Exploring the views of Voluntary Community Sector professionals on partnership working and community engagement with Clinical Psychologists in an NHS child and family service.

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ABSTRACT

Background: There is increasing recognition that effective partnership working is fundamental to improving access to Children and Young People's Mental Health Services and helps to better meet the needs of ethnic minority children and families. With growing expectations that Voluntary Community Sector professionals should work in partnership with Clinical Psychologists to bridge culturally accessible support, it is essential that their voices and perspectives are heard.

Aims: This study explored Voluntary Community Sector professionals' views and experiences of partnership working with Clinical Psychologists within Children and Young People's Mental Health Services. A critical realist epistemological position explored Voluntary Community Sector professionals' perspectives regarding facilitators to partnership work and whether co-production and community engagement approaches improved culturally accessible support within Children and Young People's Mental Health Services.

Method: Semi-structured interviews were facilitated with ten Voluntary Community Sector professionals working in partnership with Clinical Psychologists in a Child and Adolescent Mental Health Service. Interviews were analysed using Thematic Analysis, producing three key themes: 'Establishing Trusted Relationships', 'Reciprocity' and 'Breaking Down Systemic Barriers'.

Analysis: Findings showed that building trusted relationships, with long-term connections enabled Clinical Psychologists to earn communities' trust and develop a shared language. Voluntary Community Sector professionals emphasised the need for reciprocal, bi-directional partnerships, based upon shared need, cultural respect and flexibility to meet families' needs. Partnerships were perceived to break down systemic barriers to accessing Child and Adolescent Mental Health Services. Understanding how fear and stigma impacted help-seeking and acknowledging the partnerships' frustrations regarding funding uncertainties were key systemic challenges. Providing reassurance, increasing knowledge and promoting awareness of services were considered key to improving community engagement.

Conclusions: This is the first known qualitative study to identify facilitators to partnership work and community psychology approaches between the Voluntary Community Sector and Clinical Psychologists within Children and Young People's Mental Health Services. Findings suggest Voluntary Community Sector professionals perceived that partnership work improved engagement and enabled more culturally appropriate Child and Adolescent Mental Health Services support. Implications are multi-level including recommendations for: commissioning, policy, psychology training, community psychology and Children and Young People's Mental Health Services.

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1. INTRODUCTION

1.1 Overview

This chapter begins by defining relevant terminology. A narrative review explores the current context and challenges facing UK Children and Young People's Mental Health Services in meeting the mental health needs of ethnic minority and marginalised communities. This includes evaluation of the pivotal role of the Voluntary Community Sector in Children and Young People's Mental Health Services and the rationale for culturally appropriate support. Alternative participatory approaches are explored, including partnership work, co-production and community engagement. These will be considered as ways forward for clinical and community psychology engagement. A scoping review identifies what is already known about partnership working, community engagement and community psychology approaches between the Voluntary Community Sector and Clinical Psychologists within Children and Young People's Mental Health Services and adult populations. This leads to the current rationale, aims and research questions of the present study.

1.2 Terminology

This thesis acknowledges the importance of defining terms which are often fluid, socially constructed and used interchangeably. This paper adopts a critical realist approach, maintaining awareness that reality is shaped by social, political and historical context (Willig, 2008); assuming there are no objective 'truths'. Therefore, a brief definition of key terminology is provided:

1.2.1 Voluntary Community Sector

The 'Voluntary Community Sector'[1] is an amorphous umbrella term used within this thesis to describe a variety of not-for-profit, charity and community

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[1] Use of punctuation quotients are used to question the subjective, contentious and socially constructed nature of terminology

organisations. Often referred to as the ‘third sector’, the Voluntary Community Sector provides a vast array of unique services alongside statutory mental health support, often considered more flexible, informal and culturally sensitive. The terms ‘Voluntary Community Sector professional/worker’ are used interchangeably, whilst recognising many Voluntary Community Sector employees may not identify with these labels, and how broad descriptions can obscure important differences.

1.2.2 Community

With no universal definition for the term ‘community’ (British Psychological Society, BPS, 2018) the concept is considered dynamic, fluid and socially constructed. The following definition is considered appropriate and widely accepted within community engagement guidelines:

“A community is defined as a group of people who have common characteristics. Communities can be defined by location, race, ethnicity, age, occupation, a shared interest (such as using the same service) or affinity (such as religion and faith) or other common bonds. A community can also be defined as a group of individuals living within the same geographical location” (National Institute for Health and Clinical Excellence, 2008, p38).

1.2.3 Marginalised and minority communities

Within academic literature, marginalised groups are often defined as populations outside of ‘mainstream society’ (Schiffer & Schatz, 2008). Marginalisation is a broad, dynamic construct where individuals may move in and out of such groups and exist within multiple categories simultaneously, emphasising the complexity of research within this area. This thesis considers the definitions within the Equality Act (2010), with an emphasis on ethnicity, race, religion and culture. Aligned with Division of Clinical Psychology (DCP, 2020a) recommended terminology, ‘marginalised’, ‘minority’ will be used interchangeably, and ‘ethnic minority’ as cited in literature, whilst fully acknowledging the complexities and limitations of these terms.

1.2.4 ‘Black and Minority Ethnic’

Language is used and experienced in multiple ways when referring to ‘race’ within everyday conversation, research and academia. The terms ‘Black and Minority Ethnic (BME)’ and ‘Black and Asian Minority Ethnic (BAME)’ are often used interchangeably, featured routinely in census, research and governmental literature (Winker, 2004) and are only used to remain consistent to literature cited. This thesis recognises the limitations of these umbrella terms, and how these acronyms are no longer considered helpful, due to their ability to disguise and minimise differences (Sewell et al., 2021).

1.2.5 Culture

‘Culture’ can be a shared collection of ideas, traditions, behaviours, attitudes and values that are shared inter-generationally amongst a group of people. Fernando (2012, p.113) describes culture as “something that is difficult to define or pin down, something living, dynamic and changing - a flexible system of values and world views that people live by”. Key cultural differences can centre around individualism and collectivism (prioritising the group over the individual) and how this consequently shapes individual, group and organisational behaviour (Brownlee & Lee, 2006).

1.2.6 Race

With over one hundred definitions within the Oxford English Dictionary, the concept of ‘race’ is derived from the idea humans can be divided into discrete categories based on biological characteristics such as skin colour, blood group and hair texture (d’Ardenne & Mahatani, 1999). Race has no biological basis but prevails within a social-political context (Smedley & Smedley, 2005). Many argue it was historically used to justify abuses of power, domination and construct concepts of racial inferiority and superiority (Durrheim, et al., 2009). This thesis critically questions the socially constructed nature of ‘race’, perceiving it is more concerned with issues of power than biological differences (Rathwell & Philips, 1986).

1.2.7 Ethnicity

‘Ethnicity’ can be considered more psychological in nature, based around shared group identity, cultural heritage and sense of belonging or self-ascribed, influencing how we perceive ourselves and others (Fernando, 2002). It is important to remain aware of the risks of using ethnic categories, since broad umbrella definitions can cause harm through homogenising individuals from minority groups, by masking significant distinctions within groups (Solake, 2020). This thesis attempts to consider how individuals and communities describe their own ethnicity within their wider context, where possible.

1.2.8 Partnership working

A partnership can be defined as any situation where people work across organisational boundaries towards a shared goal or positive end (Huxham & Vangen 2005). For this thesis, ‘community partnership’ or ‘partnership work’ refers to relationships between statutory mental health services, including Clinical Psychologists and the Voluntary Community Sector. Such partnership work often bridges gaps, by providing culturally appropriate support for marginalised groups. This thesis will consider partnership working as an umbrella term encompassing community engagement and community psychology approaches. However, important distinctions between these approaches will also be explored.

1.2.9 Children and Young People’s Mental Health Services

Children and Young People’s Mental Health Services is a new umbrella term describing all National Health Service (NHS) services supporting children and young people with their mental health and wellbeing. The term Children and Adolescent Mental Health Services describes children and young people’s NHS community support at a local level. Both terms will be used accordingly throughout this thesis.

1.3 Narrative Review

This review is structured within two parts. The first section explores challenges facing Children and Young People’s Mental Health Services in providing support to marginalised communities, followed by alternative participatory approaches.

1.4 Access to Children and Young People's Mental Health Services

Evidence demonstrates that Children and Young People's Mental Health Services are repeatedly failing to meet the rising mental health needs of children and young people and families in the UK (Centre for Mental Health, 2020). Referrals to Children and Young People's Mental Health Services increased by 35% in 2019-2020, whilst the number of children and young people accessing support increased by only 4%[2] (Children's Commissioner, 2020). Data suggests one in six children and young people are likely to experience mental health problems, with 50% of these developing before the age of 14. Understanding the increased demands and pressure on Children and Young People's Mental Health Services is complex. Evidence suggests a number of interconnecting factors include increasing child population and family breakdown, socioeconomic deprivation, awareness of mental health risks and the influence of different cultural, ethnic and community values (Tjoa, 2019). Considering this complexity, the need for early intervention and prevention approaches is strongly advocated (Department of Health, DOH 2015). However, reports show many children and young people struggle to access services, experience long waiting lists and feel let down and frustrated with the system (Children's Commissioner, 2020). Austerity measures and weak national policy have led to chronic underfunding, often leaving vulnerable and marginalised communities' worst affected (The Lancet, 2020). It is therefore important to briefly review the current structure and challenges facing Children and Young People's Mental Health Services.

1.5 Child and Adolescent Mental Health Services Transformation

With increasing concerns about the adequacy of Child and Adolescent Mental Health Services, government guidance including Future in Mind (DoH, 2015) and the Five Year Forward View for Mental Health (NHS England, 2016) provided recommendations to 'transform' services to improve accessibility, quality of care and outcomes. Clinical Commissioning Groups are responsible for local implementation and many Child and Adolescent Mental Health Services have

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[2] As the current research was undertaken in 2019, the impact of COVID-19 on Children and Young People's Mental Health Services is not included

transitioned from a traditional tiered system, where children and young people were assigned to a tier associated with level of complexity and need, to a more integrated, holistic model. Children and Young People's Mental Health Services provide multi-disciplinary support, often comprising psychiatrists, psychologists, social workers, nurses and therapists. Clinical Psychologists often offer both direct (individual therapy) and indirect (consultation and working with children and young people's wider systems and networks). Aiming to provide more flexible and accessible support, a 'single point of access' for referrals intends to minimise delays and inequities (Department of Health, 2015).

Access to Children and Young People's Mental Health Services varies geographically and can begin with a child or young person directly seeking support from a GP or through self-referral. However, more often children and young people seek help within their network of adult 'gatekeepers', including parents, carers and teachers, who often share concerns and refer to Children and Young People's Mental Health Services (Appleton & Hammond-Rowley, 2000; Garralda, 2004). It is therefore essential that services are designed to be accessible for children and young people and their gatekeepers. Partnership working with other agencies, including schools, health and Voluntary Community Sector organisations, is now considered imperative in providing consistent, accessible support. However, effective partnership working is complex, with significant barriers reported including changing thresholds, limited capacity, lack of knowledge regarding services and different approaches to information sharing (Department for Education, 2017). The value and need for preventative Voluntary Community Sector mental health support for both Children and Young People's Mental Health Services and communities is now recognised within the NHS England (2019) Long Term Plan. Ambitions for the next ten years involve providing support that is accessible, closer to home, and available and appropriate when needed. The NHS Long Term Plan emphasises such goals necessitate sophisticated partnership working between Voluntary Community Sector, statutory services and commissioners.

1.6 Voluntary Community Sector Role in Children and Young People's Mental Health Services

Voluntary Community Sector organisations are increasingly funded and commissioned by NHS services to contribute preventative and holistic support. Building partnerships between statutory and Voluntary Community Sector organisations involves innovation, developing working methods with different stakeholders, with less funding and increased pressures to better meet needs (Sebba et al, 2018). Glisson and Williams (2015) highlight traditional approaches tend to be driven by rules, focused on processes, outcome, accountability and hierarchy, whereas innovation is often more mission-driven, dynamic and focused on results, improvement and relationships. The authors highlighted the value of collaborative design and co-production with stakeholders, valuing learning and adaptation as ongoing processes.

Ofsted's Feeling Heard (2020) report highlighted the strengths of partnership working, where the Voluntary Community Sector is considered more accessible for marginalised communities and increases the system's capacity. Voluntary Community Sector organisations are often governed by culture and ethos that values accessibility, self-organisation, service-user-defined outcomes, informality and relational-based approaches (Macmillan, 2013). Most rely on statutory funding, faced with expectations to provide 'more for less', and the uncertainty of short-term contracts and funding cuts. Such services often go unrecognised, despite bridging overwhelming gaps in statutory support and providing innovative, high quality care with minimal resources and support (Tribe, 2019).

Evidence demonstrates an increasing need for accessible and responsive mental health support, highlighting how the current system lacks flexibility to meet the specific, complex needs of those marginalised and stigmatised (Perkins, 2021; Centre for Mental Health, 2021). Voluntary Community Sector organisations frequently hold a unique position and ability to reach and build bridges and relationships with marginalised groups, who experience inequalities and barriers to accessing health services. Children and young people and families have reported Voluntary Community Sector services being more accessible, approachable and relatable and offering culturally appropriate support. It is evident that mental health professionals must work in collaboration with communities. Clinical Psychologists adopting a whole-systems approach are well placed to reach out and develop partnerships with key community members who have existing relationships with children and young people and families (Perkins, 2020; BPS, 2018). As services experience greater pressure and financial restructuring, opportunities for Clinical Psychologists and Voluntary Community Sector professionals to engage in innovative, responsive work with communities is increasingly limited (BPS, 2018). Unsurprisingly, insecure funding for partnerships and Voluntary Community Sector organisations has been found to create uncertainty, reduced motivation and low morale (Ware, 2013).

1.7 Voluntary Community Sector Research

Despite documented value in partnership working, there is minimal research exploring its effectiveness between the NHS and Voluntary Community Sector (Tait & Shah, 2007). Many Voluntary Community Sector organisations are experienced in undertaking small-scale evaluation research, often under time constraints and pressured to evidence outcomes or sustain funding (Hagger-Johnson et al., 2006). Such research is seldom published in academic journals, and therefore referred to as ‘grey literature’ (Cordes, 2004). Consequently, sourcing and circulating Voluntary Community Sector-led research is problematic, often perceived as less valuable than academic research. However, psychology can learn much from Voluntary Community Sector approaches and research regarding working flexibly and responsively to meet the diverse needs of different cultures and communities (Tribe & Tunairu 2017; Hagger-Johnson et al. 2006). Research highlights how Voluntary Community Sector professionals supporting Black Minority Ethnic communities are often unheard and under-researched (Craig, 2011; Ware, 2013). This thesis will now review the context and need for Voluntary Community Sector partnership approaches supporting marginalised communities.

1.8 Culturally Appropriate Support

Individuals who identify within the Black Minority Ethnic category doubled in the past decade and children and young people from ethnic minorities represent 25% of the childhood UK population under ten (Sunak & Rajeswaran, 2014). Mental health professionals and researchers have a responsibility to create culturally sensitive services that respect the values and needs of diverse communities (DoH, 2014). As world populations diversify, it is essential services listen to, adapt and meet cultural, social and mental health needs of marginalised and minority communities (Dogra et al. 2012). However, meeting the mental health needs of children and families amidst the UK population's growing cultural and linguistic diversity is often perceived as a challenge for Clinical Psychologists working within Children and Young People's Mental Health Services (Ayo et al. 2020). Services often fail to accommodate cultural differences, religious beliefs and stigma within mental health support (National Collaborating Centre for Mental Health, 2019).

Ethnic minority communities have been long underrepresented in Child and Adolescent Mental Health Services, compared to the White British majority (Kramer & Garralda, 2000). Despite this, literature and action regarding cultural issues and competence in Children and Young People's Mental Health Services is severely lacking and has received significantly less attention than adult populations (Papadopoulos et al. 2008). Under-represented groups and communities can unhelpfully be labelled as 'hard to reach', positioning the problem within communities (Byrne, 2020), as opposed to questioning the current systems. Community outreach, complex partnership working and valuing shared learning are positive developments in increasing Child and Adolescent Mental Health Services access for minority families (Krause & Afuape, 2016; Ayo et al., 2020). Authors suggest commissioners need to develop community partnerships with Voluntary Community Sector organisations within marginalised communities to develop alternative community-based models of care.

1.9 Health Inequalities

Community partnership working is an important tool in addressing deep-rooted health inequalities (Johnstone & Whaley, 2015). Evidence shows intersecting health inequalities often begin before birth and increase with time (Marmot et al., 2020). Research demonstrates ethnic minority communities experience worse health and social inequalities, poverty, deprivation, housing issues, physical health problems and educational and employment opportunities (Centre for Mental Health, 2020; Karlsen et al., 2002; Nazroo, 2003). They are less likely to access psychological therapies with a higher propensity for negative experiences and poorer outcomes in mental health care than White British service users (Mercer et al. 2019; Crawford et al. 2016). Social and health inequalities cannot be separated from structural racism where Black and Asian Minority Ethnic communities experience discrimination, aggression, exclusion, stigma and negative psychological outcomes (DCP, 2020b).

Ethnic mental health inequalities are longstanding, disproportionate and alarming. Evidence repeatedly demonstrates the failure of current statutory service provision in meeting children and young people’s mental health needs and adult minority populations on the grounds of accessibility, relevance and appropriateness (Fernando & Keating, 2009; Kramer Garralda, 2000; Malek & Joughin, 2004; Messent & Murrell, 2003). Research shows Black and Asian Minority Ethnic individuals are four times more likely to be detained under the Mental Health Act and within the criminal justice system, compared with White British groups (Care Quality Commission, 2018; Mann et al., 2014; Morgan et al., 2009). Shockingly high and disproportionate, this has been labelled the country’s ‘dirty secret’ (Mulholland, 2017, p1) requiring urgent change and attention. Despite numerous targeted government policies, such as Delivering Race Equality in Mental Health Care (DoH, 2005), national inpatient data reveals minimal impact in reducing the health gap (Care Quality Commission, 2011).

Despite these glaring inequalities, surprisingly little literature and research exists on the mental health needs of children and young people and families from minority ethnic groups and communities (Street, et al., 2005). Reviewing the damaging nature of such inequalities highlights a drastic need for change. Suggestions to reduce inequalities include significant social change, community-led initiatives and peer support, reinforcing the need for partnership and community engagement approaches with the Voluntary Community Sector (Centre for Mental Health, 2020). However, better research is needed regarding the mental health of children and young people in Black Minority Ethnic groups and barriers to accessing services (Vostainis et al., 2013).

1.10 Access Barriers for Ethnic Minority Communities

The World Health Organisation (2015) states statutory services must acknowledge that marginalised communities are less likely to experience the right to health and should consider how to better address their needs. Therefore, The Equality Act (2010) legally protects individuals from discrimination under nine protected characteristics, including mental health. Public bodies, including the NHS, have a legal duty to consider the equality impact of their actions and cultural competency and ensure communities are involved in addressing difficulties relating to their healthcare. In seeking more accessible approaches, consideration of consistent barriers for children and young people and adult populations is crucial. It is important to acknowledge the complex and intersectional nature of research regarding service access, with limited reliable data regarding prevalence and access available (Time to Change, 2012). The current narrative review found consistent perceived barriers experienced by children and young people and adults from minority groups, (see following for more detailed review: Memon et al., 2016; Faulkner, 2014; Lavis, 2014; Keating, et al., 2002; Reardon, et al., 2017). Several key barriers are discussed below:

1.10.1 Stigma

Fear and stigma surrounding mental health is complex, influenced by varying cultural beliefs and understandings, models of psychological distress and shaped by social and cultural context (Kirmayer & Bhugra, 2009). Stigma related to help-seeking was a universal barrier reported within all studies reviewed above. It posed significant, serious challenges to seeking and accessing mental health support across multiple cultural, community and ethnic backgrounds (Reardon et al., 2017). Children and young people from Black Minority Ethnic communities shared concerns regarding ‘going outside the family’ and the challenging social consequences within their community (Kurtz & Street, 2006). Stigma in acknowledging and disclosing mental health difficulties was consistent within Black Minority Ethnic and Orthodox-Jewish communities (Memon et al., 2016; Faulkner, 2014; Loewenthal & Rogers, 2004).

1.10.2 Cultural differences

Faulkner (2014) summarised findings from a consultation with over eighty participants from Black Minority Ethnic communities in England. Participants described their distress as interwoven within family, racial and cultural backgrounds, and consequently considered the Western biomedical approach to mental health disconnected, inappropriate and paradoxically detrimental and damaging. This aligned with other studies, where children and young people felt staff and services lacked awareness and sensitivity towards their cultural, community, religious and family background (Kurtz & Street, et al., 2005; Lavis, 2014). Many fear their religious and spiritual beliefs will be criticised, neglected or disrespected by secular services, who often lack cultural sensitivity, and ask questions that conflict with their faith or culture (Healthwatch 2018; Mustafa & Byrne, 2016).

1.10.3 Trust

Many communities shared a prolific mistrust of statutory services with increasing levels of unmet mental health need (DCP, 2020). Trust was considered paramount, where Black Minority Ethnic children and young people and adult service-users explained how fears around confidentiality breaches within their community acted as a barrier to seeking support (Kurtz & Street, 2006). Barriers to help-seeking within the Orthodox-Jewish community included mistrust of outsiders, worries about breaching Jewish religious laws, and fears statutory services would not understand or accommodate their religious beliefs and needs (Loewenthal, 2006; McFarlane, 2006). Studies highlighted trust was also impeded by imbalanced power between service users and professionals. This could be acutely felt in directive and insensitive communication, leaving people feeling helpless and passive (Memon et al. 2016). Evidence repeatedly highlighted how Black Minority Ethnic communities experienced negative experiences of care received (Robertson, et al., 2017), fuelling an avoidance and mistrust of services (Arday, 2018).

A pivotal paper by Keating and colleagues (2002) highlighted the ‘circles of fear’, where many African and Caribbean communities are often fearful and distrusting of mental health services. Similarly, service providers can be wary of Black service users, conversations about ‘race’ and culture and feel uncertain how to respond. This can contribute to individuals avoiding mental health services until times of crisis, increasing the likelihood of being sectioned and experiencing coercive treatment, driven by fear and racist stereotypes. Here, a negative spiral is created and maintained and unfortunately remains very prevalent within current mental health services (Byrne, et al., 2017).

