Liberation psychology, originally developed by Martín-Baró (1996), acknowledges the role of systemic oppression and marginalisation on psychological wellbeing. The focus of liberation psychology heavily incorporates social justice into therapeutic practice. Such approaches would be highly relevant when applied to the needs of Black adults who experience racial trauma, as the shift moves away from individual pathology to an awareness of collective, structural dimensions of trauma.

Interventions that incorporate social justice and racial empowerment can help individuals tackle both personal trauma but also develop resilience from ongoing structural oppression (French et al., 2020). Given study findings highlighting that Black adults rarely reported how racism was incorporated into formulations or interventions despite it being a significant burden, this finding becomes more pressing. Future research should explore how these

elements can be incorporated into existing treatment models and how they impact long-term recovery. Further, studies may wish to examine the effectiveness of interventions that combine both mental health support with community activism, fostering both individual and collective healing to oppression (Prilleltensky, 2003).

These considerations may be achieved effectively through participatory action research (PAR). PAR offers a promising avenue that centres collaboration with community members in the co-design of research that ultimately impacts the affected communities (Baum et al., 2006). PAR is a suitable approach to future research as it challenges the top-down imposition of Western mental health frameworks and research, and alternatively would centre the agency and expertise of Black adults. Black adults have historically been dismissed within health research paradigms that exclude their input and fail to address their needs (Dawson et al., 2018), potentially implicating the trust these groups have with participating in research. PAR disrupts this pattern, as methods platform collaboration with researchers and participants, ensuring approaches are culturally resonant.

Further, a key principle and impact of PAR is in self-determination (Baum et al., 2006), which would be highly applicable when considering racial trauma. By actively involving Black adults within research frameworks, PAR acknowledges their lived experiences as influential to knowledge production. It also promotes trust, potentially addressing historical mistrust of health research. Future research should consider PAR methods to develop and evaluate trauma interventions, potentially considering the input of Black community members or leaders, based on evidence from my systematic review and qualitative studies. These approaches ensure that interventions can be grounded in the cultural needs of Black adults whilst simultaneously understanding through research how to target trauma distress.

6.3.2 Longitudinal Research

Another focus of further research should be on longitudinal studies to analyse the long-term impact of complex trauma among Black adults and adverse mental health outcomes over time. Studies may provide valuable insight into the trajectory course, development, and impact of trauma across key developmental milestones and social outcomes in childhood, adolescence, and later adulthood.

Further, longitudinal research provides a means to test aspects of protective or risk factors that may influence health experiences over time (Anstey & Hofer, 2004). This may relate to tracking psychological well-being outcomes for Black adults with complex trauma over time

and developing measures of risk or protective mechanisms (e.g., spirituality, as identified in this study). Longitudinal research can then depict outcomes of these measures and identify protective factors against poorer mental health outcomes over time. This will also allow for an explorative understanding of experiences of Black adults, alongside demographic variations in experiences and outcomes. Exploring this from an intersectional approach, such as exploring intersections between trauma and race and gender for example, may provide a more nuanced understanding of complex trauma among Black adults over time.

A key justification of longitudinal research based on study findings is therefore for the ability to assess the durability of interventions as well as identify protective factors that may contribute to improved wellbeing and support. Embedding intersectionality frameworks (Phoenix & Pattynama, 2006) would need to be an important factor when considering much of this work. Research that neglects and awareness of intersecting identities risks overlooking crucial nuances in trauma experiences and recovery processes. I say this given the intersectional differences between Black men, women, and/or LGBTQ+ groups from my qualitative work, their experiences, and desired support (e.g., cultural matching) within the care they desired. By integrating an intersectional, longitudinal approach in future work, researchers can develop a more comprehensive understanding of the enduring impact of racialised trauma and the most appropriate pathways to healing that would cater diverse intersectional needs.

6.3.3 Culturally Adapted Assessment Tools

As identified in this study there was a significant under recognition of complex trauma among Black adults in this study, notably including enquiry around racism and discrimination in trauma experiences. This neglect of clinical concern causes missed opportunities for healthcare professionals to identify levels of clinical need and tailor appropriate support plans. Future research may benefit from developing and evaluating assessment tools around complex trauma among Black adults, which may be through collaboratively designing self-report measures or clinician administered measurements.

The feasibility and acceptability of these measures should be explored with Black adults. This may relate to testing pilot studies with adapted screening tools with researchers examining if adapted routine assessments identify more traumatic experiences compared to validated trauma measures, or, if Black services users find these measures acceptable and acknowledges their needs. In addition, barriers, or implementations to administering these

measures, should also be explored. This may be especially useful in clinical settings where discussions around race may provoke discomfort amongst clinicians (Day-Vines et al., 2018), or to explore the impact of adapted assessments on service users, given literature reporting trauma service users citing negative experiences undergoing mental health assessments (Faulkner et al., 2021).

However, a key finding that emerged within the qualitative segment of this work related to some participants finding current clinical practices either rely extensively on questionnaires, or what is currently asked within assessments is deemed inappropriate. With this in mind, researchers should explore in greater depth the need of Black adults with complex trauma when designing and testing these assessment tools to ensure they do not exacerbate distress or harms for those undergoing them.