1.10.4 Racism and discrimination

Perceived discrimination, particularly racism, was universally reported across studies and strongly associated with a detrimental effect on psychological wellbeing and help-seeking (Fernando, 2014). Individuals felt they received poorer care, unfair treatment and were afforded no accepted space to discuss the psychological impact of racism (McKenzie, 2003). Such discrimination contributes to services being inaccessible, reducing opportunities for early intervention support (Lavis, 2014), contributing to an overrepresentation of Black Minority Ethnic adults in inpatient and crisis settings (Malek & Joughin (2004). Edbrooke-Childs and Patalay (2019) analysed data from 14,500 children and young people accessing Children and Young People’s Mental Health Services and found that children and young people from minority ethnic backgrounds were at higher risk of accessing services through compulsory, as opposed to voluntary pathways. Authors recommended the need for national and local policy alongside practice guidelines to ensure early identification and appropriate referrals and interventions.

1.10.5 Practical difficulties

Practical difficulties impacting upon Black and Asian Minority Ethnic service users’ engagement with services were highly prevalent, including language barriers, long waiting lists, inaccessible locations and rigid and inflexible service structures (Reardon, et al. 2017; Morgan et al., 2009). Difficulty in finding information on local mental health services and awareness of what support services offered was a key barrier identified by over 90% of Black and Asian Minority Ethnic participants (Healthwatch, 2018). These findings suggest that mental health services need to be more flexible and responsive to meet the varied needs of minoritised communities.

1.11 Who is 'Hard to Reach'?

This review has highlighted the numerous barriers children and young people and families face, demonstrating that mental health services are often inaccessible and even harmful to marginalised communities (Keating et al., 2002). Therefore, mental health services and professionals have a responsibility to consider how these barriers can be better navigated or removed, through becoming more culturally accessible, flexible and rebuilding minority communities' trust and faith in statutory services (Grey et al., 2013). This highlights the question: is it communities or services and professionals who are 'hard to reach'? (Flanagan & Hancock, 2010). Labelling 'hard to reach' communities positions the problem within communities rather than critically questioning the background, culture and values of statutory professionals and systems (DCP, 2020). Byrne (2020, para. 9) argues we must "turn the lens around to look at how we can provide services that are genuinely accessible and relevant to the communities we serve".

Therefore, this thesis argues that services and professionals need to take greater responsibility in reaching out and being easier to reach. This feels particularly important within the reviewed context of damaging health inequalities and the evidenced need for preventative, early intervention support within childhood (Marmot, et al., 2020). This thesis will now consider how mental health services can work more collaboratively with marginalised children and young people and communities. Recommended and evidence-based approaches that involve children and young people, families and communities in designing and delivering more culturally appropriate mental health support, are now explored.

1.12 Participatory and Partnership Approaches

Participatory approaches in practice and research directly address the powerlessness and low self-esteem associated with structural inequalities and can improve access and uptake of services. Joint partnership work between statutory, local Voluntary Community Sector and faith organisations is regularly recommended within government and health legislation (NHS England, 2019). This section considers how partnership approaches introduced at different systemic levels improves cultural accessibility of psychological services. Acknowledging how these approaches overlap and interconnect in practice, within this thesis, co-production, partnership work and community engagement will be outlined as three distinct approaches.

1.13 Co-production and Cultural Accessibility

It is increasingly recognised that to be more effective, services need to become more culturally accessible, and research demonstrates that co-production can be key in achieving this (Lwembe et al., 2017). Co-production is defined as a value-driven, collaborative way of service users and providers working together to achieve a collective outcome (Involve, 2018). Co-production is recommended and recognised to reduce stigma, discrimination and ensure equitable service access (National Institute of Health Research (National Institute of Care Excellence, NICE, 2013; Mental Health Taskforce, 2016). When used effectively, co-production aims toward equal collaboration, to develop knowledge and interventions which are of higher relevance and quality to service users.

Cultural adaptation is key to creating more accessible support and is defined as the ‘systematic modification of an evidence-based treatment or intervention protocol to consider 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, p. 362). Community-led, co-production approaches are considered integral to this process of increasing cultural acceptability (Bernal, et al., 1995; Casale et al., 2015). Research shows collaborative, consultative approaches with local Black Minority Ethnic Voluntary Community Sector organisations moves towards a better understanding of needs and more inclusive and culturally sensitive mental health services (Fernando, 2010). Therefore, co-production provides opportunities to dismantle historical, systemic and socio-cultural barriers, designing more responsive structures to meet the needs of communities who may be wary and fearful of mental health services (Lwembe et al., 2016).

Co-production can therefore facilitate Clinical Psychologists providing more culturally appropriate support. ‘Cultural competency’ entails understanding; cultural knowledge (history, values, beliefs); cultural awareness (considering alternative cultural practices) and cultural sensitivity (respecting and accommodating cultural differences) (Brownlee & Lee, 2006). Psychological evidence of culturally adapted interventions and cultural competence remains inconsistent and untenable as a strategy to increase access to psychological therapies (Edge & Lemetyinen, 2019). Authors argue a paradigm shift is required involving more integrated models, where interventions, training and evaluation are all collaboratively co-developed with service users and communities, thus ensuring potential harm is minimised and support is effective and appropriate (Fatimilehin & Hassan, 2013).

1.14 Community Engagement

Growing evidence demonstrates, that when ethnic and religious minority communities are involved as active partners, their engagement levels, experiences and outcomes generally improve (DoH, 2008; Popay et al., 2007). Community Engagement is defined as “getting communities involved in decisions that affect them...the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities” (Popay, 2006, p2). National Institute of Clinical Excellence (NICE, 2008; 2016) guidance on community engagement, encourages equal contribution, collaborations, partnerships and co-production between statutory organisations and communities.

Policy stipulates that NHS and governmental bodies are obliged to work alongside local communities, to ensure services are more accessible, needs-focused, improve health and wellbeing and reduce health inequalities (Health and Social Care Act 2012; The Equality Act, 2010). However, such partnership working can encounter various challenges, including cultural differences, statutory services reluctance to share control and power, and insufficient time to develop trusting relationships with local communities (NICE, 2016). A NICE review summarised that strong relationships, organisational culture, sharing power and investing time, resources and infrastructure are facilitators to community engagement (Harden et al., 2015).

Building upon NICE (2008) guidelines, Lane and Tribe (2010) proposed a stepped practical guide to facilitating community engagement with Black Minority Ethnic community groups. Such ways of working challenge traditional psychological practice, rooted in inequalities of power, knowledge and hierarchy. Mental health professionals, including Clinical Psychologists, are often hesitant and apprehensive about stepping out of the comfort zone of 'the clinic' (Tribe, 2019). However, meeting in community spaces considered trusted, safe and non-stigmatising, is widely recognised to improve relationships and access (Durcan et al., 2017). Tribe and Tunariu (2017) highlight how bidirectional training and learning around diverse cultural understandings of distress between community and Western professionals, improves service accessibility.

1.15 Acculturation

Acculturation theory can be a useful framework to consider when supporting cultural adjustment within participatory approaches. Acculturation is defined as the process of cultural and psychological change arising from adjustment, exchange and negotiation between two cultures (Sam & Berry, 2010). Evidence shows adapting to this fusion of cultures can increase psychological distress (Berry, 2004). The main model categorises individuals into one of four acculturation strategies: assimilation, integration, separation and marginalisation (Berry, 2005). Research indicates those 'ready' and able to combine the two cultures experience more positive adaptation and outcomes and less psychological distress (Berry, 2004). This approach is criticised for its linear, unidimensional approach to understanding culture as a monolithic construct and risks losing the dynamic, socially constructed nature (Tardif-Williams & Fisher, 2009).

More contemporary theories acknowledge how acculturation is bi-directional, rich and multi-layered. Research highlights acculturative style is heavily mediated by context, establishing there is no single ‘best’ or ‘appropriate’ way to acculturate, as this depends on complex negotiations regarding individual-environmental fit (Birman, 2016). Community partnership working is critical to supporting acculturation and understanding and meeting individuals’ needs within diverse communities. This thesis will now consider how acculturation is considered within psychological approaches to partnership working.

1.16 Role of Psychology

1.16.1 Power sharing in partnership work

This section explores how community engagement and partnership working with Voluntary Community Sector organisations translates into Clinical Psychology practice and guidance. Hagger-Johnson et al. (2006) highlighted the problematic nature of past British Psychological Society (BPS) partnership initiatives, such as ‘bringing psychology to society’ and ‘giving psychology away’, where Voluntary Community Sector partners received these approaches as patronising and condescending. This emphasised the need for a paradigm shift from a one-directional model, where ‘expert’ psychological knowledge is ‘imparted’ to the Voluntary Community Sector, to a more bi-directional exchange addressing power imbalances through valuing dialogue, mutual learning and shared expertise.

Recent BPS guidance on ‘working with community organisations’ advocates collaborative approaches and continual co-production across multiple levels of partnership working (BPS, 2018). Co-produced approaches have been found to develop a better understanding of communities’ needs, which in turn provides more accessible, culturally appropriate psychological support and services (Howitt et al., 2020). The authors emphasise the importance of Clinical Psychologists adopting a position of cultural humility, allowing statutory services to benefit from their community partners' invaluable cultural context and develop greater cultural competence. Clinical Psychologists working in partnership with religious and spiritual leaders is an increasingly recognised approach to providing more tailored, culturally accessible, psychological support within marginalised communities (Aten & Worthington, 2009; Morgan et al., 2009).

Co-production involves acknowledging and maintaining an awareness of how power is distributed within community partnerships (Byrne et al., 2017; BPS, 2018). The importance of sharing and deconstructing power was acknowledged in guidance regarding partnership working by Howitt et al., (2020), which was co-developed by Clinical Psychologists and a Voluntary Community Sector professional. Both papers noted how this more equal sharing of power provided opportunities to build and develop authentic, trusted relationships between Clinical Psychologists and Voluntary Community Sector and community members. Clear communication, long-term commitment, openness to change, sufficient time and resources and joint training are often essential to power sharing and effective partnership working (NICE, 2008; 2016, Hagger-Johnson et al., 2006; BPS, 2018; Howitt et al., 2020). Several papers highlighted a lack of specificity and evaluation, emphasising the need for further evaluation and research into community partnership perspectives (BPS, 2018; Howitt et al., 2020). This thesis will now explore how power operates within traditional and community psychology approaches.

1.16.2 Traditional psychological approaches

The Western world often perceives mental health and psychological distress through the traditional medical lens of 'mental illness' and as an exclusively individual issue. Through ignoring the wider context and societal factors, which are evidenced to contribute to poor mental health (Tribe & Bell, 2018) we risk medicalising misery and pathologising human responses to adversity (Bracken et al., 2012). Over forty years ago, Illich (1976, p11) highlighted how "the medical establishment had become a major threat to health", warning about the multiple risks and losses inherent within the medicalisation of society. He suggested that medicalisation (e.g. the use of drugs, medical advances and technologies) resulted in the removal of personal responsibility for suffering and distress, whilst simultaneously creating a dependence on ‘treatment’ within healthcare institutions, such as the NHS, which can result in further harm. It can be argued that this reactive, medicalised approach to health is significantly contributing to the current crises facing the NHS, which is oversubscribed, under-funded, culture blind and unable to meet the diverse needs of the UK population. This necessitates the need for Voluntary Community specialist services to exist.

These issues are compounded by the professionalism of mental health, which remains elitist, with training and treatment often only accessible for the privileged, where Eurocentric approaches ignore the needs of modern, multicultural communities (Perkins, 2021). Psychology originated from White, Western, middle-class values, which historically dominated science and psychology (Katz, 1985). Therefore, Western culture and ethnicity are considered inherently superior and consequently, privileged. Psychological interventions risk being shaped by inherent assumptions and expectations about family and societal structure and how mental distress ‘should’ be expressed (Williams, et al., 2006). For example, many Muslim communities widely accept that Jinn (described as spiritual creatures) are believed to cause psychological distress, and equally, how faith can be central to wellbeing and recovery, illustrating why many prefer religious support over biomedical approaches (Khalifa et al., 2012).

Ethnic minority communities, service users and Clinical Psychologists unify in their criticism of how British Clinical Psychology continues to be culture-blind, unconsciously and consciously racist and fundamentally inaccessible to marginalised communities (Wood & Patel, 2017; Patel & Fatimilehin, 2005). Psychology and psychiatry tend to ignore their White, theoretical Euro and Ethno-centric underpinnings and often translate Western research and understandings to other cultural contexts, without sufficient consideration (Tribe, 2014). Research demonstrates including faith and spiritual beliefs within psychological therapy is considered important and increases engagement (Rose et al., 2001). However, Clinical Psychologists are predominantly White females and identify as less religious than the general population (Smiley, 2001). Many Clinical Psychologists acknowledge discomfort discussing religion with service users, which can result in overlooking and ignoring the fundamental role that spirituality holds within mental health (Byrne et al., 2011).

Patel (2010) critically challenges assumptions a diverse workforce would remedy issues of Eurocentricity, suggesting Clinical Psychology must question the cultural appropriateness of individual therapy, alongside the theory and models it is based upon. Often derived by White, Western men, Eurocentric approaches cannot meaningfully consider or discuss the realities of racism, cultural and ethnic identity that many minority groups experience (Bernal et al., 2002). Compounding this issue, individuals from minority groups are often described as lacking ‘psychological mindedness’ or not ‘sufficiently integrated’ within Western culture to ‘engage’ with services (Wood & Patel 2017; Kareem & Littlewood, 2000).

Conventional mental health approaches increasingly rely on individually focused interventions, predominantly psychiatric medication and psychological therapy. Despite significant increases to the Clinical Psychology workforce, trained to primarily deliver individual interventions (Norcross & Karpiak, 2012), one-to-one therapy will never be readily available to accommodate all needs, or work preventatively to address causes of distress (Harper, 2016). Consequently, should psychology move beyond operating at the individual level and adopt approaches grounded in prevention and collaboration? This would involve multi-systemic changes within mental health and NHS systems, moving away from incentives to focus on ‘treatment’, towards prevention (Tribe & Bell, 2018).

1.16.3 Benefits of a community psychology approach

Community psychology developed from a dissatisfaction with traditional approaches, moving beyond locating ‘problems’ within the individual toward preventative action (Perkins, 2011). Community psychology seeks to understand people’s social and cultural context; considering wider societal, political and structural factors that impact mental health and wellbeing (Levine & Perkins, 1997). With no single agreed definition, community psychology is considered more a philosophy than a model, rooted in values and collaboration (Orford, 2008). It values opportunities to work holistically, with strong emphasis placed upon social justice, challenging inequalities and power imbalances through encouraging inclusion (Orford, 1992). It is action-orientated, often involving partnership working and co-production with marginalised, vulnerable and disempowered communities and groups (Prilleltensky, et al., 2001). This often results in dismantling professional power, emphasising the importance of overcoming personal and professional interests for Clinical Psychologists (Casale et al., 2015). If involved, professionals play a supporting role, where communities are seen as the experts in their own lives, with a focus on sustaining local empowerment and minimising professional involvement.

Increasingly popular within the UK, community psychology provides opportunities to structure and shape services, addressing wider societal and systemic determinants of distress (BPS, 2011). Sourcing published examples of community psychology practice in the UK has been surprisingly challenging. Gaining 'access' within communities, alongside managing confidentiality (Tribe & Bell, 2018), and limited time, resources and funding available are key barriers to evaluating community psychology approaches. Examples of relevant practice-based research are pioneered by The NHS Black Minority Ethnic Access Services. They work in close partnership with Voluntary Community Sector organisations and communities to make psychological therapies accessible and culturally relevant to local underrepresented communities in East London (Perry et al., 2018). Underpinned by Fountain et al. (2007)'s Community Engagement Model and a community psychology approach, Byrne (2020) describes how the service model involves co-production and partnership working with community and faith-based organisations, perceived as trusted and accessible. This involves a strengths-based approach in exploring different cultural understandings of mental distress, coping and recovery. Support often takes places within accessible community centres and religious spaces, such as churches and mosques (Byrne et al., 2017).

The Trailblazers project was a partnership project involving community consultation, workshops and co-facilitated sessions with service users. Participants found the Tree of Life approach (Ncube, 2006) aligned with their spiritual and cultural roots and promoted hopes, dreams and strengths aligned within a narrative therapy framework. Evaluation demonstrated increased accessibility and acceptability of psychological therapy for African and Carribean men (Carlin, 2009). Such practice-based research demonstrates the great value of community psychology and co-produced psychological interventions, training and research (Howitt et al., 2020).

1.17 An Ecological Perspective

Bronfenbrenner's (1979) Ecological Systems Theory (EST) is a popular theoretical and conceptual tool used in child development, public health and community psychology (Richard et al., 2011). Ecological Systems Theory helps contextualise complexities of environmental interactions across the five nested levels, highlighting the reciprocal, multi-layered relationship between individual and context. Emphasising context reduces issues of power, blame and misplaced individual responsibility, creating opportunities for change. Castillo et al. (2019) reviewed multi-sector community partnership interventions in over 150 peer-reviewed medical journals between 2015 to 2018. They found such interventions were effective in improving mental health and social outcomes, categorising interventions across different ecological levels. The Microlevel focuses on the interactions between individuals and their immediate environment (Bronfenbrenner, 1979), where partnership interventions focused on increasing access and acceptability of services. The Mesosystem recognises interactions between Microlevel relationships, where interventions often focused on psychoeducation and skills training. Organisational and institutional interventions at the Exo-level focused on embedding support within community settings, building trusted relationships and changing processes and policies to effect change. Lastly, the Macrosystem, which considers the overarching values and beliefs society places upon an individual, included community partnership interventions aimed to reduce stigma, and share resources at policy level.

Castillo et al. (2019) concluded most interventions operated at individual, micro and meso levels, in contrast to wider systems change, e.g. organisational and policy changes. This aligns with Nelson & Prilletensky's (2010) critique that psychological interventions often orientate toward Micro and Meso-level interventions and should aim for wider exo and macro-level changes, as they are most influential and sustainable. Viewing community partnership interventions within an Ecological Systems Theory framework enables exploration of power within community relationships. Castillo et al. (2019) advocate further research is needed to outline best practices for partnership structures that improve mental health, structural, and social inequalities.

1.18 Community Psychology in Children and Young People's Mental Health Services

Despite a documented emphasis on early intervention and prevention, minimal literature exists regarding community psychology with children and young people within NHS UK settings. Within BPS guidance, Casale et al. (2015) provide a comprehensive, practical overview of incorporating community psychology approaches within Children and Young People's Mental Health Services. They provide a strong argument that Children and Young People's Mental Health Services must consider the social context of distress and intervene at multiple levels, built upon co-production and community partnership working. This is supported by government initiatives, such as Future in Mind (2015), which advocates community psychology approaches can create more preventative, accessible, relatable and non-stigmatising Children and Young People's Mental Health Services.

Applying community psychology principles to practice, MAC-UK (Music and Change UK) is a charity aiming to build youth-led systems change. Through combining youth work and community psychology, co-production and young people's voices are central to enabling equitable and accessible mental health support. MAC-UK developed the 'Integrate' approach, alongside excluded young people, which emphasises the importance of trusted relationships, meeting young people in their place and at their pace and developing and delivering services with, rather than to young people (Music and Change UK, 2021). It is built upon evidence-based approaches including attachment theory, Adaptive Mentalization-Based Integrative Treatment (AMBIT), community psychology and narrative approaches (see Durcan et al., 2017 for further details). In practice, an Integrate approach engages with young people through activity-based projects (music, art, sports etc), co-designed and led by young people and within partnership work with Voluntary Community Sector and statutory organisations. Integrate is cited within national policy, including the recent Child and Adolescent Mental Health Services Taskforce report (DoH, 2015) and used by both statutory and Voluntary Community Sector services (Casale et al., 2015).

It is interesting to reflect on why community psychology principles with children and young people hold little visibility and voice within UK statutory services. Working preventatively and across multiple levels simultaneously requires energy, commitment and can be challenging within the context of funding and service pressures (Casale et al., 2015). Collaboration and co-production require “putting young people at the heart’ of psychological work” (Howard, 2018, para. 4), where equal decision-making and mutual respect underpin working together. Professionals may perceive such approaches as inconvenient, due to the perceived time and energy required and can experience discomfort as the ‘experts’ asking others for help. The majority of community psychology practice-based research has been undertaken in children and young people Voluntary Community Sector settings, where service structures enable more flexible and responsive systems. This narrative review has demonstrated the need for a whole-systems, preventative approach to Children and Young People’s Mental Health Services that is community-led and co-produced (Tjoa, 2019). Therefore, exploring and evaluating community psychology and partnership approaches used within NHS Children and Young People’s Mental Health Services is crucial to better understanding and responding to the unmet mental health needs of children and young people and families from marginalised communities.

1.19 Scoping Review

A scoping review was undertaken following guidance from Peters et al. (2015). It applies a systematic approach in order to map relevant literature in a specific field. This was considered appropriate as a scoping study suits broader topics, involving different study designs and identifying research gaps (Arksey & O’Malley, 2005).

After undertaking a preliminary scoping literature search and acknowledging paucity of literature available regarding Children and Young People's Mental Health Services and Voluntary Community Sector partnerships, two questions were considered. This enabled exploration of relevant literature available in Children and Young People's Mental Health Services and then adult populations. The scoping review involved selecting relevant search terms and systemically searching online databases, hand searching reference lists and grey literature, alongside contacting Psychologists with a published interest in the area. Inclusion and exclusion criteria were applied, with a clear justification for these choices provided. Charting the results in prose and within the search decision flow chart enabled a clear and descriptive summary of the results relevant to this study's two research questions. Comprehensive details of the search terms, strategy, criteria, search decision flow chart and included studies are found in Appendix A and B. The results will be discussed in relation to each question, providing the unique context of each study and then summarising main themes.

The scoping review identified two studies that were relevant to the first question:

1.19.1 Question One: What is known about partnership working, community engagement and community psychology approaches involving Clinical Psychologists and the Voluntary Community Sector in Children and Young People's Mental Health Services in the UK?

1. Hill et al. (2021) evaluated an innovative Child and Adolescent Mental Health Services partnership, where community consultation and partnership working informed cultural adaptation of a parenting group. Authors outlined how a partnership between Clinical Psychologists and Voluntary Community Sector professionals utilised shared expertise to incorporate spiritual and cultural aspects of Orthodox Judaism, including rabbinical approval, whilst retaining an evidence-based parenting group approach. It involved quantitative analysis of questionnaire data from thirty-six Orthodox-Jewish mothers who attended.

2. Durcan et al. (2017) evaluated three Music and Change UK (MAC-UK) community psychology projects and outlined the 'Integrate' approach, co-

produced with young people, Voluntary Community Sector and statutory professionals. Mixed methods evaluation included in-depth interviews, self-report questionnaires, observations and third-party contact data.

1.19.1.1 Building collaborative relationships. Despite different service contexts, both studies illustrate adopting a community psychology approach enabled and prioritised development of collaborative, trusted community partnerships. They found mutual learning, co-production and shared expertise were central to building trusted relationships and effective partnership working. Durcan et al. (2017) demonstrated how co-production underpinned the MAC-UK Integrate approach, which values building relationships in safe, community spaces to create more relatable, psychologically-informed environments.

1.19.1.2 Increased access and wellbeing. Collaboratively adapted interventions, resulted in increased access and engagement with services, and improvements in wellbeing for Orthodox-Jewish mothers (Hill et al., 2021) and excluded young people (Durcan et al., 2017). Both studies found that creating and adapting flexible, holistic support enabled more tailored and appropriate support.

1.19.1.3 Openness to learning. The two studies showed adopting an intensive, multi-levelled community psychology approach required ongoing commitment for partnerships to continue learning together. Hill et al. (2021) outlined the importance of collaboratively sourcing and incorporating practical and spiritual resources, in order to maintain Torah (Jewish law and tradition) values. Openness to adaptations and change from both Clinical Psychologists and Voluntary Community Sector perspectives was shown to improve cultural accessibility.

These findings provide a unique insight into community partnerships creating culturally adapted, accessible, evidence-based interventions for children and young people and families. This review demonstrates the scarcity of research, proving very little is known about Voluntary Community Sector partnership working within Children and Young People’s Mental Health Services. Therefore, the search was broadened to include adult populations and explore relevant learning.

1.19.2 Question Two: What is known about partnership working, community engagement and community psychology approaches between Voluntary Community Sector and Clinical Psychology in the UK?

As part of the scoping review, seven relevant studies were identified. The first four studies were facilitated by two Black Minority Ethnic Access Services in East London. Three of these papers evaluated service users’ experiences of accessing a culturally adapted psychological intervention involving partnership working between the Voluntary Community Sector and Black Minority Ethnic Access Service and one interviewed Voluntary Community Sector professionals. The final three studies explored Voluntary Community Sector perspectives on partnership working with statutory psychology services.

1. Perry, et al. (2018) evaluated a culturally adapted pilot psycho-education group, developed through community-based partnership alliance between Hackney Black Minority Ethnic Access Service, Jewish Voluntary Community Sector organisation Bikur Cholim, a Charedi psychotherapist and local Rabbi. Mixed methods analysis included self-reported questionnaires from thirty-four Orthodox Jewish carers attending the adapted group.

2. Perry et al. (2019) evaluated a culturally adapted group intervention, developed through collaborative partnership work and consultation between the Hackney Black Minority Ethnic Access Service and Turkish-speaking Voluntary Community Sector organisation, Derman. Mixed methods analysis included self-reported questionnaires and focus group data from seven Turkish-speaking female service users.

3. Mustafa and Byrne (2016) evaluated a culturally adapted Tree of Life group, developed through partnership working with Tower Hamlets Black Minority Ethnic Access Service, and a local Voluntary Community Sector group facilitator

specialised in Islamic emotional health and a local Imam. Themes were developed from a focus group with sixteen male Bangladeshi service users.

4. Galloway and Byrne (2016) explored the effectiveness of Hackney Black Minority Ethnic Access Service support and attitudes towards help-seeking within the Orthodox-Jewish community. It involved thematic analysis of interviews with six Jewish Voluntary Community Sector professionals supporting the Orthodox-Jewish community.

5. Flanagan and Hancock (2010) presented a qualitative pilot study exploring Voluntary Community Sector views on the term ‘hard to reach’, alongside barriers and facilitators to accessing services in Birmingham. Qualitative analysis developed themes from eight interviews with Voluntary Community Sector professionals.

6. Lester et al. (2008) undertook large-scale qualitative research exploring perspectives on effective partnership working between early intervention services and Voluntary Community Sector organisations in the West Midlands. Constant comparison method was used to analyse semi-structured interviews with forty-seven Voluntary Community Sector professionals, forty-two NHS senior managers and commissioners, alongside focus groups with sixty early intervention professionals.

7. McEvoy et al. (2017) evaluated a partnership initiative designed to improve access to a North-West England NHS Increasing Access to Psychological Therapies (IAPT) service, for the local Orthodox-Jewish community. Themes were presented from mixed-methods data analysis of demographic data, outcome measures, notes and recorded discussions with twelve members of partnership team, including Voluntary Community Sector professionals.

1.19.2.1 Trust and relationships. Studies demonstrated how close, collaborative partnership working between Clinical Psychologists, Voluntary Community Sector and religious leaders made services more relevant and subsequently more accessible by creating tailored support that sensitively incorporated culture, faith and spirituality. Close partnership working was effective in incorporating cultural understandings and community bridging techniques, including culturally relevant values, metaphors and videos relevant to the Turkish-speaking community (Perry et al., 2019). Collaborative partnership working developed also developed a successful psycho-educational programme was developed through collaborative partnership working to ensure the advertising, structure and presentation of interventions were in line with Jewish faith, including editing of text and video materials (Perry et al., 2018). Lastly, the faith in recovery approach was developed by Mustafa and Byrne, 2016, and involved community consultation and partnership working with Voluntary Community Sector partners and an Imam. Together, they developed ways to incorporate Islamic ideas into wellbeing and recovery, which led to a successful co-produced Tree of Life intervention (Ncube, 2006). The authors emphasised how consultation and partnership working created a positive spiral of engagement, developing shared expertise, trust and collaboration (Mustafa & Byrne, 2016).

Relationship building between Voluntary Community Sector and statutory professionals, was universally acknowledged to increase mutual trust, respect and learning within partnerships. McEvoy et al. (2017) explored the partnership's relational aspects, noting the importance of Dialogic engagement (Bakhtin, 2010); the process of continuous dialogue and communication throughout the project, aimed at improving community access. This enabled mutual learning, understanding and acceptance of difference, increased trust and confidence. Development of mutually beneficial, long-term and personal relationships was discussed as a key facilitator to partnership working (Lester et al. 2008), and how this increased resilience, reflexivity, trust and a perceived sense of control, which were key elements to bridging cultural differences (McEvoy et al., 2017; Galloway & Byrne 2016).

1.19.2.2 Improved wellbeing and attitudes. Findings from all studies suggested that partnership-informed, culturally adapted group interventions improved participants' well-being (Perry et al., 2018), reduced psychological distress (Perry et al., 2019) and increased awareness of therapeutic support and intentions to access (Mustafa & Byrne, 2016). Galloway and Byrne (2016) found that participants felt partnership working had influenced positive changes, both in Orthodox-Jewish communities' attitudes toward talking therapies and in statutory approaches towards the community. They perceived this had been facilitated through Voluntary Community Sector community organisations bridging communities and statutory services, where flexible and holistic support influenced greater knowledge, awareness and reduced stigma.

1.19.2.3 Flexible co-production. Many Voluntary Community Sector professionals emphasised the importance of Clinical Psychologists and services being flexible, open and adaptable to ensure partnerships could be co-produced and culturally sensitive. Shared skills, training and approaches were considered key to increase knowledge, awareness and develop a shared vision (Galloway & Byrne, 2016; Lester et al., 2008) although some acknowledged the importance of communities retaining autonomy and space from statutory services to preserve cultural and religious values (McEvoy et al., 2017).

Within their research interviewing Voluntary Community Sector professionals supporting hard to reach groups, Flanagan & Hancock (2010) concluded key themes that facilitated engagement were: relationship building with staff (e.g., attitudes, respect and trust); service flexibility (e.g. location, opening times and funding constraints); partnership working and co-production. This was supported by Lester et al. (2008) who found flexibility, shared agendas, skills and training initiatives facilitated partnership work. Conversely, barriers demonstrated a lack of flexibility between services including cultural differences, communication difficulties, risk management, operation of power and hierarchy and insecure funding and sustainability.

1.19.3 Methodological considerations

As this is a novel, under-researched area, it is important to consider what can be learnt from the studies' methodologies. All nine papers involved evaluation of practice-based research and purposive sampling procedures, demonstrating this is an appropriate methodology for the topic. Whilst open to bias, this approach may reflect the challenges of accessing research participants from marginalised communities. As several papers did not follow standardised research design or reporting structures, coupled with interventions being fluid and multi-levelled, it sometimes felt challenging to get a clear, transparent understanding of how studies were undertaken and evaluated. Therefore, findings may have benefitted from more transparent, rigorous and step-by-step research procedures and reporting. Due to the small and geographically limited samples (six out of nine studies took place in London), findings cannot be generalisable, although distinct themes appeared applicable across different groups and settings.

Three studies acknowledged time restraints were identified as a reason for Voluntary Community Sector professionals declining participation within studies. This echoes the systemic challenges facing over-worked, under-resourced Voluntary Community Sector organisations and may have impacted accessing a broad range of perspectives, holding important implications in research planning with Voluntary Community Sector groups (Flanagan & Hancock, 2010). This may explain why studies often utilised available data and resources and rarely followed formalised research methods and structures.

1.19.4 Conclusions and research gaps

The nine papers reviewed provided unique, tangible examples of how partnership work involving Clinical Psychologists and the Voluntary Community Sector facilitates increased accessibility of psychological services. Research included perspectives from Voluntary Community Sector professionals and service users from diverse UK communities, including Orthodox-Jewish, Muslim, Turkish-speaking and Vietnamese backgrounds. Studies provided insights into community consultation and partnership working processes to culturally adapt interventions. Findings were similar across both children and young people and adult settings, emphasising the importance of developing trust, collaborative relationships, flexibility and openness to learning. This often improved participants' wellbeing and access to services, providing opportunities to sensitively incorporate faith into culturally appropriate interventions.

Due to the small and unique context of these interventions, results cannot be generalised, nevertheless they provide rich learning for Clinical Psychologists. This scoping review demonstrates this area's research base is scarce, with no known qualitative studies exploring Voluntary Community Sector professionals' perspectives on partnership working with Clinical Psychologists in Children and Young People's Mental Health Services. Consequently, the current study aims to address this significant gap in the research literature.

1.20 Rationale and Aims

Following insights developed from the review above, the flexibility of practice-based, critical realist, qualitative research involving purposeful sampling was considered most appropriate. The current research was undertaken in collaboration with an anonymised Child and Adolescent Mental Health Services team in a major UK city, experienced in established partnership working, community engagement and community psychology approaches. Much of this work involved community consultation to better understand needs and strengths of local underrepresented communities. The Child and Adolescent Mental Health Services service offered Voluntary Community Sector professionals training in various evidence-based parenting programmes and culturally adapted materials collaboratively.

As a previous employee of the service, I had developed trusted relationships with the Clinical Psychologists and some Voluntary Community Sector professionals. This provided a unique opportunity to interview Voluntary Community Sector professionals working with families from marginalised communities. The research aimed to explore Voluntary Community Sector perspectives on partnership working with Clinical Psychologists, regarding provision of culturally sensitive support, and whether this work helped improve engagement and access for local communities accessing Child and Adolescent Mental Health Services.

To my knowledge, no research exists on the:
a) Views of Voluntary Community Sector professionals on partnership work with Clinical Psychologists to improve engagement with minority communities
b) Processes used to improve community engagement,
c) Accessing the voice of community organisations involved in partnership work with Clinical Psychologists

This research aims to increase knowledge and insights into community partnership working and may influence future clinical practice and guidance for both Voluntary Community Sector professionals and Clinical Psychologists. It aims to listen to and promote the often unheard, under-researched voices of Voluntary Community Sector professionals and learn from their experiences. Anonymous participation may enable participants to more readily reflect upon and identify what they would like and need from Clinical Psychologists within partnerships and address traditional power imbalances. It has potential to improve partnership practice and increase community engagement in NHS services (Hagger-Johnson, et al., 2006).

1.21 Research Questions

1. What facilitates partnership working and community engagement between the Voluntary Community Sector and Clinical Psychologists working with children and families?

2. How do community workers and leaders view co-production approaches in improving engagement with NHS services?

2. METHODOLOGY

2.1 Overview

This chapter outlines how the methodology and methods were carefully chosen to address the research questions. It begins by describing the researcher's ontological and epistemological position and evaluates the rationale for a qualitative approach and method. Ethical considerations are discussed, alongside the roles of reflexivity and power. Details of the research procedure and data analysis are described.

2.2 Epistemology and Research Position

When defining research aims or any pursuit of knowledge, considering the assumptions one holds about knowledge (ontology) is fundamental. Epistemology is known as the theory of knowledge, an area of philosophy concerned with how we believe things to be real or true and our description of knowledge seeking (Barker, et al., 2016). Adopting an epistemological position involves the researcher exploring and owning their research choices, goals and objectives, whilst considering what may and may not be possible to discover (Willig, 2008). Only then, can qualitative research be considered to possess good validity and reliability.

Epistemological positions can be perceived on a continuum (Harper, 2011). At one end lies realism, which advocates there is one objective 'truth'. This is contrasted with social constructionism, which argues no objective reality exists, instead there is an emphasis on the importance of language and how multiple realities are co-created within social contexts (Ratner, 2014). Critical realism is situated between these two positions, assuming a form of 'reality' does exist, but that it is shaped by our understanding, perception and socio-cultural context (Willig, 2008). Critical realism accepts the powerful role of language in constructing social reality, yet argues these constructions are influenced by a material world and reality (Willig, 2008). Therefore, a critical realist ontological and epistemological framework was considered appropriate for this research. This enabled acknowledgement and exploration of underpinning realities mediated by social and historical context, for example how ethnic minority communities experience social inequalities and inequitable healthcare. This stance assumes the constructs of culture, community and ethnicity have real-life consequences on people's lived experiences, partnership working and engagement with services.

Critical realism presents an opportunity to go beyond the text in the analysis (Harper, 2011) through acknowledging and questioning how these lived and socially mediated realities influence the data interpretation. A critical realist approach is considered appropriate to question the processes and factors influencing partnership work, community engagement and disparities in minority families accessing Child and Adolescent Mental Health Services, as these constructs are perceived as 'real' and 'socially constructed', holding implications for change (Price & Martin, 2018). Simultaneously, adopting this position allowed me to critically assess how the production of knowledge and interaction with participants is rooted in social context and power inequalities (Kolar, et al., 2015).

2.3. Rationale for Qualitative Approach and Methodology

Consideration of the research questions emphasised the need for an exploratory approach, as the research objective was not to determine causality or derive theory. With an interest in understanding the experiences and perspectives of participants within a wider context, an interpretative epistemological position and qualitative methodology was deemed appropriate (Thompson & Harper, 2012). Qualitative research methods can be considered a powerful toolkit for exploring how people make sense of their experiences and fit well within the core values of community psychology (Banyard & Miller, 1998). This methodology promotes the 'voice' of individuals as opposed to 'expert' opinion and is therefore appropriate for researching the richness of community consultations (Lane & Tribe, 2010). It has also been shown to be effective when researching marginalised groups, where the 'voice' of individuals can be heard, as opposed to 'a more objective, expert' opinion (Ussher, 1999). Although the aim of the research was to 'give voice' to participants (Smith, et al., 2009), it was essential to maintain awareness that this research was shaped through my own lens of interpretation and understanding. Therefore, a qualitative approach to data collection and analysis, alongside a reflective position was considered most suitable.

With no previous research into the relationship between the Voluntary Community Sector, Clinical Psychologists and community engagement, a qualitative methodology provided a good starting point for participants to share their experiences in a rich and meaningful way. NHS England (2017) endorses qualitative research to explore gaps in insight regarding local experiences of healthcare, thus contributing to shaping policy, programmes, services and improvements. A qualitative study into a very valuable but under-researched group of Voluntary Community Sector professionals may benefit NHS service design and commissioning, aligning with the NHS Long Term Plan and values regarding co-production and partnership working (NHS England, 2019). Facilitating focus groups was initially considered, due to the naturalistic setting and rich meaning that can be gained from shared interactions (Finch, et al., 2014). However, issues of power and anonymity in light of current working relationships between services emphasised the need for a contained and private space. Therefore, semi-structured interviews were considered suitable, as it was hoped the use of open-ended questions, active listening and responsivity could provide a safe space to share experiences.

2.4 Rationale for Thematic Analysis

A number of qualitative research methods can be considered when approaching data analysis, each underpinned by different epistemological and theoretical positions. In line with my interpretative epistemological stance, potential approaches involving interpretative analysis will be discussed, including Interpretive Phenomenological Analysis (Smith et al., 2009), Grounded Theory (Charmaz, 2006) and Thematic Analysis (Braun & Clarke, 2006).

Interpretive Phenomenological Analysis is concerned with perception, producing rich and detailed accounts of how people experience the world (Smith et al., 2009). Although phenomenological research aims to describe and document the experiences of participants, it is not interested in explaining why such experiences happen (Willig, 2013). I would argue that the research questions aim to move beyond sharing participants' experiences, to a more interpretative level, acknowledging the social, historical and material context of lived experience (Willig, 1999). Interpretive Phenomenological Analysis holds distinct epistemological and ontological positions necessitating adherence to a specific framework and analytic procedures, which was considered restrictive for this research. Furthermore, Interpretive Phenomenological Analysis requires a homogenous sample that was not appropriate here, as participants represented diverse organisations within the Voluntary Community Sector, and identified from different ethnicities, communities, services and working practices.

The use of Grounded Theory was also considered, where research aims to produce new theories or models that are grounded within empirical data (Green & Thorogood, 2004). As Grounded Theory has been extensively used with exploratory research questions, I considered whether it could help conceptualise factors that would facilitate partnership working between the Voluntary Community Sector and Clinical Psychologists. However, since my objective was not to develop a theory, and no current researched understanding exists into how the Voluntary Community Sector and Clinical Psychologists work in partnership within Children and Young People's Mental Health Services, a more interpretative approach was explored.

Despite many shared features with both Interpretive Phenomenological Analysis and Grounded Theory, Thematic Analysis has a number of unique features that made it most appropriate for this study. Developed by Braun and Clarke (2006), Thematic Analysis focuses on identifying, analysing and reporting patterns by their content and meaning, across an entire data set. In contrast to an idiographic approach in Interpretive Phenomenological Analysis (where the focus is on data items analysed at an individual level), Thematic Analysis was chosen to recognise and capture broad themes. This enabled exploration of experiences of partnership working from a participant group with rich and diverse experiences. It also provided opportunities to make meaning of patterns across the whole data set, rather than individual characteristics of interviews. Whilst tempted to explore the rich contextual differences between the cultural, ethnic and community backgrounds of participants, it was decided this would be too vast for the scope of the research project at this time.

Due to the lack of research in this area, an exploratory, flexible and accessible approach to analysis was imperative. Such requirements suit Thematic Analysis, which is not aligned with a specific epistemological or theoretical paradigm (Wood, et al., 2012). Thematic Analysis is considered highly compatible with a critical realist position, as it explores social and contextual factors during the analysis (Willig, 2013), which complimented the research aims. Furthermore, Thematic Analysis enabled a deeper understanding of how contextual factors, such as culture and community impact Voluntary Community Sector professionals' experiences, contributing to a more systemic lens and approach to partnership working and accessing services. With transparent steps, themes and a report presented on completion of Thematic Analysis, it was hoped this analysis would produce relatively accessible and useful results for both Voluntary Community Sector professionals and Clinical Psychologists.

Thematic Analysis provides a systematic and transparent approach to capturing latent and underlying meanings, where reliability and validity checks can be incorporated to understand how results were reached through coding and collating themes. It is important to consider the ways in which themes are developed: whether they are deductive (arising from a theoretical idea brought by the researcher) or inductive (data driven). This research adopted a dual-deductive approach (Joffe & Yardley, 2004), acknowledging the impact of preconceived ideas on data, whilst holding an open and curious approach to developing ideas and themes. This required an awareness of how the research questions specifically aimed to explore Voluntary Community Sector workers' perceptions of partnership working, engagement and co-production, as well as the multiple theoretical, personal and professional understandings of these constructs.

2.5 Ethical Considerations

2.5.1 Ethical approval

As some participants were employed by community organisations that involved partnership working commissioned by an NHS Clinical Commissioning Group (CCG), Health Research Authority approval was sought (Appendix C). Ethical approval was received from the Health Research Authority and Care Research Wales on 23rd July 2019 and an ethical amendment granted due to an administrative error and minor changes in wording (Appendix D). The local NHS Research and Development Department Team provided permission for the study to take place (Appendix E) and permission from the field service was granted.

2.5.2 Informed consent and confidentiality

All participants were given the opportunity to discuss the research with the field supervisor (a Clinical Psychologist within the anonymised Child and Adolescent Mental Health Service) and gave consent to be contacted by the researcher. Prior to commencing interviews, participants were given an Information Sheet (Appendix F), detailing the study's purpose, aims, involvement, confidentiality, data storage and anonymity. This included contact details for the researcher, supervisor and university officials for any follow-up questions or concerns, together with clarification that identifiable data would be kept for 1 year after participating and anonymised data kept for up to 5 years and then destroyed. Participants were invited to ask questions before, during, and after the interviews and reminded of their right to withdraw at any time, take breaks or reschedule. Guidelines on community consultation (Lane & Tribe, 2010) recommend careful consideration regarding the management of data. A Consent Form (Appendix G) was presented and signed following the Information Sheet, to document participants' understanding of the study and how their information would be used and stored. The Information Sheet outlined the study's Data Protection arrangements: that all names and identifiable information would be password protected and accessed solely by the researcher; that data would be treated confidentially with all names, places and identifiable information changed.

2.5.3 Anonymisation

The aim of anonymising data was to protect and conceal participants' identities, but as a researcher, I faced challenges in balancing the priorities of providing maximum protection whilst simultaneously retaining the value and richness of the data (Saunders, et al., 2015). Providing a context where participants could be honest about their experiences was paramount, and to gain this confidence, they needed to see I understood the importance of protecting their ongoing working relationships with the field service. Consequently, I advised participants in person, and in the Information Sheet that due to the close working relationships, there was a possibility that quotations might be identifiable by relevant services. In order to reduce this risk, it was specified that quotations would be amended to ensure their cultural details and service identity were unidentifiable.

The process of anonymisation became more complex once the data was transcribed: due to the unique and identifiable nature of the community organisations and partnerships in focus; because of interconnecting dual identity some participants shared with the communities they supported; and identifiable aspects of the local area. Sensitivity to the open audience of this research was crucial in maintaining trust and integrity, as many participants represented marginalised communities, which were accessed through relationships with the field service. Therefore, anonymisation of place names, cultural and religious details was deemed necessary. However, this presented dilemmas in terms of decontextualising the data (Baez, 2002) and loss of meaning. Consequently, situating the research within a major UK city borough was considered important in providing minimal context.