6.4 Implications for Clinical Practice

In this section I discuss implications for clinical practice based on the findings emerged from this study. These implications centred on cultural competency frameworks and anti-racism, improved routine screening for complex trauma, and building relationships with community-based services and support systems.

6.4.1 Cultural Competency Frameworks and Anti-racism

A greater need for training staff around culturally resonant and trauma informed care would yield great benefits for service providers and users. More efforts to establish anti-racism within training frameworks has great utility here. For example, this may relate to key learnings around historical and systemic racism within healthcare, or the impacts of racism on health presentations or behaviours. Practically, multi-modal approaches would be advantageous to address these issues, which may include experiential methods (e.g., clinical skills building through role plays or simulation discussing sensitive issues related to racism), e-learning modules, workshops, and/or seminars on the cultural needs of Black adults with trauma. A comprehensive, multi-modal approach within services also allows healthcare professionals to apply theoretical concepts to in-person realities and apply these approaches in their everyday clinical practice.

Leveraging the knowledge, skills, and experiences Black adults who have experiences of complex trauma, and/or poor experiences accessing support, into the design and delivery of these training methods only strengthens its validity. In fact, this may operate as a powerful

tool to reclaiming power and agency over trauma and/or negative experiences of healthcare, as it signals the vitality of their lived experiences to shape and influence healthcare practice and policies. Further, this provides opportunities for the voices of Black adults who have historically been ignored into the design or delivery of healthcare to be platformed, not silenced.

Reflective practices are also a potential avenue for improving both the care offered to service users but also individually for clinicians themselves. Many clinicians may already engage in reflective practices to discuss their work amongst their peers or in supervision as part of their professional duties (Mann & Gordon, 2009). Encouraging adaptive reflective practice sessions to address key learnings or challenges clinicians themselves or their peers have when embedding culturally competent care could be of significant use here (e.g., cases of successful or challenging examples in their work). This in turn may strengthen individual and group-led responses to achieving culturally competent care within wider teams. Reflective practices (both individual, supervision, and group based) also encourage healthcare professionals to reflect on their own biases, assumptions, or responses to challenging cases. Reflective practice sessions facilitated by trained supervisors can also offer appropriate guidance or identify accountability, and establish opportunities for individual and collective growth with clinical teams.

A key factor that would underscore any routine training or reflective practices would be the regular evaluation and feedback from those engaged with these practices. This ensures these methods can be adjusted to meet the needs of the workforce and strengthen learning outcomes. Feedback mechanisms may include the use of surveys following training sessions to understand aspects of knowledge, skills, or confidence following engagements. Surveys have great utility as they can also be anonymised, which may provoke more honest responses from clinicians who may struggle to assert their voices in other ways. This may to a greater extent be of use when voicing sensitive experiences of racism or bias. Surveys can also be administered longitudinally, again, another advantageous option to assessing changes or improvements over time (Lynn, 2009).

Most importantly though, I argue a shift is necessary in attitudes towards this type of clinical work. To truly tackle the racial inequalities within healthcare systems, I believe any action towards achieving equity should never be seen through ‘one off’ interventional approaches. For example, meaningful, sustainable change to provide culturally sensitive and appropriate

care requires more than a *singular* session or workshops on culture, whether that is within professional work settings or through an academic programme. Teachings should be encouraged throughout clinical training pipelines or employment contracts as this treats anti-racism work as an active and integral part of clinical practice rather than as mere optional or passive work.

To achieve successful implementations of the above, this may look like embedding learning and practices into mandatory continuing professional development (CPD) competencies which should be considered a necessary requirement for healthcare professionals, or similar mandatory requirements on an academic programme. This may involve accredited courses or modules around trauma-informed practices in the healthcare environment with tailored focuses on race and cultural adaptations as part of professional re-certification processes or examinations. This reflects a continuous effort to progressive learning on cultural competency for all those in the healthcare system, benefiting both professionals providing services as well as users receiving them.

6.4.2 Routine Screening for Complex Trauma

As indicated in both the clinical records study and the qualitative studies, documentation of complex trauma appeared inconsistent, suggesting an apparent under-recognition of trauma experiences among service users, including Black adults. Within the clinical records data it was not possible to determine whether this reflected a true absence of assessment or limitations in how assessments were recorded. However, when combined with the qualitative findings, which described limited opportunities for service users to disclose trauma, the evidence points to the value of embedding more routine enquiry into complex trauma.

Current practices did not consistently explore the role of race, racism, and/or culture, and how these factors influence trauma experiences among Black adults. More routine practices to assessing for trauma is therefore warranted to better validate and understand the needs of Black adults with complex trauma. Adaptations to current practices may include more direct enquiry into exploring experiences of racism, discrimination, or injustices associated with the experiences of racially minoritised groups.

Experiences of racism are known to contribute to stress and negatively impact psychological wellbeing (Harris et al., 2018). It is crucial to therefore create spaces for service users to discuss the ways by which racism operates and influences their health. This then opens the window to explore the harmful impacts of these experiences on service users, further

identifying levels of clinical need and support. Efforts to explore racism and associated stressors into these assessments also normalise discussions of racism into the therapeutic context. This may in turn contribute to the validation of experiences among Black adults who may feel listened to and understood should services make active efforts to explore the intersection of racism with their experiences of trauma.