Upon reflection, I realised that references to participants' religious, cultural or ethnic background could risk deductive disclosure (Kaiser, 2009), making them identifiable. I concluded that generalised descriptions, e.g., referencing faith or culture, would be most ethical and in line with UK guidance (UK Data Service, 2013). These were complex decisions to make as eliminating such rich, contextual information risked 'white-washing' the data (Parry & Mauthner, 2004), which will be considered further in the discussion. Lastly, I reflected on the use of pseudonyms and felt conflicted in renaming participants respectfully, without alluding to their cultural or religious identity. Therefore, to ensure identities were not compromised, alphabetical initials based on interview order was considered more culturally respectful than numbers, (e.g., PA represents Participant A) and pseudonym names were used for Clinical Psychologists.

2.5.4 Debriefing

Once interviews were completed, participants were given a debrief sheet including the researcher’s contact details, and a list of supportive agencies (Appendix H).

2.5.5 Reflexivity and power

To produce meaningful, reliable and credible qualitative research, reflexivity is crucial, enabling the researcher to notice, acknowledge and critically reflect on their personal contribution to the process (Spencer & Ritchie, 2012). Both personal reflexivity (how my values and experiences shape the research) and epistemological reflexivity (the assumptions I hold about knowledge from a critical realist position) were considered throughout (Willig, 2008) and explored further in the discussion.

The opportunity to recruit participants for this study resulted from relationships I had developed as a past employee (Assistant Psychologist) within the field service, and previous involvement in some of the community partnerships in question. This included an existing working relationship with the Clinical Psychologist who facilitated recruitment for this research as the community partnerships lead. I was mindful that I had a previous connection with four of the ten participants; I had co-worked with one participant within a community project and had met three other participants during training events and was aware of their community work. I felt extremely grateful for the opportunity to interview participants considered as gatekeepers to marginalised communities. These existing relationships created the potential to aid open expression through increased trust and familiarity. However, it was crucial to maintain awareness of the multiple identities I held as a past employee, researcher and Trainee Clinical Psychologist. This included potential expectations of what participants felt they ‘should’ say in a ‘professional’ context, i.e. feeling obliged to provide positive feedback, and the subtle power relationships underlying the interviews (Charmaz, 2006).

None of the participants were directly employed by the field service, so there was a minimal risk that their employment would be impacted by participating. However, I remained aware that participants could have concerns that what they shared in the interviews may have social and political consequences, i.e. worries that the field service could be displeased or disappointed with the experiences shared. As the researcher, I had ensured the field service and supervisor were aware that I was interested in seeking both positive and negative experiences, which they fully supported for learning and improved practice within Clinical Psychology. I was also conscious of the wider socioeconomic context, where the Voluntary Community Sector is chronically under-resourced and joint working with Psychologists can often be associated with securing project funding or resources. Therefore, to minimise issues of professional power and politics, it was vital that the information sheet, interview schedule and my approach clearly communicated the research was exploratory and independent of any service evaluation or funding.

To ensure ethical research, I tried to adopt a systemic lens, considering how assumptions about culture impacted power dynamics and shaped the research. I reflected on the cultural and power differences between participants and myself as a White, British female, alongside organisational differences between small, grass roots Voluntary Community Sector organisations versus a powerful healthcare provider such as the NHS; built upon a White, Western concept of healthcare. All research decisions were governed by the four key ethical principles of respect, responsibility, competence and integrity, outlined by the BPS (2018) Code of Conduct. This included transparent consideration of my personal and professional reflexive positions and how this impacted decision-making throughout. Discussions within research, field and peer supervision, alongside maintaining a reflective journal enabled me to reflect on my role and biases within the construction of the research knowledge (Blaxter, 2001).

My previous work within the field service resulted in a strong appreciation and admiration for Voluntary Community Sector professionals and how little they appeared to have been listened to within the world of research. This led to a desire to listen to and learn from Voluntary Community Sector workers who had such unique partnerships with the field service and links with communities considered ‘hard-to-reach’. I hoped this practice-based research could illuminate both positive and negative experiences for the future learning and psychological practice in Children and Young People’s Mental Health Services.

2.6 Research Procedure

2.6.1 Interview schedule

A semi-structured interview schedule (Appendix I) was developed following an in-depth literature review and discussions with field and research supervisors. Questions were designed to gather information related to the research questions and focused on two areas: experience of partnership working and engagement with services. They were structured openly, for example “can you tell me about...” and included prompts to use if further clarification was needed. This was particularly important, considering English was not the first language for many participants and many of the concepts referenced were socially constructed and ambiguous, e.g., ‘community’ requiring clarification. The interviews were conversational in style, and gentle probing enabled space for participants to elaborate on their experiences and understanding (Kvale, 1996).

2.6.2 Pilot study

After discussions within supervision, it was agreed a pilot interview would determine whether the interview and research questions were culturally sensitive and appropriate to the research questions (Turner, 2010). This was undertaken with a Voluntary Community Sector professional who met the inclusion criteria, allowing the full recruitment, consent and debrief procedure to be trialled. Verbal feedback was sought on the interview experience and questions, and repeated in writing a few days later, to provide time for reflection. The pilot participant fed back that they considered the interview forms and questions to be clear and that they did not identify or anticipate any significant issues with understanding the language and structure of questions from the perspective of participants who speak English as a second language. They highlighted how different participants would have a different experience and relationship with some of the terms and constructs included, such as “community” and emphasised the need to make it clear that participants had the flexibility to ask questions and for the researcher to use prompts if necessary. Following my own reflections and feedback and consultation with supervisors, two small amendments were made to the schedule. This involved presenting the wording in two questions to be more open (e.g. rather than beginning two questions with “do you”, the questions were changed to “how do you”) to encourage more open, exploratory answers.

The pilot participant also offered some suggestions about how to sensitively capture demographic information, as they perceived that being asked to complete a form asking for demographic information regarding participants ethnic and cultural identity, may be a barrier to participating. They proposed that basic demographic information could be collected informally from the interview content so participants could speak more naturally about the communities they supported. They discussed how participants could be informed before the interview commenced that basic demographic information would be collected informally from the interview content, which would be presented independently of quotations, to preserve anonymity yet provide some meaningful context. These recommendations were deemed appropriate and it was agreed that demographic information, including the community each participant worked with, whether they shared dual identity with this community and how long they had partnership worked with the NHS would be informally collected from the interview content.

2.6.3 Inclusion and exclusion criteria

The criteria for this research was guided by the literature review and extensive discussions with clinicians in the field service and research supervisors. The following inclusion criteria were agreed:

- Participants were Voluntary Community Sector professionals who worked in partnership with the field service (anonymised Child and Adolescent Mental Health Service) for over 1 year
- Aged 18 and above

The following exclusion criteria were agreed:

- Participants would not be direct employees of the NHS

2.6.4 Recruitment

Due to existing relationships, the field supervisor initially identified and approached twelve eligible participants who were involved in community partnership working and asked if they were open to being introduced to the researcher. Two of the eligible participants responded that they were unable to participate due to being on paternity and compassionate leave. Once informal consent was granted, I made contact by telephone or email to confirm their interest in taking part in the study. Information sheets and consent forms were emailed to participants, inviting them to ask questions. Interviews were scheduled at a convenient time and place for participants, at either a community or NHS setting. Lone working procedures were agreed with the field supervisor to ensure safety and potential risks were considered, e.g., interviews were held within working hours and a telephone call was made to inform the location and start and end of interviews.

Consultation with the field service enabled space to reflect on how to ensure interviews were approached in a culturally sensitive manner, due to their existing relationships with Voluntary Community Sector professionals and established understanding of the communities, e.g., it was not appropriate to contact some participants on certain days of the week due to religious activities. Attention to the researcher’s dress code was also particularly important to ensure participants felt comfortable during the interview and their religious and cultural beliefs were honoured and respected.

2.6.5 Participants

The study used purposive sampling, aiming to interview 8-10 participants, following Thematic Analysis guidelines for small projects (Braun & Clarke, 2013). Between June and September 2019, ten participants participated in the study. Interviewees comprised of both unpaid volunteers and paid employees within a wide range of diverse and specialist voluntary community organisations, including community centres and charities. Some participants were employed by community organisations that involved partnership working commissioned by an NHS Clinical Commissioning Group. Minimal information has been included to preserve anonymity. To provide some context, the following basic demographics are included. 90% of participants shared dual identity with the communities they supported. The table below shows the number of Voluntary Community Sector participants and the respective ethnic communities they supported.

2.6.6 Table 1

Participant Demographics

Number of participants	Working with the following ethnic community
4	Orthodox-Jewish
2	Afro-Caribbean
1	African Heritage
1	South Asian Muslim
1	Muslim
1	Turkish-speaking

2.6.7 Interview process

Interviews took place over a three-month period, within a private room, each lasting approximately 40-90 minutes. After participants had read the information sheet, semi-structured interviews were guided by the interview schedule. This included introductions to build rapport and explanations of the purpose of the interview and my role as researcher. I clarified the definitions of ‘partnership working’ for the purposes of this research, acknowledging everyone may not be familiar with this term. I explained approximately five minutes were allowed for each question and highlighted their right to withdraw.

I explained all identifiable information would be anonymised, including cultural and religious details, names of staff, services and locations. Participants were informed that basic demographic information would be collected informally from the interview content, such as the community each participant worked with, whether they shared dual identity with this community and how long they had partnership worked with the NHS. It was explained this information would be presented independently of quotations, in order to preserve anonymity yet provide some meaningful context. On two occasions, this information was unclear within the interview questions and was clarified toward the end of the interview.

A Consent Form was signed and time given for arising questions. I balanced adherence to the interview schedule alongside facilitating conversation, to give space for participants to share and generate meaning from their experiences (Hollway & Jefferson, 2000). Interviews were audio recorded using a Dictaphone, then transcribed and analysed at a later date. Accuracy was ensured by listening to each recording twice and a transcription key adapted from Smith (2008) (Appendix J) was used.

2.7 Thematic Analysis

2.7.1 Transcription

Transcribing the interviews enabled familiarisation with the data and the first step in beginning the analysis (Bird, 2005). I carefully transcribed recordings verbatim, including contextual information, laughter, pauses and emphasis to capture additional meaning and anonymised as described above.

2.7.2 Thematic analysis approach

Qualitative data was transcribed and analysed using Thematic Analysis, guided by the six-phase approach by Braun & Clarke (2006) outlined below:

2.7.3 Familiarising yourself with the data

The first step of Thematic Analysis involved data familiarisation, making notes whilst repeatedly re-reading the transcripts and listening to the audio-recordings (Willig, 2013). I highlighted information perceived to be relevant or interesting and then cross-referenced this with notes made after each interview and my reflective journal (Appendix K) to capture as much context as possible.

2.7.4 Generating initial codes

This phase involved generating a list of initial codes, which can be described as 'a succinct label (a word or short phrase) that capture key analytical ideas in the data' (Braun, Clarke & Terry, p.100). Holding the research question in mind, I explored and highlighted what was interesting about the data and labelled provisional codes in the margins (Appendix L).

2.7.5 Searching for themes

After identifying initial codes, a review followed to visually group together similar codes, using an excel spreadsheet (Appendix M). From here, I mapped out broader provisional themes and sub-themes into a 'mind map' format using a pen and paper, and then transitioned to using post-it notes (Appendix N and O). Themes can be defined as capturing "something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, pg.77).

2.7.6 Reviewing themes

After identifying provisional themes, I reviewed and refined them, re-reading the transcripts and chosen extracts to explore the relationships, both between themes and to the data set as a whole. This was a dynamic process, with codes and themes collapsed, removed, changed or expanded until I perceived they were representative of the data. In order to critically consider my impact upon the coding process, I used King and Horrocks' (2010) code-defining approach, to enhance the quality of the analysis. Twenty-five percent of five transcripts were independently coded by a peer researcher on the doctorate course, who was familiar with Thematic Analysis (Appendix P). This opportunity to compare coding fitted well with my critical realist position and ideas regarding production of knowledge (Fletcher, 2016), enabling me to validate ideas around developing codes and themes, and raising reflexive questions about decision making.

2.7.7 Defining and naming themes

This phase involved creating a word document, where I developed a succinct summary and title for each theme and sub-theme highlighting its relevance to the research questions and developed provisional thematic maps (Appendix Q).

2.7.8 Producing the report

To conclude, the analysis was considered within the wider context of the research questions and literature review, carefully selecting examples which best illustrate the themes. Throughout the analysis, I continued to critically reflect on my role and biases in interpreting participants’ experiences (Kvale, 2007).

3. ANALYSIS

Following thematic analysis, three themes and nine sub-themes are summarised in the table below and presented within a thematic map (Appendix R).

3.1 Table 2 and 3

Table 2. Overview of Themes

Theme	**Sub-theme**
Theme 1. Establishing Trusted Relationships	1.1. Building trusted relationships 1.2. Maintaining long-term key connections 1.3 Earning the trust of the community 1.4. Developing a shared language
Theme 2. Reciprocity	2.1. Shared need 2.2. Flexibility meets families' needs 2.3. Shared cultural respect
Theme 3. Breaking Down Systemic Barriers	3.1. Understanding fear and stigma 3.2. Acknowledging frustrations and funding uncertainty 3.2. Increasing knowledge and awareness

*Table 3. The Number of Participants Who Contributed To Each Theme**

Participants	**PA**	**PB**	**PC**	**PD**	**PE**	**PF**	**PG**	**PH**	**PI**	**PJ**	**Total number of participants represented within each thematic construct**
Theme 1: Establishing Trusted Relationships											10
1.1: Building trusted relationships	2	2		1		1	2		1	2	7
1.2: Maintaining long-term key connections	1	1		1			1	1		1	6
1.3: Earning the trust of the community			3			1	2			1	4
1.4: Developing a shared language	2	1	1		1	2				1	6
Theme 2: Reciprocity											10
2.1. Shared need	2	3	1	1	1	2	1				7
2.2. Flexibility meets families' needs	2	2		1						3	4
2.3. Shared cultural respect	1		3	4		2	2			1	6
Theme 3: Breaking Down Systemic Barriers											10
3.1 3.1. Understanding fear and stigma	1	1	3	1		3	1	1	2	1	9
3.2. Acknowledging frustrations		3			1	1	1	1		1	6

and funding uncertainty											
3.2. Increasing knowledge and awareness	2	1		1	2	1	1		1	2	8
Total number of quotes presented by each participant	13	14	11	10	5	13	11	3	4	13	

* Although participants contributed to varying degrees, for each overall theme there was contribution from all participants.

3.2 Theme One: Establishing Trusted Relationships

This theme captures the significance Voluntary Community Sector professionals placed upon building trust and relationships between Clinical Psychologists and communities. Building trusted relationships, based upon honesty, open communication and consistent contact were perceived to bridge cultural differences with communities. This was enhanced through maintaining long-term key connections with Clinical Psychologists, which increased trust and accessibility and helped to earn the trust of the community. Participants often described their role as an advocate and gateway for families to access statutory support. Understanding, listening and containment from Clinical Psychologists helped create foundations for developing a shared language through supervision and shared training within the partnerships, where psychological support could then be adapted to meet communities' needs.

3.2.1 Building trusted relationships

All participants reflected on the fundamental importance of relationship building and developing trust within community partnerships. This was universally considered to improve access and engagement with Children and Young People's Mental Health Services. Participants perceived the development of trust within relationships as the glue that connects marginalised communities, the Voluntary Community Sector and Clinical Psychologists:

> PG: relationship building *is* key (.) once you've got that trust between professionals and parents they're more likely to come in and access that support and engage

> PB: the importance of relationships being at the core of all good work and really to help people (.) that trust (.) enables people (.) to help themselves

> PG: building that trust and relationship consistency so it's not always consistency in service delivery because you have to change and adapt that according to need

Participants often discussed the importance of sustaining strong and established relationships with both families and Clinical Psychologists within community partnerships and identified key components. Honesty, open communication and familiarity were often named as facilitators to partnership working, and perceived to bridge cultural differences with families, staff and organisations:

> PF: we're always going to be honest with each other what we can and can't do (.) and there will be times when either side might say no to something that the other one's suggesting

> PA: there are cultural differences at organisational level like for example even written (.) communication is different (.) so (.3) but most important thing is that we have always had these channels open to discuss without leaving it there...definitely (.) open communication

> PJ: so without an agenda coming in and just actually meeting the families (.) and that is *so* helpful because people are becoming familiar with the person who's coming in (.) and you're just having an open conversation with the families which are here and from that open conversation it opens up tunnels

Participants often linked open communication with Clinical Psychologists being more responsive to families' needs and wishes, enhancing trust, confidence and community engagement. Many emphasised how close, consistent working relationships and regular contact with Clinical Psychologists strengthened trust in community partnerships:

> PD: I think more time and more often sorry you do things together (.) so getting the opportunity to do it on a regular basis as opposed to once in a blue moon (.3) makes a big difference

> PJ: I think it’s just that constant relationship and that working which is really helpful because there’s never been a moment where we don’t know about each other’s teams and knowing that we can phone them at any time

This was supported by other participants, who acknowledged how developing trust, consistency and attuned relationships mediated uncertainty, differences and power differentials between organisational approaches:

> PI: we don’t really know what’s happening (.) behind that closed door but we know that if Kay comes and says something to us that we know that it’s for the child and it’s for the family (.) it’s like constantly working together

> PA: it is going very well I must say (.4) being near each other and understanding each other better (.2) and there is a very balanced power between us I guess (.2) so (.2) these two organisation (.3) has (.) different cultures (.) so organisational level and also facilitation level so we are more in tune with each other

3.2.2 Maintaining long-term key connections

All participants emphasised the value in building and maintaining genuine relationships with a key individual or small number of Clinical Psychologists. This close bond enabled Clinical Psychologists and Voluntary Community Sector professionals to develop strong trusted relationships, and this long-term consistency enhanced the partnership work and community engagement:

> PB: the best work we've done has been when it's (.3) with that long term connection so (.2) you can respond to the changing need (.) if people are embedded in a community...with Julie (.) she'd formed the relationships over time (.) so she was a human (.) she was someone who was accessible

> PH: we developed a relationship with Colette...and started running the workshops and you know what it was the *best* thing that partnership has grown and developed over the years...since 2009
> PJ: a lot of our parents they've known Grace for years (.) she's a trusted person within our community

Many perceived that maintaining consistent and long-term relationships with key Clinical Psychologists benefited the partnerships, enabling trust, familiarity and time efficiency:

> PG: but that relationship is always there... it's almost like picking up from where you left off (.) and I think that's really important to mention that that's to do with the relationship that Grace built with members of staff and you know that's happened over a number of years (.) that allows you to do that...it's not sort of like reinventing the cycle

> PJ: I think Grace's become a part of our family like (.) when I think of [anonymised Child and Adolescent Mental Health Service] I automatically put her name

Several participants expressed how consistent partnership working with a key Clinical Psychologist led to developing close friendships. Some emphasised how building authentic relationships enabled flexible negotiation of different roles within the partnerships and organisations:

> PA: organisational level we have relationship but then facilitator levels we have very close relationship (.3) we kind've become close friends you know (.) and we were available to each other at all times

> PD: we consider Grace a friend as well (.) she's our main contact in [anonymised Child and Adolescent Mental Health Service] it could be that when she wears her hat as a supervisor (.2) she's (.2) how shall I say (.) steering the (.2) session in a different way because she's wearing a hat as a supervisor (.) and we're aware of that but I find it just as easy to deal with her if she is or isn't doing this or that job

3.2.3 Earning the trust of the community

Building upon these strong relationships, many emphasised how Clinical Psychologists being present and visible within communities was vital to earning trust from families and Voluntary Community Sector staff. Word of mouth and sharing experiences of working with Clinical Psychologists within the wider community were regularly identified to improve community engagement:

> PG: they tell one another and it's you know a huge driving force within the community in terms of you know people spreading the word for us (.) almost doing our outreach (laughs) yeah once they believe in something and they're behind it they'll be the advocate

> PC: so here you can't keep secrets so that is *very* good when it comes to services...I had a phone call... we heard you got this *wonderwoman* she's working with people (.) obviously I gave them Grace's details and she's got in here and she's got many more people working because they can't even contain everybody (.) once somebody from the outside gets inside and gets the *trust* of the community (.2) it's everywhere (.) so everybody will come to them

Participants outlined the importance of experiencing and modelling positive relationships with Clinical Psychologists to engender reassurance and trust and promote community engagement. Many perceived their crucial dual role as gatekeepers and advocates in tuning in, and bridging positive relationships between families and professionals:

> PJ: we’re the gateway (.) we’re doing it at grassroots level so the key ingredient is trust (.) relationship building (.) those are the key ingredients because if the community is happy with *our* relationships that we’ve built (.) they’re more likely to engage with professionals

> PC: because people trust me they trust her and everybody wanted to talk to her

> PF: when I did my very first parenting group... I felt a bit like a sales lady...I can just picture myself just sitting there in the children’s centre making these phone calls (.2) and having *long* conversations with people because they were worried because there was going to be a person from outside the community in the room... there was a lot of reassuring we needed to do

Participants perceived a delicate balancing act between understanding, communicating and bridging both families’ and Clinical Psychologists’ needs. Maintaining trust with both parties was considered key to ensuring Voluntary Community Sector workers could help families find the most appropriate support and build trusted reputations within communities:

> PC: then came I think it was Grace...she is not [from the same cultural background] but I liked her very much (.) and I could see that people would like her very much and I could see that she could do (.) very good things and I started by referring people...that I felt needed some help (.3) and they took to her like a house on fire (.) they loved her so then they came with the baby (.2) now in our community you don’t need twitter people (.) we don’t have social media we have the best social media in the world it’s called tell a friend (.3) if I know something and you know something and you’re from the community tomorrow everybody knows it (.) it’s news here it caught like wildfire

> PG: they come and ask for services now (.) and that's partly to do with us advocating for those services (.) again it's that gateway (.) you know we are in both directions

3.2.4 Developing a shared language

Many shared how trusted relationships provided foundations to feel more comfortable and connected to Clinical Psychologists, leading to opportunities to develop a shared language to better support families, through supervision and training. Participants shared how feeling listened to and heard by Clinical Psychologists was integral to established trusted relationships where Voluntary Community Sector professionals and communities felt understood, accepted and contained:

> PA: I mean I think it was [anonymised Child and Adolescent Mental Health Service] (.5) curiosity (.3) you guys were always trying to understand our approach (.2) try to find better ways of you know (.2) *engaging* with our community...so you try to in tune and you actually followed our sometimes our lead as well (.) I think that helped

> PC: speaking to any of them (.) they give you a feeling of a person that listens (.) that (.) accepts that (.) contains you that (.) accept whatever differences that that really I think the word accepting is very very important and it is important to our community and as organisation

Many expressed how these values enabled opportunities for change and were further developed within supervision with Clinical Psychologists, where reassurance, containment and validation were perceived to shape participants' confidence and work with children and young people and families:

> PB: what the psychologist did was meet with these mentors and give them the belief in themselves (.) of the value of what they were offering (.) but also act as a (.7) as a *validator* to the support that we had the potential to offer (.) they gave me the confidence to say I can manage this... if I've got someone behind me saying no that's safe (.) and what you're doing is

> good practice... that was really good partnership working (.2)... it *felt* amazing
>
> PE: we benefit a lot from the supervision a lot (.2) well they've got an amazing ability to be able to (.) I always feel it (.) I walk away from the session feeling good about myself... there's active listening (.) paraphrasing (.) empathising all the things that's useful for clients is useful with us... it's also you know really good professional tips coming our way and offering really practical advice
>
> PF: supervision I feel that we've grown amazingly from when we started

This journey of tuning in and developing mutual trust was also described where the majority of participants talked about the benefits of receiving free training from Clinical Psychologists, which created a shared language, insights and increased confidence:

> PF: they trained us in the Solihull approach (.) we are working on the Solihull approach they're working on the Solihull approach you know I think it's really helpful... I suppose it's created this relationship that's so strong (.) because we're both talking the same language
>
> PJ: was *really* good for me personally doing the Solihull training (.) I think it's really helpful it opened our eyes to different ways of working with families understanding different families (.) and I think that's made me see the work that [anonymised Child and Adolescent Mental Health Service] do in a different light as well (.) I'm now able to ask for services better tailor-made to the families
>
> PA: we felt quite isolated before (.3) so it's all about organisations self-confidence too I guess (.) it just builds up through this kind of partnership work

3.3 Theme Two: Reciprocity

The theme of reciprocity was embedded throughout participants' perspectives on partnership working and connects closely to the first theme of building trusted relationships. Many participants considered reciprocity as a process of two-way sharing, where the relationship between Voluntary Community Sector professionals, Clinical Psychologists and respective services was bi-directional and mutually enriching.