However, for these practices to be efficient, clinicians must approach these practices with sensitivity and safety. This may indeed require clinical training on cultural competency as I reported earlier to further increase skills and knowledge within this area. But not forgetting core competencies in any clinical practice, either. As in, drawing on effective interpersonal skills when approaching difficult and sensitive discussions with service users such as around (racial) harm or trauma. Discussions should provide safe spaces for the disclosure of difficult experiences without Black adults feeling they may be misunderstood or dismissed. This is arguably a stronger need for those with complex traumatic histories who may have already faced silencing or mistreatment (Cook et al., 2005). And so, perhaps clinicians should approach their interactions with service users with an awareness of power differentials, and acknowledge the potential of both historical or dismissing experiences Black service users with complex trauma may have had within (and outside of) healthcare services. Or, as detailed in the qualitative segment of this study, potentially explore the role of collaboration within assessments to explore unmet needs, and what could potentially be adapted in the therapeutic approach. This may in turn make service users feel safe and empowered within their own care planning.

6.4.3 Building Relationships with Community-based Services and Systems

Another key finding when synthesising data from this research was a notable value within community networks and systems in supporting Black adults. On one end, this referred to more Black-led community or voluntary services that cater to the explicit needs of Black adults. But also, Black adults finding value within their own informal community networks (e.g., from their local churches or within their neighbourhoods).

Clinical services may wish to consider the relationships they hold between their own statutory services and local community-led organisations or networks and question how best to work in tandem with community systems of support for Black adults. For example, this may be considering the role of mental health hubs delivered within the local community (e.g., inside churches), which may address barriers to accessibility, or provide an awareness of a

variety of support that is offered from local services. More so, collaboration with trusted leaders in these spaces would be another crucial opportunity to identify how best to work in partnership to meet the needs of the local community. Again, findings from this work demonstrate significant value in collaboration and partnership work, and collaboration at this level may signify credibility of services trusting the value of the community in supporting Black people's wellbeing.

Ultimately, clinical services strengthening their relationships with community support systems ensures that what they offer is truly reflective of the values and priorities of the populations they serve. Unique insights from the local community can infer adaptations to practices or interventions that may currently fall short at addressing the holistic and cultural needs of Black adults, a narrative consistent within my work.

6.4.4 Moving Towards a Relational Approach

One major implication emerging from this work is the necessity of trauma care to move beyond procedural and symptom-focused models towards a far more relational and holistic approach of care. Relational mental health practice centres the human connection (Gómez et al., 2016). It involves healthcare professionals showing up as people, not just professionals, and capable of bearing witness to suffering without retreating into distance. Building on much of the findings in this work, this means professionals being mindful of power and recognising how racism may show up in service user's narratives, and equally, within therapeutic environments too.

Practically, this is a call for services to invest greater efforts in continuity-focused models of trauma care that allow relationships to be built and maintained, something Black adults in qualitative work expressed was virtually non-existent. It means valuing to the greatest degree reflective practices and adhering to the cultural context as core competences (not adjuncts). Clinical supervision and organisational cultures must support professionals to be relationally present in the face of complex traumatic presentations rather than defaulting to risk-driven or defensive strategies.

This work also shows how in order to centre relational care, there needs to be an awareness of the community or collective healing practices that are already relational in nature. These are the support structures that may already be of great value to Black adults, as this work suggests. Healing for many Black adults therefore is not solely an individual task, healing may exist within families, friends, communities, faith groups, peer networks, and so forth.

Services must not disregard this, and should work in tandem or collaborate with community or collective networks to explore how to relational approaches can be better integrated into practice.

6.5 Implications for Policy

In this section I discuss the implications for policy informed by findings within this work. Key implications included the need for continuity of care and more efficient integrated care models, diversifying the mental health workforce, routine ethnicity data collection, and revising trauma guidelines.

6.5.1 Continuity of Care and Integrated Care Models

Continuity of care is an established fundamental principle to offering efficient healthcare (Adair et al., 2005). Policies that build on improving integrated care systems whereby mental health providers are closely connected with primary care, secondary care, social services, and community services, seek to enhance the holistic support that can be provided to service users. Many individuals with histories of complex trauma may indeed have multifaceted needs that occur alongside their mental health difficulties (e.g., difficulties in housing, employment, substance misuse). What integrated care models offer is centralised care co-ordination to address these more complex issues. For those with complex trauma who may typically ‘fall through the gaps’ of services as my work suggests, this is particularly essential. Seamless collaboration and communication between providers directly hinder challenges to care becoming too fragmented for Black adults seeking support. As picked up in this work, this fragmentation of services results in individuals accessing piecemeal or short term (medical) interventions that treats difficulties in isolation rather than supporting Black adults holistically with a variety of needs.

Referral pathways to specialist trauma support, as detailed in the qualitative study, are reported challenging or even non-existent. Many barriers reported in the qualitative segment detail frustrating journeys Black service users had attempting to access these services. I was both struck and saddened by the emotional toll this additionally caused many who were already facing distress, forcing many to withdraw from the system entirely. Many reported feeling ‘bounced between services’ without any being able to receive effective support or referrals to address their complex trauma. I question many things here. Is it that current care pathways to referring to specialist trauma services are too complex? Is eligibility to access

these services too exclusionary? Are clinicians feeling adequately supported to identify and work with complex trauma presentations in Black adults, let alone refer onwards?

Whilst the picture appears complex, I do believe more efforts for integrated care models can address many of these barriers and instead provide solutions, despite the challenge. Efficient integrated models of care acknowledge that complex health challenges requires complete continuity of care and continuous support, often from multiple providers (Hughes et al., 2020). Practically, I believe multi-disciplinary based work (such as mental health professionals, social workers, community services, or emergency services working together) can be strengthened, including the use of potential centralised hubs physically or virtually to discuss complex cases. This ensures insights are directed with an interconnected focus to address the multifaceted needs of individuals with complex needs.

Within these models though, I argue that more efforts for trauma-informed care practices (e.g., efforts on collaboration with service users, an awareness of cultural manifestations of trauma, empowerment, etc) are crucially needed and platformed. I believe these approaches may mitigate against those with complex trauma ‘falling through the gaps’, as their care is streamlined and continuous, with greater opportunities around engagement and support whilst they navigate appropriate care pathways for trauma.

Here, within these integrated systems I therefore believe there are opportunities for more informed routine trauma screening and referral processes embedded within these systems, including identifying complex trauma within Black adults and supporting them to accessing tailored support. These care models generate a more holistic and streamlined model of care that can be offered to Black adults and increases accessibility the trauma treatments Black adults desire or need. I believe policy has great potential to influence hopeful measures to address the issues outlined. To improve the continuity of integrated care, national standards may be useful that outline guidance for health, social, and community care providers to adhere to integrated care models.

Policy makers should also consider funding more initiatives and training for those working within these integrated care systems to identify and work efficiently with those with complex trauma presentations. This may include ways of assessing or identifying complex trauma with specific support around delivering more culturally competent care for Black adults with these presentations. Greater emphasis should be considered to expanding access to trauma interventions, both within statutory services but also within referrals to community support.

More funding for this expansion reduces the inaccessibility of trauma care and has potential for improving service user outcomes. By adhering to these recommendations, care that Black adults with complex trauma seek has less delays and disruptions to accessing support and ensures that what is on offer is equally culturally appropriate and effective.

6.5.2 Diversifying the Mental Health Workforce

Both my systematic review and qualitative study highlighted the role of choice around service users and providers being culturally matched. Reasons for this were cited in building better trust, rapport, alliances, and feeling understood. However, many Black adults reported this was rarely an option when attempting to seek support for complex trauma in statutory services. Some Black adults who were not culturally matched detailed harmful experiences within services, forcing them to disengage entirely and seek alternatives to protect further harm.

These issues would be rectified by policies investing in diversifying the mental health force within statutory services. Indeed, benefits to diversifying the mental health workforce are reported in the literature (Kyere & Fukui, 2023). Diversifying the workforce platforms the choices service users have should they wish to work with someone from a similar cultural background. To achieve this, policy makers may wish to consider investments into scholarships or funding programmes open to those from Black racialised backgrounds to clinically train within mental health specialisms.

Achieving these goals may be for policy to invest and launch outreach campaigns specifically targeting Black adults. This will powerfully signal the value of racial representation in the workforce and the vitality of these experiences to better support the specific needs of those accessing mental health services. Equally, it is important for efforts to reduce discriminatory practices within the workforce, such as racial discrimination in hiring practices (Quillian & Midtbøen, 2021), are additionally enforced to mitigate against barriers to professional development amongst the workforces.

However, whilst training more Black mental health professionals is vital, so is providing support and retaining healthcare professionals with opportunities for career progression. According to a national workforce analysis conducted in the NHS, people from racially minoritised backgrounds are significantly under-represented in senior positions (Ross et al., 2020). Efforts therefore into mentoring and supportive programmes that seek to address the needs of Black mental health professionals have even greater utility. Practically, this may

involve similar elements of cultural matching between Black mental health prospective students or trainees with more experienced and senior clinicians from similar backgrounds. Support at this level may offer unique advice and guidance with particular attention to some of the barriers or challenges clinicians may have faced in their own clinical career journeys. This ensures that Black mental health professionals are supported within their career development pathways and effectively retained within the workforce to not just enhance their own wellbeing within the profession, but equally support diverse service user populations. These initiatives can be enhanced through regular monitoring measures that investigate diversity recruitment targets within mental health services. This ensures accountability to achieving these targets and reflects a broader commitment to achieving a more inclusive workforce.

6.5.3 Routine Ethnicity Data Collection

The clinical records study depicted the limitations of missing or incomplete ethnicity data on electronic healthcare records. Firstly, incomplete data used in research weakens comprehensive conclusions regarding study findings (Wells et al., 2013). Incomplete data in electronic healthcare record analyses also limits the ability to identify systemic inequalities or patterns within healthcare data pulled from secondary data sources (Getzen et al., 2023). To work against these issues, policy makers may wish to mandate ethnicity data collection within healthcare services and ensuring that reporting becomes standardised across the national healthcare system. Further, policy may wish to invest in digital technology systems that may simplify the reporting of data or identify areas where reporting is substantially lacking. Giving the increasing use of digital technologies used to optimise healthcare delivery (Sharma et al., 2018), this may be a promising area for policy and research.