3.3.1 Shared need

Participants reflected on the importance of collaborative working, acknowledging the values of equality and mutual respect. Feeling included appeared to reduce issues regarding hierarchy and rebalance power within the partnerships:

> PF: [anonymised Child and Adolescent Mental Health Service] have often treated us just like a member of the team which is really very special... we went to do Train the Trainer course and it was like all psychologists and us (.) and we were like treated as equal which was really very nice because we're not (.) we haven't had these years and years of training (.) and university education at all (.) so that's been very very nice
>
> PE: mutual respect (.) which I have to say (.) they treat us as real partners (.) there is none of this sort of being on high *we're* the clinical psychologists and you're not (.) so they value our opinions they value our feelings...and that means a lot to us
>
> PA: we always felt that we were on the fringe (.) and we were being used as translators (.) we weren't acknowledged because of our qualifications (.2) so most of the time we were approached because other (.) organisation needs to access our (.) *target* groups but (.) our partnership with [anonymised Child and Adolescent Mental Health Service] was totally different... there was always mutual respect (.) and then also like joint and equal partnership work (.) so we didn't feel that we were at the fringe or that we are supporting you it felt we are (.) we are sharing the work

Sharing was seen as a core process, where community partnerships were considered mutually beneficial. Participants viewed that working together and sharing expertise significantly enhanced and enriched both Voluntary Community Sector professionals' and Clinical Psychologists' practice:

> PB: I started co-hosting parenting sessions with the psychologist...and that was *brilliant (.)* because we have the community relationships (.) and we knew the needs and the dynamics (.) and they of course (.) have the expertise and what that meant for mental health and wellbeing... the more I've done in partnership with psychologists (.) the more I've learned...we're sort of using the same tools (.) but they come with knowledge and (.) expertise that really *boosts* what we're able to do

> PF: developing a relationship with an organisation that is focused on a particular culture will only enrich everyone's experiences enrich the experiences of the clinicians so they've got a better understanding (.) and it will enrich the experience of the patients of other departments or clients even if the community organisation isn't present in the room...I think that we've both organisations have gained tremendously from it

> PB: she also really really valued the expertise of us as an organisation so it was a real meeting (.) but she would always take the time to design what we were doing together

The professional expertise and knowledge that Clinical Psychologists contributed to the partnership was seen as very valuable and beneficial to families and Voluntary Community Sector workers, including community organisations gaining more respect and recognition:

> PA: they quite like expert knowledge our families they really want to hear from the professionals from the doctors [laughs] so it is very important for them (.) and when we reiterate the same messages from (.3) the same as the professionals says it always clicks and they very well received it so (.3)

> I think it was important for parents as well for us (.) as a peripheral inter organisation but also part of the bigger system (.) so I think their perspective change about us as well... the community organisation became more recognised

> PC: it means [our organisation] is doing the right things because we've got real professional up to date person who can tell us the right and the wrong...and we've got any of us *any* concern we go to Grace

Some considered the partnerships mutually cost-effective, financially benefitting both organisations and society whilst reaching marginalised communities:

> PB: it's not one sided it's not just that the (.3) so the community organisations *need* mental health intervention and support and relationships (.) and the mental health team *need* the relationships with the community so I think it's a really positive (.2) dynamic and... I really truly truly believe that it saves the country a huge amount of money

> PC: that was actually a little bit of money doing a lot of good...we're all volunteers the NHS liked it because for so little they are giving so much

Many participants expressed gaining new learning opportunities and perspectives on working cohesively with both families and statutory services. PD and PG both acknowledged the mutual responsibility to be flexible at personal and organisational levels:

> PD: we've learnt is not only that we can talk to each other but that we can actually work together (.) I think has done an enormous amount to improve community relations... we gain a great deal from working with [anonymised Child and Adolescent Mental Health Service] and the NHS in that sense so (.2) so we can see working with them the eventual benefit for the people we work with in the community (.) so its (.) how shall I say a bit of a juggling act

> PG: understanding both perspectives and bringing the two together so it’s not always about expecting the professionals to change the way they think it’s about changing the way we think as community as well

3.3.2 Flexibility meets families’ needs

Many participants shared the importance of professionals and services working flexibly and responsively to meet the needs of families and each other within the partnership. Being mutually flexible, adaptable, open, curious and willing to trial new ways of working were seen as vital ingredients for Voluntary Community Sector staff and Clinical Psychologists being able to work together effectively:

> PA: whomever we facilitated with you were very open to try new things (.) I mean yeah I think its about curiosity (.) being natural (.2) not having any prejudice (.3) or assumptions

> PD: a willingness to be flexible... obviously being open to (.3) novel ideas that might come up being able to absorb more than (.) I see in my little bubble and that makes partnership

> PJ: it’s just our journey together (.) our educational journey together learning from each other I think that is the key part

Several participants acknowledged how collaborative, flexible partnership working facilitated Clinical Psychologists meeting families in trusted community settings, hosted by Voluntary Community Sector organisations. They perceived this flexibility helped dismantle power dynamics and bridge gaps, resulting in communities feeling safer and comfortable to engage:

> PB: what happens for those families that really can’t come and who are chaotic and don’t turn up... coming and seeing people in the community space that they feel safe in definitely works (.) I’ve seen that time and time again (.) that flexibility to say well we’ll come to where you are...I think that when it’s designed in collaboration it’s really brilliant

> PJ: being able to provide in-house support as well as external support and you know (.) being able to offer that to the family is quite helpful and I suppose that has broken down a few of the barriers (.) because once upon a time it was more like *doctor* parent but now we're bridging that gap between us (.) and making services more accessible for families

Many participants reflected that as Voluntary Community Sector workers, they often worked more flexibly with families, without the time and systemic restraints of statutory services. Consequently, flexible co-working was perceived key to ensuring partnerships were attuned and provided tailored, responsive support, which increased community engagement:

> PA: we are more flexible I guess it may sound a bit unprofessional sometimes [laughs] but it is the way we do things as long as it is safe and like (.) at the end of the day I think we managed to in tune each other's yeah (.) culture I guess

> PB: the co-leading of those workshops is *really* brilliant and we had a *really* high turnout and people came (.2) often and it was about designing in relation to the needs of their children (.) er so we were really able to respond to what we were seeing in the young people

> PJ: the psychologists have been able to come here tailor make services have evening sessions weekend sessions (.) and tailoring certain services for the [anonymised] community as well like I said when the [religious leader] and Jake ran this parenting session (.) which was so well turned out

3.3.3 Shared cultural respect

Participants perceived cultural respect as a shared, reciprocal process, essential for partnership and engagement work. Many reflected how sharing cultural and religious knowledge, awareness and insights increased Clinical Psychologists' cultural competence and enriched the partnership. Several participants expressed that sharing dual cultural, religious and/ or community identity with the families they supported provided a unique and valuable contribution. They regularly emphasised how Clinical Psychologists responded to their cultural expertise by listening, understanding and adapting to improve community engagement. This was viewed as a mutual exchange and perceived to improve the practice of all professionals within the partnership. All participants acknowledged that getting to know the different communities and their needs was crucial to engagement.

Many viewed Clinical Psychologists' communication style and approach as caring, non-judgemental, understanding and accepting of cultural differences:

> PD: they're very approachable (.3) they seem to be (.) well they're very understanding as well I mean the staff they employ are very very good so they've (.) they also seem to have a good cultural awareness so we don't feel when (.) talking to them like we've really got to explain everything from the beginning so obviously done a lot of (.) research and (.) they're very respectful of the (.) cultural norms of our community

> PC: they were always very very very caring very understanding (.) very open to accepting differences very unjudgmental

> PA: acceptance of difference...your staffs (.2) respect and acceptance of the culture of our participants as well they *loved* you guys [laughs] both you and Elena and (.4) the cultural sensitivity I guess you showed

Several participants emphasised how respect arises from cultural awareness, a commitment to making time and continuous self-reflection. PG and PC acknowledged the complexities of understanding culture and spirituality and the risks of making assumptions:

> PG: you're not going to engage with a community group if you're not going to understand their starting points (.) or you know (.) why their beliefs are what they are (.) and sometimes you know I would say that you know that beliefs are rooted in a faith but sometimes beliefs are rooted in the culture

> and understanding and differentiating between that (.) is quite important
>
> PC: everybody took to her like bees to the flowers because from day one she treated people with respect and (.2) wonderful (.) but people come and they don’t treat people respectfully and they don’t understand the different culture (.) and it doesn’t work

Demonstrating cultural awareness and sensitivity through being curious, asking questions and visibly showing sensitivity to families’ needs was key. This mirrored the earlier sub-theme, acknowledging time and long-term, consistent relationships are required to develop cultural awareness. Four participants mentioned the importance of cultural awareness training and knowledge sharing. They referred to establishing ‘cultural do’s and don’ts’, alongside adapted resources to make communities feel comfortable:

> PC: you should give it to Grace that she hasn’t ever betrayed the trust... I’m talking about understanding the culture (.) behaving in a way I remember in the very early days she said to me tell me yes what to do what not to do and I gave her a list of do’s and don’ts and she took it when she could have thought (.) well they’re strange people why do they want these customs you understand (.) but she didn’t (.) I dunno what she was thinking but I know what she was doing (.) she was taking it and actually acting with that (.) and so she came to people’s homes and they felt comfortable with her because she dressed the way she should have dressed (.) she didn’t shake hands with a man (.) she didn’t look at the man in the eyes she did all the right things and (.) now it carries to the others and I’m sure she’s sort of giving them cultural awareness
>
> PD: statutory services are (.) they’ve got more training needed perhaps to become more aware that different things suit different people (.) at different times...it’s a combination from both sides (.) making it work for both sides (.) I think [anonymised Child and Adolescent Mental Health Service] really tries to do that and maybe that is why they have managed

> to make the inroads that they've done because (.) they do try to accommodate (.) and people do appreciate that

PD and PF echoed how Clinical Psychologists' commitment to making cultural and religious adaptations often required resourcefulness, creativity and innovation:

> PD: if a child came in and was given (.) a box of figures with spiderman and (.) what these characters are called they wouldn't understand what's going on because the majority of children in the community do not watch television (.) so (.) they went to get a box of little [culturally specific] men (.) so children recognise because they have these at home and so it's much more effective and they use books that are written for the community (.) so they can engage with the children a lot better so I think that's another point (.) the resources are culturally appropriate (.) which I think makes a big difference to the effectiveness of the service

> PF: Carl was sending me these videos and asking whether I think they're culturally appropriate anyway he worked out in one of the videos that every time there was a picture like of a lady or whatever it was in the left-hand corner of the screen (.) so he said if I put a post it note there how will that do (.) and it did brilliantly so It's been really resourceful and being respectful we wanted we had to very careful when we are showing videos that it's not going to offend anybody at all because the community has zero tolerance (.) for anything that might be not quite right

Participants discussed the importance of Clinical Psychologists accommodating religious and cultural practices of families and Voluntary Community Sector professionals, e.g., ensuring prayer facilities and appropriately timed contact during religious festivals. Several participants described the process of collaboratively adapting psychological training materials, including the Solihull Approach. Such changes were supported with Clinical Psychology supervision, to better meet different communities' cultural and religious needs:

> PF: the other adaptation we made to the group was putting [religious] thoughts like religious ideas into many of the sessions (.) and that really er evolved as the group happened

> PG: initially it's about sitting down looking at the Solihull program (.) adapting it (.) so then that means we would have to involve [religious] scholars (.) look at the content...it will still come from you know its roots but just adding bits maybe to make it more relatable for the community

Clinical Psychologists' innovative and responsive approach was appreciated by many. Facilitating gender-specific spaces and customs to respect cultural and religious wishes was paramount for both families and professionals:

> PD: they don't have an expectation that (.3) a woman would have to come with her partner or husband to discuss something they understand that a woman would feel more comfortable talking to a woman and a man might not [smiles] feel so comfortable er (.) so they try to accommodate that by (.) putting on facilities for fathers with children (.) and mothers with children separately

> PJ: Jake and the [anonymised religious leader] ran a parenting session for fathers which was a first in our community...and I thought there'd be no turn out or very little but I remember that it was in the twenties at points where parents were turning up fathers were turning up in the evenings and meeting all the clinical psychologists and [anonymised religious leader] and that was a massive success

3.4 Theme Three: Breaking Down Systemic Barriers

This theme represents how participants perceived community partnerships as a catalyst in breaking down systemic barriers to marginalised communities seeking support. Many described the importance of understanding how fear and stigma impacted help-seeking. Participants acknowledged the partnerships' frustrations regarding funding uncertainties and systemic issues which adversely impacted access to Child and Adolescent Mental Health Services. They often suggested partnerships could break down barriers through providing reassurance, increasing knowledge and promoting awareness of services offered.

3.4.1 Understanding fear and stigma

Many participants emphasised how understanding the unique needs and fears of a community enabled them to identify multiple systemic barriers families and professionals faced in seeking and providing support. All ten participants strongly associated stigma as another significant barrier in seeking statutory support, where fears that community members would become aware of their engagement with statutory services was a key barrier:

> PD: a lot of people (.) are very very nervous about being labelled (.) if I have to go and see [anonymised Child and Adolescent Mental Health Service] then I'm not as much of a coper as I thought I was... it's a close-knit community (.) people know people (.) people are related to people and people worry about what others think

> PI: when people hear things like Child and Adolescent Mental Health Services and you actually find out what Child and Adolescent Mental Health Services actually means (.) I think for some parents it's like no (.) you know I'm going to be stigmatised

All ten participants shared how stigma around social services was extremely prevalent and a barrier to help-seeking. They expressed how parents feared engaging with Clinical Psychologists could result in social services involvement and concerns their children would be taken away:

> PI: some parents think that they're going to be referred to social services and they'll take my children away yeah (.) and I'm like no not at all it's part of the service is to talk...it's seen as a weakness (.) all the time... you can't ask for help (.) no you shouldn't no (.) so it's like going trying to just tear down all those barriers (.) come back with a positive approach where

> actually no we're not going to take your children away because actually they're gonna help you
>
> PC: she wants to take our children (.) and this is everybody thinks you know (.) they hear people working with social services and this and that she's gonna take our children...so she couldn't get into the community
>
> PF: are they going to be forced into social care so one lady was saying yeah we live in a crowded flat (.) the children are sometimes on top of each other and they might shout at each other and I was trying to explain to them that's normal (.) and normal parenting and you know

Several participants highlighted the importance of understanding how historical and current experiences of persecution and prejudice, often result in fear and distrust of professionals considered outside their community:

> PD: I'm a child of war survivor so a lot of the community not all of them but a lot of them are (.) grand children or great grandchildren of war survivors so when my grandparents were killed... when the refugees escaped they didn't dare (.) make any demands of the authorities or want to go for help they were just happy to be in a place where nobody was targeting them (.) so we grew up with an attitude of you make do (.) you do what you can and you get on with it
>
> PC: our community is very insular (.) very untrusting if you think about our history of persecutions people are very very scared of the outside world
>
> PA: they all feel very isolated here and they lost their trust in the system (.) the NHS

Collaborative partnerships were considered well placed to change the negative narrative around mental health and explore alternative language to make statutory support more accessible:

> PB: it's also the responsibility of (.3) the mental health professionals but also the partnership... what do people need to know in order to get through the door if they don't feel like they're wrong (.3) they just need a bit of help... rather than you're sick and you need to mend this

> PJ: you say a psychologist or if you say social worker people automatically would say aghhh (intake of breath) so I think meeting and getting to familiarise ourselves with the teams that we're working with really does help the families that we work with (.) if you say... we're doing a well-being session and there's a really lovely lady called Grace coming in and she's going to meet with you she is a clinical psychologist so she works with children it's *totally* different to when you say somebody from the psychology team

> PH: maybe the terminologies that they use need to be changed (.) make it a bit more friendly (laughs) I don't know how you make mental health sound friendly but it's yeah just making it so that parents don't feel put off before they even start

Some described how their community partnership role involved communicating clear information to reduce parents' fears, bridging the gap with statutory professionals. Many shared examples of how the community partnerships worked together to reassure families and reduce stigma around help-seeking:

> PG: a lot of people are still trying to come to terms with accessing support (.) like [anonymised Child and Adolescent Mental Health Service] or counselling (.) especially in communities like ours (.) it's still quite new so if they've heard from somebody else well actually I was facing this and I went to see so and so...that really helps

> PF: [anonymised Child and Adolescent Mental Health Service] are not looking (.) to report to social care and also people think social care coming to take the children away (.) and there was a lot of reassuring we needed

> to do
>
> PC: I think this has to have a lot of reassurance that we are not taking children away from anybody (.) that’s very important

3.4.2 Acknowledging frustrations and funding uncertainty

Several participants described the partnerships being heavily reliant on funding from commissioners and charitable grants and most shared frustrations and uncertainty regarding funding continuity:

> PB: we did also run a *brilliant* uh god that was *really good* (.) workshop for young people around anxiety... and *everybody* fed back that they *loved it* (.) it was brilliant (.) led by a team one clinical psychologist and a community worker (.) we never did that again...I suppose one of the difficult things is that there's funding at times to do certain things (.) and then that goes (.) even if you can see that it’s a success and that’s from both sides of the table so as an organisation (.) you can see something's great but you just haven't got the space to support it
>
> PG: sometimes we need to take a certain route because funding requirements say...if we just had money to support people we probably would be able to do it without all that red tape

Despite naming clear benefits and successes, participants expressed frustrations around the lack of control and challenges the partnership experienced in securing funding to plan preventative and consistent support:

> PE: it makes planning really really really difficult (.) for example you want to have a parenting group you want to be able to let people know about it (.) but we only find out a number of weeks (.) beforehand... an action point would be there should be a real strategy (.) much higher than [anonymised Child and Adolescent Mental Health Service] knowing for the next three years or at least eight nine ten months before (.) what pot of money is going to be available

> PB: it changes what you can offer and (.) you’re always trying to fundraise to get enough money to do something and then what [anonymised Child and Adolescent Mental Health Service] can offer because they’re endlessly thinking about what their budgets are and who they can offer (.) so you’ve got this (.) if it could be more solid (.) be more designed there could be more of a coherent collaboration

The need for a higher-level strategic plan regarding funding was echoed by other participants, who expressed a sense of loss when positive partnership work was stopped or significantly reduced due to funding:

> PH: I was concerned at one point that the sessions were going to go I think from funding and time resources they was going to stop...due to I don’t know is it you know politics...they said due to budget constraints

> PJ: unfortunately [our borough] lost a lot of funding (.) as many parts of the country have and so we have less contact with the psychologists coming in

Other participants echoed frustrations regarding statutory services being experienced as inaccessible, racist and rejecting by both Voluntary Community Sector professionals and communities:

> PB: I mean a system that can’t cope with vulnerable people seems quite ironic for a vulnerable people system

> PF: there is something about those layers of getting through what needs to happen (.) whereas with us its more straightforward really so it can be a bit sort of we sort of fast tracked (.) yeah I understand why [anonymised Child and Adolescent Mental Health Service] needs these procedures but because it’s an NHS service sometimes things take a bit longer than you would expect

> PB: there is a sort of systemic racism unintentional I’m sure (.) but that the structures of (.2) the statutory offer are in some ways (.6) unsuitable to help the accessibility for people

3.4.3 Increasing knowledge and awareness

Participants regularly suggested increasing knowledge, awareness and communication were helpful in addressing the fears and uncertainty caused by systemic barriers. Most participants thought communities, families and Voluntary Community Sector workers rarely knew which Children and Young People’s Mental Health Services existed and what they offered. Some felt poor cohesion and awareness between Voluntary Community Sector and statutory services were barriers to engagement and felt the partnership bridged a gap in supporting families. Many proposed prioritising awareness raising through community education and improving advertising to increase community engagement:

> PA: when you ask about engagement [parents] say they wanna hear about this project more widely because they didn’t hear (.) the ones that attended the programs are existing service users there are like thousands more but they may not know (.) so there must be wider promotion

> PB: there seems to be a lack of cohesion within (.3) the you know there’s so many different teams that also there can be a sort of lack of knowledge and awareness of each other...so yeh bringing people together (.) and knowledge and awareness

> PD: information that the services exist (.) so there’s different ways in which it can be done (.) I think word of mouth is something which is very helpful in this particular community... paper advertising is very powerful...I think education knowing that it exists and (.2) how to access it (.) how it can be helpful

However, three participants acknowledged the double bind and challenges of increasing promotion of services, questioning whether the partnership and

Children and Young People's Mental Health Services had the capacity to meet needs:

> PE: they may not feel the need to do any Public Relations because they're busy enough [laughs] often can't do (.) advertise we get another hundred people we won't cope yeah there's financial repercussions

> PJ: I suppose if we had posters and that to stick up in these places calling families in maybe you'd be able to get more (.) not that you don't have a big enough waiting list to meet you guys

> PA: I think not knowing (.) stopped them to attend it is all about promoting informing them I guess (.3) but then again if we inform everyone that we are running this service it needs to be continued service...we don't know if it will continue or not (.) that also stops our promotion and outreach

Acknowledging this challenging context, many participants perceived that Voluntary Community Sector professionals often needed determination, drive and passion, to enable them to increase community awareness and maintain their partnership role effectively:

> PF: people who work for community organisations often really have their heart in in it... because they feel very strongly about it and they will go the extra mile to help the client

> PI: we've had to push (.) push drive it forward (.) yeah I think you have to have that that what's the word that passion (.) you have to put it out there you know

> PG: a community set up when the staff wants to make a difference (.) for the community...you want people to engage (.) so you're willing to go that extra mile

These participants reflected on Voluntary Community Sector professionals' passion, often working beyond their roles to help. This included many participants reflecting upon the journey of learning psychological skills and knowledge from Clinical Psychologists and the process of sharing this knowledge and awareness within communities. They acknowledged partnership work gave marginalised communities greater access to psychology and promoted sustainability, growth and hope:

> PJ: so I think being able to pass the knowledge out which you guys have done really well (.) it's not just going to a psychologist or to [anonymised Child and Adolescent Mental Health Service] you can go to people within the community organisations (.) speaking to them as a first point of call and then being able to refer on (.) I think that is really helpful

> PE: you watch how he does it (.) clinical psychologist and I gained an enormous amount from that... I suppose we started off being initially sort of not sure what the word is (.) disciples [laughs] probably not quite the right word but we've grown a lot

4. DISCUSSION

4.1 Overview

This chapter summarises key findings in relation to the research aims and relevant literature and theory. This is followed by implications for clinical practice, future research, alongside a critical evaluation and final summary.

4.2 Returning to the Research Aims and Questions

This research aimed to explore Voluntary Community Sector perspectives on partnership working with Clinical Psychologists, regarding provision of culturally sensitive support and to understand whether this work helped improve engagement and access for local communities accessing Child and Adolescent Mental Health Services. Three themes and nine subthemes were constructed through data analysis, acknowledging the impact of my subjective role as a researcher and critical realist position.

Two questions were designed to explore the perspectives and experiences of Voluntary Community Sector professionals. Consideration of the research questions and wider literature outlined in the introduction will now be reviewed in relation to the findings, and structured around the three themes of this study.

4.3 Discussion of Findings in Relation to Existing Literature

The first two themes will be discussed in relation to the first research question: What facilitates partnership working and community engagement between the Voluntary Community Sector and Clinical Psychologists working with children and families?

4.3.1 Establishing trusted relationships

All participants reflected on the fundamental importance of relationship building and developing trust within community partnerships. This was universally considered to improve access and engagement with Child and Adolescent Mental Health Services. It supported findings from the two studies evaluating partnership working in Children and Young People's Mental Health Services, strengthening the importance of Clinical Psychologists adopting community psychology values and approaches to develop close, trusted relationships with Voluntary Community Sector partners (Hill et al., 2021; Durcan et al., 2017).

4.3.1.1 Building trusted relationships. In the first sub-theme, participants perceived development of trust within relationships as the glue connecting marginalised communities, the Voluntary Community Sector and Clinical Psychologists. Building and sustaining trust within partnerships was fundamental to earning the trust of communities. These findings are supported by previous research and emphasise how building relationships increases mutual trust, respect and learning within partnerships (Perry et al., 2018; Mustafa & Byrne, 2016, McEvoy et al., 2017). Honest, open communication and familiarity were often named as facilitators to partnership working, bridging cultural differences. Participants considered open communication led to Clinical Psychologists being more responsive to families' needs and wishes, enhancing trust, confidence and community engagement. They emphasised how close, consistent and attuned working relationships, with regular contact established trust. Valuing openness and 'constant' contact and relationships with Clinical Psychologists, echoed participants views in McEvoy's (2017) research. This strengthens the importance of dialogic engagement (continuous dialogue and communication, Bakhtin, 2010) within effective partnership working. Participants described how trust helped negotiate uncertainty and organisational and power differences within partnerships, supporting previous findings involving Voluntary Community Sector professionals (Galloway & Byrne, 2016; Flanagan & Hancock, 2010; Lester et al., 2008; BPS, 2018).

4.3.1.2 Maintaining long-term key connections. Within the second sub-theme, all participants highlighted how building and maintaining long-term relationships and connections with key Clinical Psychologists increased accessibility. Many felt these connections increased time efficiency and reassurance for families. Long-term relationships also increased confidence and provided opportunities to flexibly negotiate different roles within the partnerships, such as co-working and supervision. This supports a community psychology approach of ‘wearing many hats’ to make multi-systemic changes (Perkins, 2011) and is in line with research showing longer-term commitment, openness to change and joint training are often fundamental to community engagement (Lester et al., 2008; NICE, 2008; 2016). However, interestingly, participants did not reference challenges regarding time and resources as constraints in facilitating partnership working, as often cited in previous literature (Hill et al., 2021; Durcan et al., 2017). Many participants described how working together over time forged friendships and family-like connections, which enhanced trust and partnership working, supporting Lester et al. (2008)’s findings.

4.3.1.3 Earning the trust of the community. In the third sub-theme, participants identified Clinical Psychologists earning the trust of community members and professionals was key to community engagement. Clinical Psychologists being visible within communities and accessible spaces, was considered important in increasing comfort and familiarity for families and Voluntary Community Sector staff, supporting Durcan et al. (2017)’s findings. Word of mouth and community members sharing their experiences of working with Clinical Psychologists was often identified to enhance community engagement. Participants outlined the importance of experiencing and modelling positive relationships with Clinical Psychologists, as this reassurance led to communities being more likely to engage. Voluntary Community Sector professionals often perceived their role as a bridge, gateway and advocate between the community, statutory services and professionals, which has been found in previous research (Galloway & Byrne, 2016). Some described how they needed to ‘sell’ and advocate Children and Young People’s Mental Health Services, and experienced a delicate balancing act between understanding, communicating and bridging both families’ and Clinical Psychologists’ needs. Maintaining trust with both parties ensured Voluntary Community Sector professionals could help families find the most appropriate support.

4.3.1.4 Developing a shared language. Within the fourth sub-theme, many shared how establishing trusted relationships provided foundations to feel more comfortable and connected to Clinical Psychologists. This led to supervision and training facilitating development of a shared language, resulting in improved and responsive community support. This echoes previous findings (Lester et al., 2008; Galloway & Byrne, 2016), highlighting how shared agendas, skills and training initiatives are key facilitators to developing shared vision, trust and effective partnership work. Feeling listened to and heard by Clinical Psychologists was seen as integral to Voluntary Community Sector professionals and communities feeling understood, accepted and contained. Participants described how this created opportunities for change and was further developed within supervision with Clinical Psychologists, where reassurance, containment, validation and problem solving were perceived to shape participants' confidence and work with children and young people and families. These findings suggest the partnerships created psychologically-informed environments where evidence-based clinical practice was applied in innovative ways (e.g. relationship building, formulation, training and supervision), supporting previous findings in children and young people settings (Durcan et al., 2017). This approach was highly valued by Voluntary Community Sector professionals, and a key facilitator to partnership working. Development of attuned, containing and trusted relationships within partnerships resulted in these experiences being mirrored and filtered down into the relationships Voluntary Community Sector professionals held with communities.

This journey of tuning in and developing mutual trust was referred to in co-hosting parenting programmes, receiving free Solihull Approach training and supervision which created a shared language, insights and increased confidence. This appeared to positively influence community engagement on multiple levels, from family support to greater attunement between organisations. Bronfenbrenner's (1979) framework was helpful in conceptualising the multi-layered nature of community engagement, strengthening the belief that partnership working is essential in effectively working at multiple system levels and accommodating different cultural and religious beliefs. Many perceived the community partnership as an explorative space to learn about how to 'tune in' and work well together, and a bridge to reach and meet the needs of marginalised communities.

4.3.2 Reciprocity

Reciprocity was embedded within many participants' perspectives on partnership working. Perceived as a process of two-way sharing, the relationship between Voluntary Community Sector professionals and Clinical Psychologists and respective services was considered bi-directional and mutually enriching. This finding provides new and unique insights into partnership working in Children and Young People's Mental Health Services, as the only known qualitative study that strengthens previous research emphasising the importance of shared expertise in Clinical Psychologists and Voluntary Community Sector partnerships (Hill et al., 2021). Findings are reinforced by Morgan et al. (2009), who highlighted how a lack of bi-directional shared understanding between services and community members, negatively impacted community access. The current study's participants also described how the partnerships shared, collaborative approach helped break down barriers and rebalance power issues with Voluntary Community Sector staff and communities. Howitt et al. (2020) and BPS (2018) guidance support the importance of partnership working involving equal distribution of power (Hatzidimitriadou et al., 2012; Fountain & Hicks, 2010; Hagger-Johnson et al., 2006; Byrne et al., 2017).

4.3.2.1 Shared need. The first sub-theme emphasised that a 'shared need' existed within the community partnerships; where collaboration, mutual respect and equality were extremely important. Participants expressed how the partnerships were mutually beneficial, cost effective and emphasised how all contributions and expertise were valued and utilised. This demonstrated the importance of a strengths-based approach within partnership working, as found by Durcan et al. (2017). Valuing shared expertise was echoed in reflections from Howitt et al. (2020), although interestingly Voluntary Community Sector professionals in this study rarely named the process of addressing power inequalities directly (discussed further in 4.6). Therefore, this study provided an insight into partnerships where Voluntary Community Sector staff felt recognised and supported by Clinical Psychologists, contrasting with common narratives that they are often undervalued and unrecognised (Tribe, 2019). This suggests there is much to be learned from this mutual exchange, (see Implications in 4.4) and supports the idea Clinical Psychologists are well placed to reach out and develop more balanced partnership approaches through adopting a whole systems approach (BPS, 2018).

4.3.2.2 Flexibility meets families' needs. The second sub-theme emphasised the need for all professionals to work flexibly and responsively to meet families' and each other's needs. Collaborative, flexible partnership working enabled Clinical Psychologists to 'meet families where they're at', both physically and psychologically, within safe, trusted community settings, dismantling professional barriers and power dynamics, supporting research by MAC-UK (Zlotowitz et al., 2016; Durcan et al., 2017). Being mutually flexible, adaptable, open and curious were considered vital ingredients for effective partnership working. This journey of learning together, tuning in and tailoring support to communities' needs, was considered key to increasing community engagement and creating a more rewarding relationship to help (Reder & Fredman, 1996). These findings are supported by Glisson and Williams (2015) who recognised learning and adaptation as ongoing processes. They also support the importance of bidirectional learning and training between community and Western professionals to enable culturally accessible services (Tribe & Tunariu, 2017).

4.3.2.3 Shared cultural respect. This final sub-theme centred around cultural respect, where participants emphasised how the community partnerships were grounded in cultural understanding, awareness and acceptance of difference. Again, cultural respect was perceived as a shared, reciprocal process, where cultural and spiritual expertise provided by the Voluntary Community Sector was sensitively received and responded to by Clinical Psychologists. This was viewed to increase Clinical Psychologists' cultural competence; mutually enriching the partnership. It supports Edge and Lemetyinen's (2019) argument for a paradigm shift in culturally adapting psychological interventions and provides a successful practice-based example, of consultation, training and support, underpinned by collaborative consultation. It echoes the BPS (2018) guidance of continual co-production at multiple levels to encourage cultural respect.

Analysis showed cultural expertise was received by Clinical Psychologists with openness, curiosity, respect and a willingness to culturally adapt support innovatively and creatively. Participants provided examples of collaborative, creative partnership working that increased cultural accessibility including use of culturally appropriate children's toys and books, incorporating religious values and ideas, removing content perceived as conflicting with religious beliefs and ensuring groups were respectful of gender differences. These findings support previous research demonstrating how cultural consultation and collaborative partnership working can effectively accommodate faith and religion, creating a positive spiral of engagement and more tailored and respectful support (Mustafa & Byrne, 2016; Perry et al., 2018; 2019). Participants emphasised the importance of Clinical Psychologists adopting a position of cultural humility, enabling opportunities for more culturally competent services, supported by Howitt et al. (2020). Some participants provided examples of increasing Clinical Psychologists' cultural awareness through sharing 'do's and don'ts' when working with different communities, which may help to address previously reported barriers of services asking culturally and spiritually inappropriate questions (Healthwatch, 2018; Mustafa & Byrne, 2016).

The current findings support previous research highlighting how services need to be culturally aware and sensitive towards cultural, community and family background, religion and traditions (Kurtz & Street, 2006; Lavis, 2014). New and unique insights are provided into how partnership working with Voluntary Community Sector organisations can reduce this gap of approaching cultural competence and differences in Children and Young People's Mental Health Services, which is undocumented and under-researched (Papadopoulos et al., 2008). It also supports previous literature advocating that partnership work with Voluntary Community Sector organisations increases Child and Adolescent Mental Health Services access for minority families (Ayo et al., 2020).

4.3.3 Breaking down systemic barriers

The third theme will now be considered in relation to the second research question: How do community workers and leaders view co-production approaches in improving engagement with NHS services? This theme depicts how community partnerships were seen as a catalyst in breaking down systemic barriers to marginalised communities seeking support. When asked if partnership working improved community engagement, all ten participants unequivocally agreed it greatly supported the active, equal involvement of minority groups and community-led, co-production approaches to improve outcomes (NICE, 2008; Casale et al., 2015). This study found participants viewed community engagement approaches as working together to deconstruct the idea that communities are 'hard to reach' (DCP, 2020). It also supported Fernando's (2010) conclusions that collaboration and consultation approaches with local Black Minority Ethnic Voluntary Community Sector organisations provide more culturally appropriate services.

4.3.3.1 Understanding fear and stigma. The first sub-theme emphasised the importance of understanding how stigma impacts families seeking, and professionals providing, support. All participants identified stigma surrounding help-seeking as a huge barrier across different cultures, with families fearing being labelled and 'stigmatised' through engaging with Child and Adolescent Mental Health Services. This mirrors literature review findings which reported stigma as a universal barrier to help-seeking (Reardon et al., 2017; Keating et al., 2002), highlighting how fears around social services involvement and children being removed are still significant barriers. Several participants highlighted the importance of understanding how historical and current experiences of persecution, systemic racism and prejudice, result in fear and distrust of professionals considered outside their community, supporting Faulkner's (2014) findings. It corresponds with previous literature citing fears and mistrust of outsiders and external influences (Loewenthal, 2006; McFarlane, 2006) and sadly frequent experiences of discrimination and racism (Mental Health Foundation, 2016; Malek & Joughin, 2004).

This study provided new insights into how community partnerships are well placed to explore alternative, and more accessible narratives and language to describe mental health difficulties. This required sensitive reassurance and support within partnerships, illustrating how participatory, community psychology approaches are helpful in addressing stigma. It corroborates Lwemembe et al.'s (2016) findings, demonstrating co-production within partnerships enables historical and systemic barriers to be dismantled, creating more responsive, trusted support.

4.3.3.2 Acknowledging frustrations and funding uncertainty. Within the second sub-theme, participants commonly described frustration and uncertainty regarding funding continuity. They described both Voluntary Community Sector professionals and Clinical Psychologists experienced a lack of control in securing funding to plan preventative and consistent support. This study mirrored previous research (Lester et al., 2008; Ware, 2013) where insecure funding created uncertainty around sustainability, but did not echo previous findings of low morale and motivation. Interestingly, participants reported minimal negative experiences or challenges involving partnership working. Findings suggested funding uncertainty generated tensions and anxiety regarding planning ahead for both Voluntary Community Sector workers and Clinical Psychologists, clashing with the partnerships' open, collaborative culture. Many expressed loss when funding cuts discontinued interventions and reduced their contact with Clinical Psychologists, which corroborates the huge reported gaps in Children and Young People's Mental Health Services and funding (The Lancet, 2020). Participants highlighted the need for a higher-level strategic plan from funders and commissioners to ensure preventative, consistent community support. Some shared frustrations that the current mental health system is inaccessible due to being bound by 'red tape', involving long waiting lists and inappropriate, discriminatory service structures. These findings were synonymous with reported experiences of practical barriers, long waiting lists, language barriers and rigid and inflexible service configurations (Children's Commissioner, 2020; Reardon, et al., 2017; Morgan et al., 2009).

4.3.3.3 Increasing knowledge and awareness. The final sub-theme suggested partnerships played a key role in breaking down systemic barriers through increasing knowledge, awareness and communication. Most participants thought communities, families and Voluntary Community Sector workers rarely knew Children and Young People's Mental Health Services existed and what they offered; a view supported by previous research (Healthwatch, 2018). Some felt the partnership bridged a gap in supporting families across fragmented services and many proposed raising awareness by prioritising community education and improving advertising to increase community engagement, supported by Galloway and Byrne's (2016) findings. Providing new insights, several participants acknowledged the irony and double bind of whether services had the capacity to meet needs if awareness increased. Voluntary Community Sector passion and determination to 'go the extra mile' to maintain partnership roles and effectively increase awareness was considered imperative. Findings suggested that the resilience and strength of partnerships was essential in navigating the challenging socioeconomic context, supported by The Lancet (2020). Participants felt that sharing psychological knowledge and skills through partnership work gave marginalised communities greater access to psychology and promoted sustainability, growth and hope. This study provides an important and unique contribution to the under-researched area of mental health needs of ethnic minority children and young people and families (Street et al., 2005), demonstrating how partnership work can work toward reducing health and social inequalities (Centre for Mental Health, 2020).

4.3.4 Interconnection between themes

Despite the presentation of separate themes, it is important to acknowledge how themes and subthemes noticeably overlap, due to the dynamic and multi-layered nature of partnership work. The first two themes each have a distinct focus on trust and sharing, yet both are relational and interdependent, as reciprocity only exists within the context of trusted relationships. Collaboration and co-production were connected with deconstructing power throughout all three themes, supporting previous literature emphasising power sharing (Howitt et al., 2020; Byrne et al., 2017; Lester et al., 2008).

4.4 Implications and Recommendations

This study's findings provide valuable Voluntary Community Sector insights into what facilitates partnership working with Clinical Psychologists and increases community engagement in Child and Adolescent Mental Health Services. As the most influential, sustainable change often exists within wider social systems, emphasis has been placed within Macro and Exo-levels. Arising implications and recommendations will now be considered across multiple system levels, with particular consideration of a Clinical Psychologist's role.

4.4.1 Macro and exo-level

This research has implications for a Clinical Psychologist's role concerning policy, power, politics, commissioning, organisational structures and doctoral training. Statutory, NHS and BPS recommendations (e.g., BPS, 2011) emphasise Clinical Psychologists' responsibility to ensure mental health services are accessible, acceptable and appropriate to all (Patel, et al., 2000). Clinical Psychologists are well placed to utilise their leadership skills, research, theoretical knowledge and clinical experiences across multiple levels, which will now be discussed.

4.4.1.1 Commissioning. Findings demonstrate there is more to be done at a commissioning level, regarding fulfilling the aims of the Long Term Plan (NHS England, 2019) in providing preventative, accessible Voluntary Community Sector partnership working. Commissioners must ensure and promote development of community partnerships between Child and Adolescent Mental Health Services and Voluntary Community Sector organisations to provide culturally appropriate support and meet the needs of ethnic minority families. In line with BPS guidance (Skinner & Maguire, 2012), Clinical Psychologists should be encouraged to adopt an advocacy role, through building relationships with commissioners and supporting the creation and maintenance of partnership working. This could include critically appraising whether current 'evidence-based practice' meets the local cultural needs and highlighting knowledge regarding the impact of social inequalities and discrimination to improve service development (Yalcin, 2020). Clinical Psychologists could offer their skills and experiences of working across systems and help advocate service user and Voluntary Community Sector voices/ forums within Clinical Commissioning Groups, arguing the need for commissioning to be more community-led and held within accessible locations. For example, this study highlighted the detrimental impact of funding uncertainty and insecurity on partnerships and community engagement. Consequently, a higher-level strategic plan from commissioners, including longer-term funding, is vital to ensure partnership work is preventative, planned in advance and cohesive. This could involve increased consultation and collaboration with Voluntary Community Sector professionals and Clinical Psychologists regarding appropriate funding timelines.

Some participants shared concerns regarding Clinical Psychologists being withdrawn from partnership projects too early, due to commissioning agendas involving communities leading and sustaining interventions independently. They shared this did not always match their partnership values and vision, which emphasises the need for Voluntary Community Sector professionals to be included in community-led, collaborative commissioning. This research demonstrates the need for creating service structures that prioritise time and resources to carry out innovative practice involving co-production. This could be maintained by defining these responsibilities within service and job descriptions. Commissioners should also consider working conditions that reduce staff turnover of Clinical Psychologists and Voluntary Community Sector professionals, to promote long-term partnerships and increase community engagement.

4.4.1.2 Policy. The findings strengthen the need for an overarching national policy advocating the needs of children and young people and families from minority communities (Malek & Joughin, 2004). Building psychology networks and learning from approaches highlighting the impact of context, such as, Psychologists for Social Change, present tangible examples of how to apply psychology to policy, political and social action. Clinical Psychologists' involvement in policy work could provide opportunities to tackle systemic barriers to access, including persistent inequalities, emphasising the need for early intervention.

4.4.1.3 Clinical psychology training. This research has numerous implications regarding how Clinical Psychology training could raise awareness and positively influence Clinical Psychologists' approach to partnership working with the Voluntary Community Sector. The findings highlight the potential value of including teaching from commissioners and Voluntary Community Sector professionals, where sessions could be co-facilitated alongside Clinical Psychologists, to model the strengths and values of partnership work. Involving commissioners in Clinical Psychology teaching on partnership working and culturally accessible approaches could raise vital awareness of systems processes and increase Clinical Psychologists' confidence to be involved in commissioning conversations and strategic thinking. Similarly, Voluntary Community Sector professionals could have a pivotal role in teaching and sharing their experiences of partnership work, power sharing, co-production and community engagement. In line with the findings, Voluntary Community Sector professionals could also contribute cultural awareness and humility training, incorporating service users and Clinical Psychologists, which would be highly beneficial given the growing multicultural UK population. These sessions could fit well within modules on community psychology, which could be made mandatory, as opposed to optional on some courses. This could include a greater emphasis on practice-based research; reflecting on the necessary research and evaluation skills to better evaluate community and public health approaches.