Lastly, targeted accountability measures may encourage services to adopt to these measures, with mandatory training on the importance of collecting routine demographic data and its use in shaping research, practice, and policy. With the needs of Black adults with complex trauma in mind, these implementations allow services on a national level understand the intersection between ethnicity among other intersecting identities, complex trauma, and service utilisation. These recommendations allow researchers and services to evaluate healthcare delivery on a national level and crucially identify areas in healthcare where there may be inequalities, such as in access to trauma care.

6.5.4 Trauma Guidelines

NICE guidance has a crucial role to informing clinical practice and provides evidence-based recommendations for the management of several mental health conditions in the UK.

However, whilst there is clinical guidance for the assessment and treatment of PTSD (NICE, 2018) there is currently no standardised guidance on the management of complex PTSD, nor complex trauma. As a result, there is no official standardised framework for clinicians to support those with complex traumatic presentations.

Without formal standardised guidelines, this leaves many service users potentially being misdiagnosed or put on inappropriate care pathways. Further, a lack of identification or recognition of complex trauma within Black adults means referrals to culturally specific trauma support becomes insufficient. For Black adults these challenges are further compounded by a lack of recognition of how culture may shape experiences of trauma. Current diagnostic pathways fail to explore the intersection of racial trauma and cumulative nature of adversity experienced by Black adults. And so, missed opportunities to identify levels of need rise, as well as the window for further adverse experiences Black adults have when navigating services.

Given early intervention and prevention being a consistent priority in mental health policy (Fusar-Poli et al., 2021), this should be extended to include a consideration around current policy guidelines to the management of complex trauma in Black adults. To address these issues, policy makers may evidently revise current guidelines to incorporate the needs of those with complex trauma. This may involve more refined diagnostic criteria, such as differentiating PTSD from other complex traumatic experiences whereby trauma may be prolonged or experienced cumulatively, or differently, due to cultural variations. It may also involve more routine screening efforts to assess for complex trauma including for racism and discrimination to fully address diverse cultural needs as my study findings suggests.

Additionally, current service provisions may inadvertently exclude those who have multifaceted issues that are manifested in their trauma presentations (e.g., self-injury, substance misuse). This presents as a significant challenge and barrier for many with complex trauma in accessing the trauma support they require. As a result, eligibility criteria to access services for complex trauma may benefit from careful revisions for complex cases to ensure people don't face 'closed doors', as my work suggests, in times of need. Broader implications of these changes include a more confident mental health workforce in identifying and

working with complex trauma presentations and enhancing the efficiency of the care they provide to service users. On a systems-level too, this also enhances accessing timely trauma care which is at currently significantly underachieved among Black adults.

Whilst there are many benefits to these implications, it is important though not to dismiss certain findings from my work. Some Black adults in my qualitative work argued criticisms of medicalised conceptualisations around mental health and rejected the use of clinical diagnostic frameworks. Their experiences questioned whether these frameworks reduced their lived experiences to being seen through ‘just symptoms’. Whilst these are valid critiques, it’s important to note that within the UK formal diagnoses do not just represent as labels, but are crucial indicators to determine access to treatment pathways. In other words, without a formal diagnosis a service user may have challenges being referred for a particular treatment. This therefore presents as a complex challenge: how to implement guidelines that conceptualise trauma while ensuring they remain inclusive and culturally responsive to the needs of Black adults?

An overarching approach to addressing much of these concerns is investing into trauma-informed care models that centre relational practices, as previously touched on. Trauma-informed care models should extend beyond diagnostic-specific interventions and instead focus on understanding the broader context of experiences, including relational and historical factors that contribute to trauma (Butler et al., 2011). Key principles of trauma-informed care in this regard acknowledges how cultural identity, racism, and trauma shape experiences of distress. These approaches move away from diagnostic frameworks and acknowledge interventions that validate lived experiences within therapeutic practices (Sweeney et al., 2018).

Building on the study findings, these models could extend further to involve collaboration between community organisations, peer-led support initiatives, and culturally embedded healing practices that better resonate with Black adults. Policy makers should additionally consider allocating funding towards culturally specific, trauma-informed care training for mental health professionals, ensuring that the workforce is confidently equipped to recognise and address the intersections between culture and trauma in their practices.

These models of trauma-informed care would require integrating mental health services with primary care, community support, and non-statutory services to create more accessible pathways to support. This would see benefits to more continuity within care, reducing the

fragmentation often seen in diagnostic-specific pathways. This importantly addresses the barriers posed by traditional diagnostic requirements that fail to recognise the complexity of trauma among Black adults. Regardless of the specific policy adaptations mentioned, the experiences and voices of Black adults should never be dismissed, and efforts to platform these voices to inform future adaptations and in policy discussions is encouraged.

6.6 Study Limitations

Whilst I have provided significant value in the work conducted, it is important to acknowledge certain limitations too. Whilst the qualitative study explicitly focused on Black adult's experiences, the systematic review and clinical records studies included broader racialised minorities due to the lack of available data on Black adults. This limitation was anticipated and acknowledged in the terminology section in Chapter 1, where I outlined the challenges of navigating racial and ethnic categorisations in research. Although every effort was made to centre Black adult's experiences across the studies, limitations in the scope and granularity of existing datasets and the literature meant a more focused analysis was not always possible. This broader inclusion of wider experiences, whilst pragmatic, may have diluted the specificity of findings related uniquely to Black adults. As noted in the wider literature, this conflation of experiences among racialised minorities is a common issue in research and data reporting (DaCosta et al., 2021), which obscures the rich experiences and needs between racialised minorities.