In line with incorporating more macro-level approaches, Clinical Psychology training could include more teaching on the impact of policy context within mental health on families from ethnic minority backgrounds, and on different ways Clinical Psychologists can be involved in policy making and decision, alongside increased opportunities for policy placements (Browne, 2017). Such approaches could be supported through increased coverage within training of a Human Rights Based Approach (Patel, 2019) increasing awareness and accountability of Clinical Psychologists' legal obligation as right and duty bearers to provide accessible services, involving community consultation, and supporting future partnership work.

4.4.1.4 Integrating community psychology. Partnership working and co-production are core elements Clinical Psychologists can draw upon within a community psychology framework (Kagan et al., 2011). This study illustrates how a community psychology approach creates opportunities to work holistically and challenges discrimination and social inequalities (Tribe & Bell, 2018). Adopting an 'activist-practitioner' role (Zlotowitz, 2013) can actively incorporate social action and activism, to challenge discrimination within psychological practice. The findings advocate the importance of Clinical Psychologists being visible and present in community spaces. Clinical Psychologists co-locating through working within community spaces could increase communities' confidence and access to services (NHS England, 2019).

Community psychology approaches complement wider agendas in Child and Adolescent Mental Health Services, such as, participation initiatives, a commitment to strategic collaboration, and involving children and young people and families in service design, planning and provision (Child and Adolescent Mental Health Services Press, 2014). Guidance on incorporating community psychology approaches within mainstream services should also be better promoted and developed (Casale et al., 2015; BPS, 2018). This could move away from the traditional concept of single 'hero' leadership (Murphy, 2020) and complement a shared leadership approach, involving: openness; trust; a shared purpose (mutual goals); social support (practical and emotional support); voice (where all are heard and valued) encouraging trust and openness (Carson et al., 2007).

4.4.2 Meso and micro-level

Many of the multi-systemic recommendations above will undoubtedly influence the individual practitioner, yet the findings also present learning opportunities regarding individual and collective Clinical Psychology practice.

4.4.2.1 Service-level recommendations for partnership work. This research demonstrates the need for community partnerships to be developed to provide and improve culturally accessible psychological support for marginalised communities. For existing partnerships, this thesis adds to the evidence-base through providing a positive, well received example of practice-based research. Findings may be used as a starting point to scaffold and initiate further conversations and evaluations within other Clinical Psychologist and Voluntary Community Sector community partnerships and strengthens the rationale for longer-term funding. For Children and Young People's Mental Health Services that are not involved in partnership working, it demonstrates how important this work is and advocates how long-term commitment to partnership working is extremely worthwhile and aligns with goals of the Long Term Plan (NHS England, 2019).

The study emphasises the importance of Clinical Psychologists receiving appropriate cultural awareness training from Voluntary Community Sector and community members, which could be recommended as a core part of induction within new employment as a Clinical Psychologist. It demonstrates how community access and engagement can be improved through creating and embedding psychologically-informed environments, allowing partnerships to draw on the strengths of both Voluntary Community Sector and Clinical Psychologists and apply evidence-based practice more flexibly. Community consultation and collaboration should be central to development, and may include supervision, reflective spaces, thinking together, mapping and formulation. MAC-UK's Integrate model is largely synonymous with these findings and may be a helpful framework for Clinical Psychologists and services to consider when partnership working with the Voluntary Community Sector (Durcan et al., 2017). Many of the identified facilitators to partnership work involved relational processes, therefore practice-based recommendations are summarised below:

- Prioritise time to build and develop trusted relationships
- Encourage open, honest communication and support between the partnership's multiple levels (commissioning, Voluntary Community Sector, Clinical Psychologists and communities) to increase trust, respect and a shared understanding
- Promote principles of dialogic engagement (Bakhtin, 2010) through ensuring regular, consistent communication and meetings between partnership members so they feel connected and valued
- Value and ensure mutual flexibility, availability and willingness to be curious, work creatively and learn from each other
- Develop attuned, contained, reciprocal relationships within the partnerships (valuing equal collaboration, contribution, shared respect and power) enabling these experiences to be mirrored in the relationships that Voluntary Community Sector professionals form with community members

- Consider cultural respect as a shared, reciprocal process, where cultural and spiritual expertise are sensitively received and used to adapt approaches collaboratively
- Use the community partnership's shared expertise to explore alternative and more accessible narratives and language to describe mental health difficulties

4.4.2.2 Personal and professional attributes. Participants stated that willingness to develop authentic and genuine relationships and friendships, whilst conveying a non-judgmental, respectful, caring, open, flexible approach, were values they appreciated in Clinical Psychologists. Working in a shared, reciprocal way involves a conscious and deliberate sharing of power (Howitt, et al., 2020), with Clinical Psychologists being willing and able to put their professional interests aside, heading towards community sustainability, where ultimately their role may no longer required in the same way. This further supports the principle of 'doing with, not to' children and young people and families (MAC-UK, 2021). Clinical Psychologists could, therefore, utilise flexible, strengths-based approaches and interventions which value context, such as, narrative, systemic and community psychology approaches (Harper, 2016).

Participants also valued innovative and resourceful approaches to culturally adapting approaches and materials. Therefore, creativity can be considered a helpful approach toward partnership work and meeting the needs of marginalised communities (Afuape & Hughes, 2016). Personal motivation to use supervision and reflective spaces to consider cultural competence, cultural humility and anti-racist practice (Patel & Keval, 2018) are important factors. Working in this way often involves adopting a curious, not-knowing, questioning approach to systems and structures that Clinical Psychologists find themselves within (Galloway & Byrne, 2016) and being able to sit with a level of uncertainty and unpredictability.

4.5 Critical Evaluation

This research will now be evaluated in relation to how effectively the research questions were answered. Several qualitative frameworks were explored (Treharne & Riggs, 2015). Spencer and Ritchie's (2012) model was chosen to structure the evaluation, due to its holistic focus on contribution, credibility, rigour and reflexivity.

4.5.1 Contribution

Contribution relates to a study's value in addressing gaps in current research literature, and how it influences the development of related theory, policy and practice (Spencer & Ritchie, 2012). This research provided a unique insight into Voluntary Community Sector professionals' experiences of partnership working with Clinical Psychologists. It demonstrated how all ten participants considered partnership working had undoubtedly increased access and engagement with Child and Adolescent Mental Health Services for ethnic minority communities. It produced a detailed Thematic Analysis, exploring experiences and perspectives of Voluntary Community Sector professionals supporting Clinical Psychologists in Children and Young People's Mental Health Services in the UK, which no other study has explored. Furthermore, it provides rich qualitative insights into how partnership work can contribute to creating culturally appropriate psychological support through a socioeconomic and cultural lens. Alongside many studies within the literature review, due to its small, specific, purposeful sample, results are not intended to be generalisable to a wider population. However, such insights could be used to initiate conversations within other Clinical Psychologist and Voluntary Community Sector community partnerships, providing an opportunity to compare and contrast experiences.

Although minimal demographic information was collected to protect anonymity and cannot be used to infer associations or causation, it felt important to include the broad context of participants' backgrounds, in line with my critical realist position. Demographics showed participants who contributed represented professionals supporting a number of marginalised communities who are under-represented within Child and Adolescent Mental Health Services (Kramer &

Garralda, 2000). This included Orthodox-Jewish, Afro-Caribbean, British and South Asian, Turkish-speaking and African heritage communities. It highlighted 90% of participants shared dual identity with the communities they supported. Therefore, the majority provided a unique dual perspective, as Voluntary Community Sector professionals supporting minority communities, and as individuals from ethnic minority backgrounds, and can be considered largely under-represented, unheard and under-researched (Craig, 2011; Ware, 2013). This demonstrates a rich and unique insight into communities who are often considered private and 'hard to reach'. As we know there is minimal research into partnership working between the Voluntary Community Sector and NHS (Tait & Shah, 2007), this also highlights the unique and valuable nature of this participant sample.

4.5.2 Credibility

Credibility relates to the reliability of findings. This was addressed within the current research by following King and Horrocks' (2010) guidelines. A code-defining approach was considered most appropriate, where twenty-five percent of five transcripts were coded independently by a peer on the course, familiar with Thematic Analysis. I chose to present a broad sample of transcripts due to the purposive sample and distinct cultural backgrounds of participants and considered this amount appropriate due to time constraints. Critical comparison of the coding was extremely helpful, verifying several of the existing codes developed (see Appendix P). Initial subthemes and thematic maps were then discussed with field and research supervisors to seek other perspectives and critically review decisions made. A data credibility check was undertaken to identify the number of participants who contributed to each theme and sub-theme. This credibility check also enabled the researcher and reader to track which participants contributed to each sub-theme to ensure sub-themes were balanced and developed from a number of different respondents. These approaches improve the quality of the research and were pertinent to my critical realist positioning, acknowledging explanations of reality are influenced by existing knowledge and experiences (Fletcher, 2016).

Credibility was also improved by running a pilot study to assess the appropriateness of language and framing of questions for Voluntary Community Sector professionals with English as a second language and different cultural backgrounds. Seeking respondent feedback, through taking the analysis back to participants to check if fits with their lived experiences (Birt et al., 2016) would have been extremely valuable in this research. However, this approach did not feel possible within the scope and time limitations of this thesis but would be very relevant for future research in partnership working. Results will be presented to Voluntary Community Sector participants and field supervisors in a shorter, accessible summary document to consider their resonance and collaboratively consider potential clinical implications. Planned publication in a peer-reviewed journal aims to promote the findings to key stakeholders, including commissioners, NHS staff and Voluntary Community Sector organisations.

4.5.3 Rigour

Rigour relates to transparency of the research process and how this is communicated to the reader. This research aimed to be transparent through detailing the methodological process and decisions made. The recruitment, procedure, anonymisation and epistemological position are outlined in Chapter Three and further scrutinised through examples of coded extracts (Appendix L and P) and development of thematic maps (Appendix Q) to represent the analytic journey. The process of choosing Thematic Analysis over other qualitative approaches was illustrated and stepped guidelines on Thematic Analysis were provided (Braun & Clarke, 2006). Influence of my critical realist and reflexive positions are explored next.

4.6 Reflexivity

Reflexivity has underpinned every stage of this research process, as illustrated in the Method section (see 2.5.5) and is now explored in relation to the findings and limitations.

4.6.1 Epistemological reflexivity

4.6.1.1. Assumptions. It is essential researchers question their methodological decision-making (Dowling, 2008). Therefore, I will consider how my critical realist epistemological decisions impacted the research and knowledge produced. Willig (2008) emphasises how formulation of research questions have ethical and political dimensions. Upon reflection, it could be argued my research questions were developed upon assumptions partnership working is a successful approach, e.g., the research questions focused on facilitators (as opposed to barriers) and improving (not exploring) community engagement. Even though interview questions were deliberately worded openly, the design of the research questions may have limited findings through encouraging a space to share positive experiences and stories, as opposed to challenges. This bias is also echoed in the purposive sampling and the relationships I held with the field service in my multiple roles as past employee, researcher and Trainee Clinical Psychologist. Although I was committed to deriving themes from the data, I acknowledge how my hopes that the results would produce positive findings and useful implications may have biased the data.

4.6.1.2 Dual roles. It was important to remain aware of the positive and negative influence I held as a past employee of the field service. To some degree, I felt this enabled me to provide a safe, trusted space for interviews to take place, drawing on existing cultural knowledge of the local communities and services. I tried to remain aware of how my personal 'lens' shaped the process of creating the provisional and finalised themes (Lyons & Coyle, 2016). Keeping a reflective journal throughout the research process (see Appendix K) using discussions within supervision and a Thematic Analysis peer support group, enabled me to explore arising thoughts, feelings and observations and reflect upon my role. Noting my assumptions and emotional responses before and after interviews enabled me to reflect on my relationship to the data.

I attempted to remain aware of how my dual roles shaped the interview process. As a Trainee Clinical Psychologist and past employee, I felt naturally drawn to empathise, validate and ask questions. Semi-structured interviews provided the flexibility to use probing questions, but I also maintained awareness of adhering to the interview schedule and balancing my clinical and research roles. Some participants expressed positive and kind comments about my previous role within the partnerships, and I noticed how this made me feel uncomfortable and more likely to move onto the next question, without additional probing. Journaling enabled exploration of my discomfort in adopting a more formal, detached research role and how I felt compelled to limit personal interactions, worrying it would significantly shape the data. However, on balance, I believe the trusted relationships that my prior affiliation created, enabled access and insight into intimate community partnerships, with clinical implications which may not have been explored otherwise.

Interestingly, participants reported minimal negative experiences or challenges involving partnership working. Due to my association with the field service, I wondered if participants felt able to voice unhelpful experiences and whether my questions were sometimes perceived as a service evaluation, creating inadvertent pressure to provide positive feedback. Some expressed concern they had not answered questions ‘correctly’. Upon reflection, the dynamics within the formality of the interview process created an imbalanced power dynamic, clashing with the typical collaborative culture of the partnerships. These limitations and dilemmas may have been better approached through Participatory Action Research process, which is further discussed (see 4.7.1).

4.6.1.3 Power and Whiteness. Furthermore, complex, ethical dilemmas related to power were involved in the decision to anonymise identifiable information including participants’ cultural, religious and service identities. When designing the research, I was mindful of protecting participants’ relationships with the field service. I hoped that such anonymisation would create a space to speak openly and freely and reduce potential pressure to provide positive feedback. However, I had not anticipated the impact of removing so much context and this initially felt like a huge loss, conflicting with the core value of acknowledging context within community psychology and a critical realist position. It felt like the anonymisation white-washed participants’ rich cultural experiences and lost valuable insights into the specific challenges and nuances different communities faced in access and engagement with services. It felt disappointing and frustrating to remove such meaningful context, from a study invested in valuing cultural differences.

The process made me reflect on how the current NHS structures, are based upon White, Western concepts of health and healthcare, and consequently experienced as pathologising and inaccessible for many minoritised communities. This is due to the predominant approach of medicalising health within the NHS, which leads to a singular worldview; creating a culture blind environment, which facilitates racism through a lack of acknowledgement and appreciation of diversity. Such structural inequalities create the need for community partnerships to exist, and are demonstrated in a number of ways, e.g. disproportionate rates of minority groups being detained and subjected to coercive treatment. A lack of cultural and spiritual understanding also contributes to disrespectful and unhelpful diagnoses and compounds the unequal and discriminatory care received. This is largely unsurprising when considering the racist foundations of both psychiatry and psychology and how the role of eugenics was instrumental in shaping the development of theories and methods (e.g. behaviourism) and the foundations of treatment in NHS. It is often argued that the majority of psychological research and treatments are evidenced upon, designed and aimed toward White, Western, educated, industrialised, rich and developed populations, which are fundamentally cultural blind and inappropriate.

By adopting a traditional research framework, also built upon such White and Western approaches, this study inadvertently added to the oppression of Whiteness through obscuring difference. This research has exposed the need for structural change and personally reinforced the importance of critically questioning the systems I work within and the structural inequalities embedded within psychological practice and research. Such questioning will help me to regularly consider whose interests are being served, who is marginalised and consequently rendered invisible and led me to consider alternative research approaches (see 4.7).

Whilst acknowledging these limitations, findings have provided rich learning and rare insights that minimised potential risks to participants and have made tentative steps toward positive systemic change regarding culturally accessible Children and Young People's Mental Health Services. It has reinforced my awareness that despite best intentions, the power of White privilege underpins my practice within clinical psychology, requiring ongoing critical learning, awareness and reflection to ensure ethical practice.

4.6.2 Limitations regarding demographics

Discussions arising from the pilot interview concluded that basic demographic information could be collected informally from the interview data. This included describing which community participants worked with, alongside whether they shared dual identity and how long they partnership worked with the NHS. Upon reflection, it would have been better to include a consistent script and further information including the rationale and details regarding demographic information and anonymisation. This would have provided participants the opportunity and time to consider the language they used to describe their own cultural identity and that of the communities they supported, as opposed to being collected from interview conversations. It may have provided participants with more clarity and ease, and potentially shaped the information that they felt comfortable to share, e.g., some participants were initially reluctant to use staff names until reminded this would be anonymised.

I had also planned to include information about how long participants had partnership worked with NHS services. As this information was collected before/ after the recording happened in the interviews and my note taking was unclear for two pieces of this information, it was decided not to include any information related to duration of partnership working. These limitations also strengthen the rationale for a more robust procedure to capture relevant demographic information within future research. They highlight how the previous relationships and familiarity I held with some participants resulted in me overlooking and avoiding the formality of collecting cultural demographics. These dilemmas connect with the following theme regarding complexities of community psychology evaluation.

4.6.3 Challenges in evaluating community psychology work

Casale et al. (2015) recognise the challenges of effectively evaluating public health and community interventions, as they can often be cumulative and involve multi-systemic change. Research frameworks and Clinical Psychologists therefore, need to shift from researching ‘on’, to researching ‘with’ participants, which can be time and resource intensive. When colloquially speaking with Clinical Psychologists in my search for relevant research, many acknowledged they had written or published very little due to systemic pressures of time and resources. It is important to acknowledge the challenges of evaluating interventions within an active and stretched NHS setting, where time and resources are often limited (Bateson et al., 2008). Voluntary Community Sector professionals echoed this within many of the studies through high numbers declining to participate due to time pressures.

I wondered if undertaking and documenting such work comes at the expense of impassioned individuals working far beyond and above formalised expectations. I reflected on the inherent power imbalance involved in gaining open access to published research, often requiring university or paid access to academic journals. These thoughts reinforced why I had found it difficult to source relevant literature and led me to reflect on the multiple barriers inherent in accessing research. This led me to question how power and knowledge intersect and who decides what constitutes ‘good’ or ‘relevant’ evidence for such interventions, where research frameworks often privilege ‘scientific rigour’ over case studies.

Cultural capital was coined by Bourdieu (1990) and can be considered a form of cultural knowledge that metaphorically serves as currency. Such cultural knowledge helps people to navigate the norms and expectations of a culture, whilst simultaneously changing the experiences and opportunities available to them, often impacting social status and power. It is important to be aware of the cultural capital I gained as a researcher, e.g. through the opportunities of learning new research skills and credentials, alongside cultural knowledge and information that will likely improve both personal and professional skills and opportunities. It is also vital to consider how participants may have felt compelled to provide positive feedback about the dominant culture (in this case the anonymised Child and Adolescent Mental Health Service) in order to protect their social relationships and employment opportunities. As the UK health system places prestige and value upon formal education and research, by participating in this research, participants may be considered to acquire increased cultural capital, e.g. more advantageous opportunities for the community organisations they work for, i.e. positive reputation through engaging in research, leading to potential increased funding and support. It is therefore, always important to maintain a critical awareness of how the complex exchange of cultural capital and power dynamics is a key factor that can impact the researcher, participants and key stakeholders and may partly explain the highly positive responses provided by participants.

Sharing negative experiences or perspectives may have equally reduced the power and cultural capital for participants within their respective partnerships through impacting the social relationships with Clinical Psychologists and potential support received for families who are already face marginalisation and social inequalities. Within the interviews, it was noticed that some participants commented on whether they were providing “correct” or “helpful” answers, suggesting a positive or constructive narrative may have been expected due to the close working relationships involved within the research context. Even though participants were reassured that the anonymisation would not impact or risk their partnership relationships, it is important to be aware that this risk could never be fully mitigated and the powerful influence this may have held within the wider cultural context.

4.6.4 Personal reflexivity

A critical realist approach considers the researcher’s subjective role in co-producing data and knowledge (Silverman, 2001). Therefore, reflecting on how I shaped the research, and how it shaped me are key processes. Growing up within a multicultural neighbourhood in East London, I have always been curious about how different ‘communities’ live together and yet apart at the same time. As a White, British female I was very conscious that my cultural and non-religious background and experiences differed hugely from the majority of participants. Through regularly reflecting on the influence of ‘culture’ and ‘ethnicity’ within this research process, I became acutely aware of how in contrast, my Whiteness is often rendered invisible, and privileges my experiences (Eddo-Lodge, 2017). Sometimes, I questioned whether I was best positioned to write about experiences of ethnic minority communities. However, I feel I also have a responsibility to address the structural inequalities within clinical psychology and tried to sit with this uncertainty.

Recognising the inherent Whiteness, medicalisation, racism and discriminatory practice within healthcare has highlighted the potential risks and harm of increasing access to services. For me, this has raised uncertainty and questions regarding whether encouraging individuals and minority communities to use and engage with NHS clinical psychology services, is always the most useful and ethical approach. It has taught me the value of working toward supporting systemic change, whilst acknowledging and recognising that the current support structures in place are inadequate and do not yet meet the needs of all. This research has shown me the importance of maintaining hope and working to make the best of a broken system, through recognising that there are not currently enough viable alternatives, and highlighting the importance of continuing to work toward change. It has made me reflect on the importance of listening and making time to understand a person’s or community’s relationship to help (Reder & Fredman, 1996), and the importance of building trust and transparency.

Racial and ethnic inequalities were brought into sharp focus for me, receiving global attention in the context of lives lost to COVID-19 and the murder of George Floyd and Black Lives Matter protests. As these events happened after my data collection, it did not feel appropriate to include them in the literature review, but it feels important to acknowledge how they shaped my analysis and write-up. Thinking about mental health and ethnic inequalities within a wider context involves recognising the inherent power dynamics in society that institutionally disadvantage specific groups. It made me reflect on the challenges of trying to create equitable partnerships and service access, within the context of pervasive social inequalities, which we have minimal individual control over. The process of literature searching into ethnic minority access to Children and Young People’s

Mental Health Services increased my frustration and disillusionment with the current structures and systems purported to ‘help’.

These experiences have strengthened my alignment with community psychology values and my role as an advocate to provide space for voices often unheard and excluded. This research process has felt simultaneously inspiring and intimidating, where I have often felt pressured to do ‘justice’ to the partnership work and participants experiences. I reflected on how humble and brave the Voluntary Community Sector professionals and Clinical Psychologists have been in allowing me intimate entry into their established partnerships and communities; providing permission to explore and evaluate. This has left me with a tremendous appreciation and respect for all partnership members and renewed hope that trust, cultural respect and commitment can create better relationships and access to relatable and appropriate support.

4.7 Future Research

4.7.1 Participatory action research

This study has demonstrated the importance of adopting a research framework that acknowledges Whiteness, social and structural inequalities and understands the needs of local communities and partnerships. Participatory Action Research (Participatory Action Research, Kagan, 2012) is used to develop local research and strategy, promoting a mutual exchange of learning, co-production and joint working. Participatory Action Research involves community members determining the issues to be addressed, the methods employed, and approaches in disseminating the findings (Wadsworth, 1998). This supports the idea that research priorities should emerge from community groups and their activism (BPS, 2018), rather than professional and personal interests. This approach would have been better aligned with the collaborative spirit of community partnership work, reduced power imbalances and provided Voluntary Community Sector professionals the opportunity to contribute to decisions, such as, anonymisation and other potential ways to manage consent and confidentiality. Participatory Action Research also supports a community psychology perspective, where the research goals are connected to social justice and transformative change (Kagan, 2012).