A limitation to the systematic review conducted as part of this work relates to levels of heterogeneity of studies. The systematic review explored cultural adaptations to the assessment and treatment of trauma among varied racialised minority groups. In turn, cross-cultural variations in populations, intervention types, and study designs all may have influenced meta-analytic conclusions. This was notable when exploring depression anxiety outcome severity in the meta-analysis ($I^2 > 75\%$). Additionally, the search criteria for the review only included empirical studies published in the English language. Given the context of the review and wider research aims, this may have neglected influential papers reported in non-English languages.

The clinical records study utilised secondary data extracted from electronic healthcare records, incorporating both structured fields and unstructured (free text) entries. Findings therefore relied heavily on information manually entered by clinicians during routine care. This presents several limitations. First, the accuracy and completeness of the dataset were

dependent on clinicians' recording practices. Trauma-related experiences may have been assessed in practice but not consistently documented, meaning the absence of an entry could not be interpreted as the absence of assessment or intervention. Similarly, the study could not determine whether trauma-specific support was offered but not coded, or whether recorded interventions were clinically appropriate, as outcomes or symptom changes were not available.

Second, large proportions of missing data, particularly for ethnicity and diagnostic fields, complicated interpretation. This restricted the ability to make firm conclusions regarding ethnic differences in trauma enquiry and follow-up, limiting the representativeness of the findings. This challenge is consistent with wider evidence showing that incomplete or inconsistently coded data are a well-documented limitation in empirical studies using secondary health records (Beaulieu-Jones et al., 2018). The retrospective design restricted the study to descriptive analysis of available entries, preventing causal inference or comprehensive understanding of service users' care trajectories. The findings should therefore be interpreted as highlighting patterns of documentation rather than providing definitive evidence about the presence or absence of trauma enquiry or support.

The clinical records component relied on NHS data within an inner-city borough in London. Whilst this validates aspects of data quality due to my study questions and the diversity within the borough, it may limit further generalisability to other geographical countries, or even other global health systems. This is due to specific structural practices and policies that may operate within the NHS healthcare system, such as clinical practices and referral pathways for the treatment of trauma, and mental health more broadly.

Finally, due to feasibility and timing when doing doctoral work, attempts to recruit more Black adults into the qualitative component would have been welcomed. Whilst I believe ten adults still allowed for rich exploration of Black adults and allowed for still achieving data saturation (Hennink & Kaiser, 2022), more accounts and experiences would have strengthened this further. Efforts to diversify the recruitment strategy from the onset were made to mitigate aspects of this, and I believe although a small sample, it was relatively diverse relative to disability and sexual orientation. This allowed for crucial exploration of intersectional dynamics between trauma, race and other characteristics or marginalised identities, informing important findings.

6.7 Chapter Summary

The mixed method approach used across the research has allowed for a comprehensive insight into the experiences of current mental health care for Black adults with complex trauma. This chapter provided a meta-synthesis of the evidence gathered across studies.

The systematic review detailed potential benefits in adapted trauma interventions, although more clinical trials explicitly focused on Black populations is needed. I also provided additional recommendations for greater research into both subjective experiences of adapted interventions as well as more research exploring adapted assessments for trauma. In the clinical records study, streamlined pathways from assessment to referral and treatment were rarely evident in the documentation, making it unclear whether such pathways were absent in practice or simply under-recorded. In contrast, the interview data provided richer detail, where Black adults reported dissatisfaction with a lack of trauma support offered within services. Many attempts at seeking support led to dismissals, invalidation, rejections, and thus leaving many Black adults to seek support outside of statutory services. The findings underscore a pressing need for reformed policy and clinical pathways to better support Black adults. Addressing these issues widens access for those with trauma accessing timely and appropriate support.

7 CHAPTER SEVEN: CONCLUSION

7.1 Final Reflections

As a Black researcher with lived experience of mental health systems, I did not enter the project from a stance of neutrality but from a position shaped by personal and professional commitments. Within a critical realist framework, this positionality is not a source of bias to be suppressed. Instead, this was seen as a resource that enriched the interpretive process. My standpoint afforded both sensitivity and attentiveness to issues of race and trauma which may otherwise have been overlooked or minimised. At the same time, I engaged reflexively with the ways my perspective influenced analytic choices, drawing on supervisory feedback and LEAG engagement to balance and challenge my interpretations. This combination of positionality and reflexive practice added depth to the findings and strengthened their contextual validity.

Reflecting on the research as a whole through, the lens of the ‘four planes of social being’ (Bhaskar & Norrie, 2013) has offered a deeper understanding of how trauma experiences and recovery are shaped across multiple layers of reality for Black adults. Across all studies, experiences on the natural and interpersonal planes (Planes 1-2) were central to how service users encountered and engaged with care. Physical environments, relational safety, and the quality of human connection were repeatedly emphasised as determinants of trust and engagement. Participants valued culturally affirming spaces that recognised the embodied and emotional dimensions of trauma.

However, the greatest concentration of difficulties emerged at the social structures/institutional plane (Plane 3). Both the systematic review and the qualitative study indicated that current mental health systems, through fragmented services and narrow clinical frameworks, often perpetuate alienation and mistrust among Black adults with complex trauma. Adaptations and interventions tend to focus on individual change, while the organisational and systemic structures that sustain racial inequity remain under-addressed. This imbalance highlights a pressing need for trauma-informed practice that extends wider than clinical encounters to include anti-racist policy reform and workforce development.

Finally, the personal plane (Plane 4) brought attention to spirituality and identity as vital resources for healing and resistance. Participants’ reliance on faith and community narratives

demonstrates the need for services to engage more deeply with the moral and existential dimensions of recovery, and not just viewing trauma solely through diagnostic lenses.

Viewing the research findings across these four interconnected planes thus reinforces a critical realist understanding of trauma as a deeply personal and socially embedded phenomenon. It calls for multi-level responses that recognise the natural, relational, structural, and personal contexts of trauma recovery.

Other reflections relate to the involvement of a LEAG, which was methodologically and ethically significant for this work. While their engagement was limited in number and continuity, the insights they provided meaningfully shaped the design of the qualitative study. Their contributions helped ensure that participants' narratives were approached with sensitivity to cultural and trauma-related contexts. At the same time, the challenges of recruitment and retention highlight the structural and personal barriers to meaningful PPIE in trauma research, particularly among Black communities who may face ongoing mental health challenges and systemic marginalisation. From a critical realist perspective, this shows how lived experience engagement operates across multiple planes of being (Bhasker & Norrie, 2013): institutionally constrained by research structures, interpersonally mediated through relational trust, and personally impacted by individuals' ongoing trauma. Although modest in scale, the LEAG's involvement provided crucial validation and grounding for this work and reflects the potential added value of researcher-community collaboration in addressing racial inequalities in mental health research.

All in all, I believe this work has exposed further challenges and barriers Black adults with complex trauma have navigating the current mental health system. Accessing appropriate and effective care within this system is evidently deficient. Findings from this work illustrate that addressing the unique and multifaceted challenges faced by Black adults with complex trauma demands far more than conventional medical interventions. Instead, it calls for a profound transformation in how trauma is conceptualised and treated within the context of Black experiences. This shift requires moving beyond reductive approaches to trauma and embracing frameworks that account for the intersecting impacts of race and culture.

By reframing our understanding of trauma through this lens, I believe we can foster approaches that acknowledge and address the distress experienced by many Black individuals with complex trauma. Such a perspective invites us to develop responses that are not only evidence-based but are also deeply meaningful and capable of fostering healing in ways that

resonate with the lived realities of Black adults. Only through this broader and more inclusive lens can we begin to dismantle the barriers that perpetuate disparities for these groups, and, ensure that services truly meet the needs of those they serve.

Reflecting on this research journey, this work has made me more confident as a researcher and also a passionate advocate for change. I hope this work provokes an urgent call for academia, services, and policymakers alike, to urgently review the ways by which they are tackling racial inequalities in their work. But also, to promote, fund, and research more avenues for Black communities to excel and enhance their wellbeing.

7.2 Conclusion

This research explored the unique needs of Black adults with complex trauma and their experiences and views of mental health care. By using mixed methods, I was able to synthesise various rich data strands and pull together a more comprehensive understanding of the current challenges Black adults face in accessing care and make necessary calls for future implications. I hope the work conducted as part of this research platforms the voices and experiences of Black adults with complex trauma, whose voices often have been marginalised and silenced in academic literature. Following on from this work, I hope my findings translate to actionable strategies implemented in future research, policy, and practice to truly achieve mental health equity for Black adults with trauma. To mitigate ongoing injustices and harm, the future of healthcare innovation must crucially adopt appropriate methods to accommodate the needs of Black adults with complex trauma, allowing them to thrive following on from trauma, not just survive.

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Appendices

Appendix A: Published paper for systematic review study

Appendix B: Letter of NHS access for clinical records study

Appendix C: Visual aids for qualitative interviews

Appendix D: Participant consent form for qualitative study

Appendix E: Targeted recruitment flyer

Appendix A: Published Papers

The study presented in **Chapter Three** of this thesis was published:

Benjamin, L., Gillard, S., Jones Nielsen, J., Costa E. Silva, M., & Sin, J. (2025). Cultural adaptations to the assessment and treatment of trauma experiences among racial and ethnic minority groups: A mixed-methods systematic review and meta-analysis. *Trauma, Violence, & Abuse*, 1524838025132098

The study presented in **Chapter Five** of this thesis was published:

Benjamin, L., Gillard, S., Jones Nielsen, J., CG Munoz., & Sin, J. (2025). Journeys and experiences accessing trauma support for Black adults with complex trauma: a qualitative study. *Social Science & Medicine – Mental Health*. doi.org/10.1016/j.ssmmh.2025.100498

Appendix B: Letter of NHS Access for Clinical Records Study



Joint SLaM/IoPPN Research & Development Office, PO05
Institute of Psychiatry, Psychology & Neuroscience (IoPPN)
King's College London
De Crespigny Park
London
SE5 8AF
slam-ioppn.research@kcl.ac.uk

Mr Lewis Benjamin
School of Health Sciences
City University of London
1 Myddelton St
London
EC1R 1UBS

Monday 14th August 2023

Dear Mr Lewis Benjamin,

Letter of Access for research

Project Title: Depicting ethnic variations in receipt of trauma assessment among service users accessing SLaM services between February 2022 to July 2022

CRIS Reference: 23-039

CRIS Approval: 26/04/2023

In accepting this letter, the participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **14/08/2023** and ends on **31/10/2023** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from **South London and Maudsley NHS Foundation Trust**. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from the individual organisation of their agreement to conduct the research.

The information supplied about your role in research in South London and Maudsley NHS Foundation Trust has been reviewed and you do not require an honorary research contract with the organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to the organisation.

You are considered to be a legal visitor to the South London and Maudsley NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits

provided by the organisation or this organisation to employees and this letter does not give rise to any other relationship between you and the organisation, in particular that of an employee.

While undertaking research through South London and Maudsley NHS Foundation Trust you will remain accountable to your employer **City University of London**, but you are required to follow the reasonable instructions of your nominated manager **Matthew Broadbent** in SLaM or those given on their behalf in relation to the terms of this right of access.

Where any third-party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by South London and Maudsley NHS Foundation Trust in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings. You must act in accordance with the organisation's policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the organisation in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisation's premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role, and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at that organisation.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 2018. Furthermore, you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times or are able to prove your identity if challenged. Please note that the organisation does not accept responsibility for damage to or loss of personal property.

South London and Maudsley NHS Foundation Trust may revoke this letter and may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children, this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

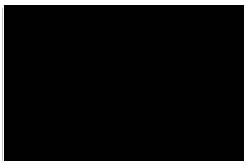
Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 2018. Any breach of the Data Protection Act 2018 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in South London and Maudsley NHS Foundation Trust and the SLaM/IoPPN R&D office.

Please note it is your responsibility to provide advanced notice to the SLaM/IoPPN R&D Office should this Letter of Access require extending.

Yours sincerely,



**Jessica Siddall
Research & Development (R&D) Facilitator
Joint R&D Office of South London and Maudsley NHS Foundation Trust and
Institute of Psychiatry, Psychology & Neuroscience**

cc: Student and Academic Administration

Appendix C: Visual Aids for Qualitative Interviews



Timeline of pathway to support for trauma



Please add:

- Steps in seeking support for trauma or the impacts of trauma and abuse, and approximate dates / waiting times
- Interim contacts with, or support from, services
- Brief note of responses (e.g. acceptance, rejection/why? Waiting list...)

Timeline – Survivor Interviews (project 1) - V1 – 15/12/22

Appendix D: Participant Consent Form for Qualitative Study



IRAS ID:

Participant Identification: _ _ _ _ _

The PATHWAY study – developing a new care pathway for people with complex trauma

SURVIVOR CONSENT FORM:

Please initial box

Required items:

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information and ask questions. If I have asked questions, these have been answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. If at any point I am concerned that my medical care or legal rights are being affected, I have the contact details of whom I should approach to discuss it, and am content that these details are thorough. ☐
3. I agree to take part in qualitative interview(s). ☐
4. I understand that interviews will be audio recorded and transcribed, and kept securely using only a number for identification purposes. This will be for the purpose of data analysis. ☐
5. I understand that some information I have given in interviews might be quoted directly in the reporting of the research, and that any direct quotation will not include information that might identify me. ☐



Consent form – Service Users and Survivors – V2 – 09/03/23 – IRAS ID 314403



Optional items:

6. I DO / DO NOT agree for my de-identified transcript to be included in further analyses conducted by staff or students linked to our research team. ☐
7. I DO / DO NOT agree to receive a summary of the results of this study at the contact details provided in the Contact Form (please cross out as appropriate) ☐
8. I DO / DO NOT agree to be invited to participate in a reflective session ☐
9. I DO / DO NOT agree to be invited to participate in a stakeholder engagement workshop ☐
10. I DO / DO NOT agree to be contacted about further opportunities linked to the PATHWAY research programme. ☐

Name of participant

Date

Signature

Researcher

Date

Signature

You will sign and date two copies of the form so that you can keep a copy and that we can keep a copy on file.



Consent form – Service Users and Survivors – V2 – 09/03/23 – IRAS ID 314403

Appendix E: Targeted Recruitment Flyer



THE PATHWAY STUDY:

We would like to invite adults of Black heritage who have experienced complex trauma (trauma that may have begun in childhood which was ongoing and repeated) to take part in an interview about your experiences accessing and experiencing mental health support. This may also include trauma related to racism or discrimination in public and/or in mental health services

Whats involved?

One or two interviews with a researcher of Black heritage who is also a survivor:

1. Discussing your experiences of assessment for trauma
2. Sharing experiences of accessing and moving between different services for your mental health and/or trauma
3. Discussing how services might be improved

You won't be asked about your experiences of abuse or trauma at any point.

You will receive £25 per interview (up to £50) in payment or as a voucher (to your preference) as a thank you and travel expenses

Interested? Please contact the Pathway team on 



IRAS: 314403, Black Interviews Flyer V2 10/01/24