4.7.2 Exploring difference

Future research could extend the scope of this thesis and explore how cultural and spiritual differences between communities impact partnership working. Analysing demographic information to explore how certain characteristics, such as, ethnicity or gender, may have influenced participants' perspectives was beyond the scope of this study and could be explored. Future studies could access a wider range of voices (BPS, 2018) through exploring commissioners', Clinical Psychologists' and service users' perspectives on how partnership work involving Clinical Psychologists. Research exploring how Voluntary Community Sector professionals and Clinical Psychologists are working innovatively within the current socioeconomic climate could encourage further partnerships. This thesis demonstrates how practice-based research provides an acceptable methodology, which should be encouraged, supported and shared across multiple systems within community and professional networks. This provides tried and tested approaches in clinical settings and enables other services to consider how to best incorporate spiritual and cultural understandings into their work.

5. FINAL SUMMARY

This research advocates and promotes the voices of ten Voluntary Community Sector professionals, who provided unique insights into the barriers faced by under-represented, marginalised communities accessing Child and Adolescent Mental Health Services. Semi-structured interviews illustrate how effective partnership work with Clinical Psychologists is underpinned by consistent, trusted relationships, built upon reciprocity, respect and a commitment to breaking down systemic barriers to accessing services. Working together; the partnerships played a pivotal role in understanding families' fears (e.g., stigma), navigating uncertainty (e.g., funding continuity), and increasing knowledge and awareness. Many participants perceived the community partnerships as a bridge to reach and better meet the needs of marginalised communities. They noticed that feeling equally valued, respected and contained within the partnerships often resulted in these experiences being mirrored within the support they provided to communities, holding important implications for future practice.

This thesis provides novel contributions, as the first known qualitative study to identify facilitators to partnership work and community psychology approaches between the Voluntary Community Sector and Clinical Psychologists within Children and Young People's Mental Health Services. Findings suggest participants valued a community psychology approach and how co-production facilitated better community engagement through shared power, expertise and mutual respect. It provided tangible examples of how shared partnership working was fundamental to creating more culturally appropriate support. Listening to participants' experiences was inspiring and moving. I hope this research sparks interest in future partnership work between marginalised communities and Child and Adolescent Mental Health Services and encourages Clinical Psychologists to be more flexible, creative and confident in sharing power within community partnerships.

This study highlights the need for further practice-based research regarding partnership working and community psychology approaches in Children and

Young People’s Mental Health Services. Such small-scale research could shape localised support for underrepresented communities, through adapting evidence-based approaches and improving cultural awareness and humility within Clinical Psychology. It presents multi-level implications and recommendations regarding commissioning, policy, psychology training, integration of community psychology and Children and Young People’s Mental Health Services. Future research could model the collaborative spirit of partnership working through co-produced Participatory Action Research. Emphasising the importance of collaboration and trust; this thesis will end with the words of participant PG:

> “the key ingredient is trust (.) relationship building (.) those are the key ingredients because if the community is happy with *our* relationships that we’ve built (.) they’re more likely to engage with professionals”

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7. APPENDICES

Appendix A: Scoping Review

1. Rationale

A scoping review was undertaken following guidance from Peters et al. (2015). A scoping review applies a systematic approach in order to “map” relevant literature in a specific field. Arksey and O’Malley (2005) outline how a scoping study is suited to broader topics, involving different study designs and identifying research gaps. As the current research area involves exploration of broad areas but is not widely researched, a scoping review was considered most appropriate for this exploratory study.

After undertaking a preliminary scoping literature search for the research proposal, and acknowledging the paucity of literature available, I decided it would be best to focus on the two following questions:

1. What is known about partnership working, community engagement and community psychology approaches involving Clinical Psychologists in Children and Young People’s Mental Health Services in the UK?

2. What is known about partnership working, community engagement and community psychology approaches between Voluntary Community Sector and Clinical Psychology in the UK?

This enabled an exploration of the literature available in Children and Young People’s Mental Health Services settings and to explore relevant literature involving adult community populations, who are also considered relevant due to their gatekeeping responsibilities for children and young people.

2. Search terms

Due to the socially constructed nature of this thesis and how many of the relevant terms are used interchangeably within the literature, a range of search terms and related synonyms related to the research topic were used and applied in varied combinations. Use of the CHIP framework (Shaw, 2010) was helpful in structuring the use of search terms. ‘OR’ and ‘AND’ were used to combine the search terms and refine combinations.

Table 3

Use of the CHIP Tool in the search strategy

Study components	Description	Search terms	Exclusion
Context	Voluntary community sector, Community engagement, Clinical Psychology, CAMHS, Child mental health, Community psychology UK, Britain, England	“voluntary community sector” OR “community organisation” OR “third sector” “community engagement”, “clinical psycholog*” “community psychology*” “CAMHS” OR “child mental health” or “child” AND “mental health”	Last 20 years Studies outside the UK
How	Qualitative/ Mixed Methods	Qualitative	
Issues	What facilitates	“partnership work*”	

	Partnership working and Community engagement, Perspectives of Co-production in improving engagement, Access to services, engagement with services, Culturally sensitive support/ accessibility	“community engagement” “co-production” “access to services” “culturally sensitive” “culturally competent” “culture” “bme mental health”	
Population	Voluntary community sector workers/ leaders, ethnic minority groups, BAME, marginalised communities, UK	“marginalised communit*”, “minority group” “voluntary community sector”	Studies outside the UK

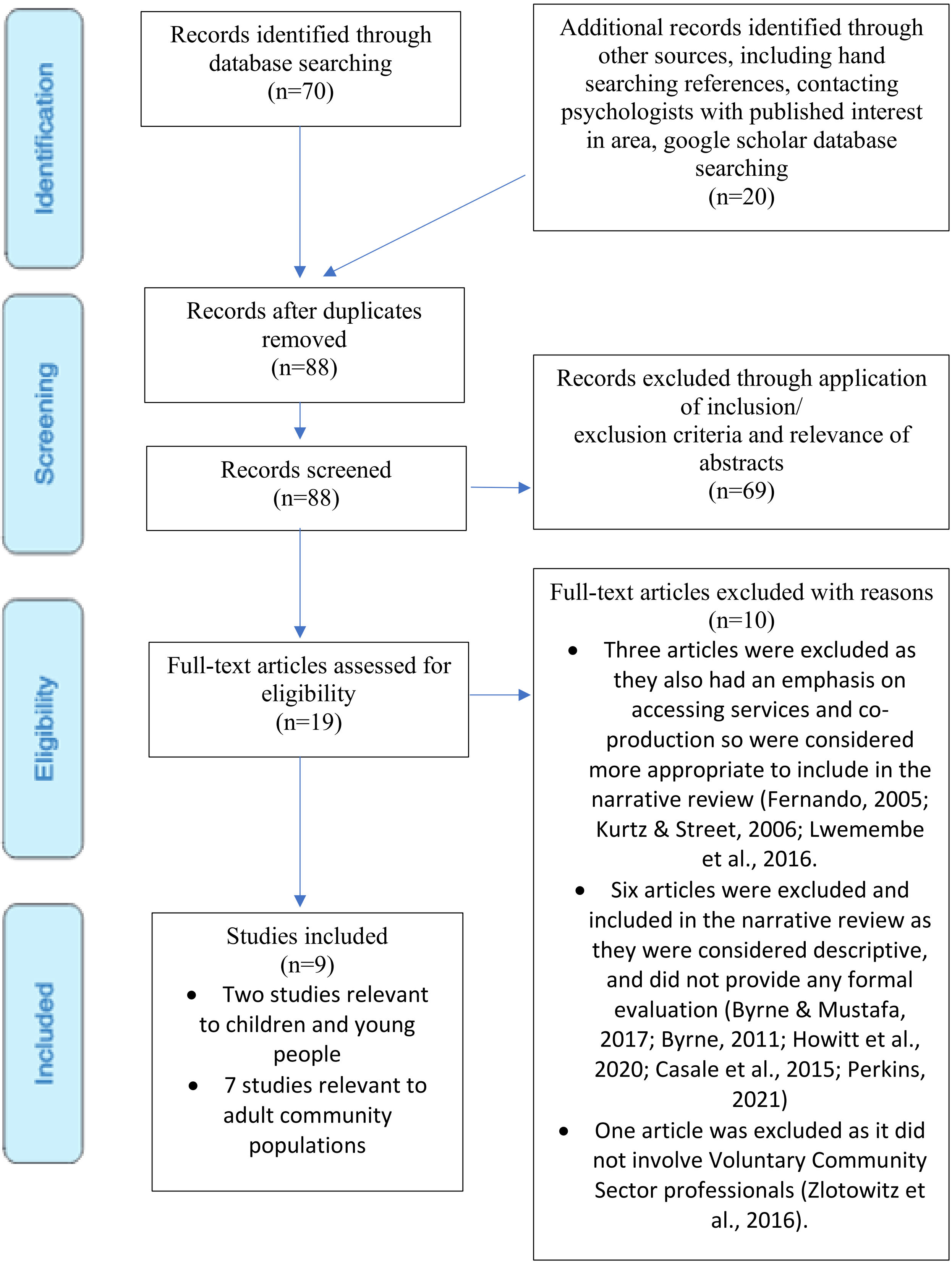
3. Strategy

The scoping review was conducted through searching online databases via EBSCO including, PsychInfo, Academic Search Complete, Child Development and Adolescent Studies, CINAHL Plus with Full Text, APA PsychArticles and APA PsychInfo. A total of 70 pieces of literature were identified via EBSCO, and a further 20 records obtained through hand searching reference lists and grey literature through Google scholar searches and contacting Psychologists with published interest in the area. The titles and abstracts were examined for relevance to the literature review titles, where 69 articles were excluded through applying inclusion/ exclusion criteria and perceived relevance. 19 full text articles were reviewed where three articles were excluded as they also had an emphasis on accessing services and co-production so were considered more appropriate to include in the narrative review (Fernando, 2005; Kurtz & Street, 2006; Lwemembe et al., 2016. Six articles were excluded and included in the narrative review as they were considered descriptive, and did not provide any formal evaluation (Byrne & Mustafa, 2017; Byrne, 2011; Howitt et al., 2020; Casale et al., 2015; Perkins, 2021). One article was excluded as it did not involve Voluntary Community Sector professionals (Zlotowitz et al., 2016). This resulted in 9 studies included in the scoping review, 2 relevant to the first question regarding children and young people and 7 for the second question related to the adult community population. Please see table in Appendix B summarising included research studies (currently being written under structure study, location, focus, sample, data collection, method, findings, limitations, relevance).

4. Criteria

Inclusion criteria involved studies from the last 20 years due to the new and under-researched topic areas and studies in English were selected. Qualitative studies were considered most appropriate due to explorative focus and due to paucity of available literature, relevant mixed-methods and quantitative designs were also included. Research was restricted to the geographical location of the UK, so results could be relatable and relevant to the UK setting of the research. Due to the limited literature available in this area, non-peer reviewed doctoral theses were included and relevant ‘grey literature’ was identified through Google scholar and hand searching reference lists of relevant articles. As this research is focused on community psychology and engagement principles it may be less compatible with traditional research design and consequently less visible. Therefore, key professionals and academics published in the area of community engagement and community psychology were contacted and provided relevant articles.

5. Search Results



Records identified through database searching
(n=70)

Additional records identified through other sources, including hand searching references, contacting psychologists with published interest in area, google scholar database searching
(n=20)

Records after duplicates removed
(n=88)

Records screened
(n=88)

Records excluded through application of inclusion/ exclusion criteria and relevance of abstracts
(n=69)

Full-text articles assessed for eligibility
(n=19)

Full-text articles excluded with reasons
(n=10)

- Three articles were excluded as they also had an emphasis on accessing services and co-production so were considered more appropriate to include in the narrative review (Fernando, 2005; Kurtz & Street, 2006; Lwemembe et al., 2016.
- Six articles were excluded and included in the narrative review as they were considered descriptive, and did not provide any formal evaluation (Byrne & Mustafa, 2017; Byrne, 2011; Howitt et al., 2020; Casale et al., 2015; Perkins, 2021)
- One article was excluded as it did not involve Voluntary Community Sector professionals (Zlotowitz et al., 2016).

Studies included
(n=9)

- Two studies relevant to children and young people
- 7 studies relevant to adult community populations

Appendix B: Summary of Scoping Review Results

Study **Location**	**Focus and aims**	**Sample size, ethnicity, role**	**Data collection method**	**Findings**
Hill et al. (2021) Hackney, London	Innovative service evaluation project study. Aimed to assess the efficacy of a culturally adapted community Child and Adolescent Mental Health Services parenting group for the Orthodox Jewish community	36 Orthodox Jewish mothers who attended a culturally adapted parenting group over a 5-year period	Data was collected through standardised questionnaires	Increased access to groups, significantly improved maternal wellbeing and some significant improvements in the parent-child relationship.
Durcan et al. (2017) London	Evaluated three Music and Change UK (MAC UK) community psychology projects. Aimed to establish whether	Young People, staff and Voluntary Community Sector community stakeholders	A mixed methods evaluation involved in-depth interviews, alongside self-report questionnaires, observations and third party and contact data	Relevant findings included how co-production, relationship building and creating wider social change through partnership working with Voluntary Community Sector organisations were key to increased wellbeing

	the INTEGRATE model and projects benefited Young People and the wider community			and reduced stigma.
Perry et al. (2018) Hackney, London	Pilot project evaluating community-based partnership between Black Minority Ethnic Access Service and Voluntary Community Sector services, a Charedi psychotherapist and local Rabbi	34 Orthodox-Jewish carers aged 25-34. The majority were married, female, aged between 25 and 34 years	Practice-based research. Data collection involved a self report measure assessing well-being and qualitative questionnaire	Findings suggested overall improvements in well-being, increased intent to access psychological services and that the group provided a supportive function. Themes included appreciation, imparting knowledge, acquiring more knowledge
Perry et al. (2019) Hackney, London	Pilot study evaluating the cultural adaptability of a third-wave cognitive behavioural group intervention	Seven first generation (i.e. born outside the UK) Turkish-speaking women, ages ranged from 42 to 62	Self report questionnaires and evaluation form. mixed-method analysis with a one group pre/post-test design to examine the effectiveness of a 7-session culturally adapted ACT group intervention and a descriptive approach was implemented to assess usefulness,	Positive tentative conclusions were developed through significant improvements on measures of anxiety, depression and distress, alongside qualitative data illustrating the benefits of the group setting. Themes included: group process, change factors, reflections/

	Aim was to develop a culturally acceptable group that was responsive to the therapeutic needs of participants from Turkish-speaking communities.		relevance and acceptability.	considerations
Mustafa & Byrne (2016) East London	16 Bangladeshi men attended a session – doesn't specify number for focus group	Aimed to develop culturally sensitive interventions, through using partnership working to integrate Islamic concepts of wellbeing and recovery into psychological services. No demographics available.	The intervention was evaluated using focus group methodology	Three themes were identified: the importance of hope arising from peer support and the inclusion of faith, alongside new learning opportunities and a safe space to reflect on existing knowledge and strengths
Galloway & Byrne (2016) London	Aimed to explore whether attitudes towards talking therapies within the local Orthodox Jewish community had changed following	6 Jewish Voluntary Community Sector professionals working with Orthodox Jewish communities: four male, two female	Purposive sampling Semi structured interviews Thematic Analysis	All participants felt there had been changes in attitudes of Orthodox Jewish communities toward talking therapies and in statutory approaches towards the community. Community services bridging two worlds was considered key and greater

	support from the Black Minority Ethnic Access service and identify relevant facilitators and remaining barriers to accessing psychological support.			knowledge, awareness, reduced stigma, positive experiences and flexible holistic support were key themes.
Flanagan & Hancock, (2010) Birmingham	Qualitative pilot study, which aimed to explore participants views on the term ‘hard to reach’, alongside barriers and facilitators to accessing services	Eight representatives from Voluntary Community Sector organisations designed to support stigmatised, marginalised or ‘hard to reach’ groups	Interviews	Four key themes impacting the engagement of marginalised groups, including relationship building with staff, (e.g. attitudes, respect and trust), service flexibility, (e.g. location, opening times and funding constraints), partnership working with other organisations and involving service users within service development.
Lester et al. (2008) West Midlands	Explored partnership working between early intervention services and Voluntary	47 Voluntary Community Sector professionals, 42 National Health Service senior managers and commissioners and 60 early intervention	Large-scale qualitative research involving focus groups and interviews A constant comparison method was used to for data analysis	Participants identified partnership work facilitators as shared agendas, skills and training initiatives, flexibility and how mutually beneficial and long-term relationships increased mutual

	Community Sector organisations	professionals	(Glaser 1978) and generated common themes.	trust and confidence. Partnership working barriers included cultural differences between services, communication difficulties, management of risk, operation of power and hierarchy and insecure funding and sustainability.
McEvoy et al. (2017) North West England	Evaluated a partnership initiative designed to improve access to an NHS Increasing Access to Psychological Therapies (IAPT) service for the local Orthodox Jewish (OJ) community in North West England. The study was interested in relational aspects and accommodation		Mixed methods data analysis was undertaken on routine demographic data, clinical outcome measures, notes, correspondence and recorded discussions Data was coded and analysed using MaQDA software.	Three overarching themes; establishing an arms-length relationship, building a collaborative partnership and building a mature collaborative partnership.

	of otherness			

Appendix C: HRA Ethical Approval

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Ms Susie Haynes
Trainee Clinical Psychologist
Camden & Islington NHS Foundation Trust/ University
of East London
School of Psychology, University of East London
Water Lane
Stratford
E15 4LZ

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

23 July 2019

Dear Ms Haynes

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**EXPLORING THE VIEWS OF VOLUNTARY COMMUNITY SECTOR MEMBERS ON PARTNERSHIP WORKING AND CO-PRODUCTION WITH NHS CHILD AND FAMILY SERVICES.**
IRAS project ID:	**263178**
Sponsor	**University of East London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is Please quote this on all correspondence.

Yours sincerely,

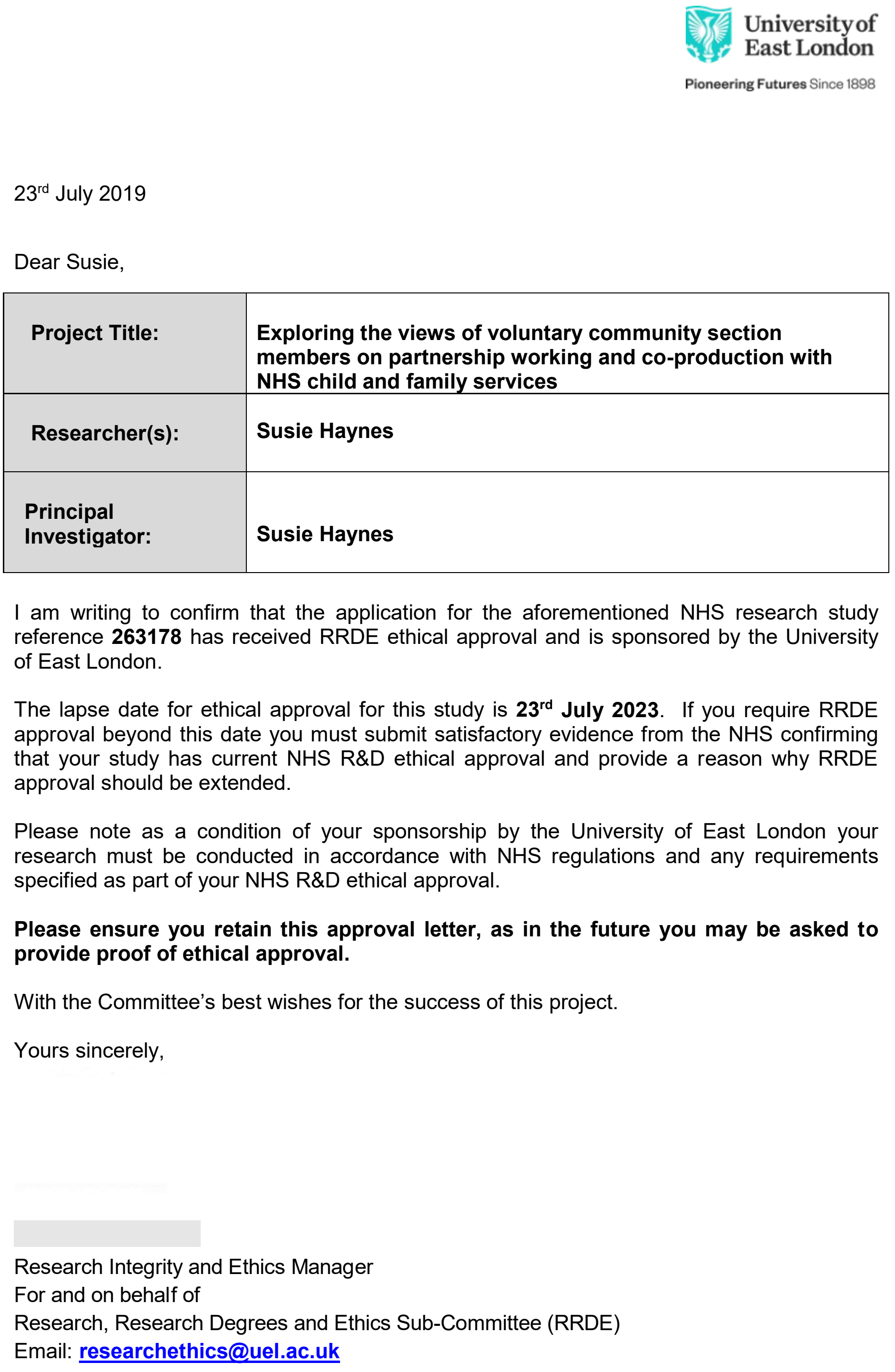
[redacted]

HRA Approvals Manager

Telephone: [redacted]
Email:

Copy to: [redacted]*, Sponsor contact*

Appendix D: Sponsorship Letter Containing Error and Ethical Amendment Confirmation



University of East London
Pioneering Futures Since 1898

23rd July 2019

Dear Susie,

Project Title:	**Exploring the views of voluntary community section members on partnership working and co-production with NHS child and family services**
Researcher(s):	**Susie Haynes**
Principal Investigator:	**Susie Haynes**

I am writing to confirm that the application for the aforementioned NHS research study reference **263178** has received RRDE ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **23rd July 2023**. If you require RRDE approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why RRDE approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

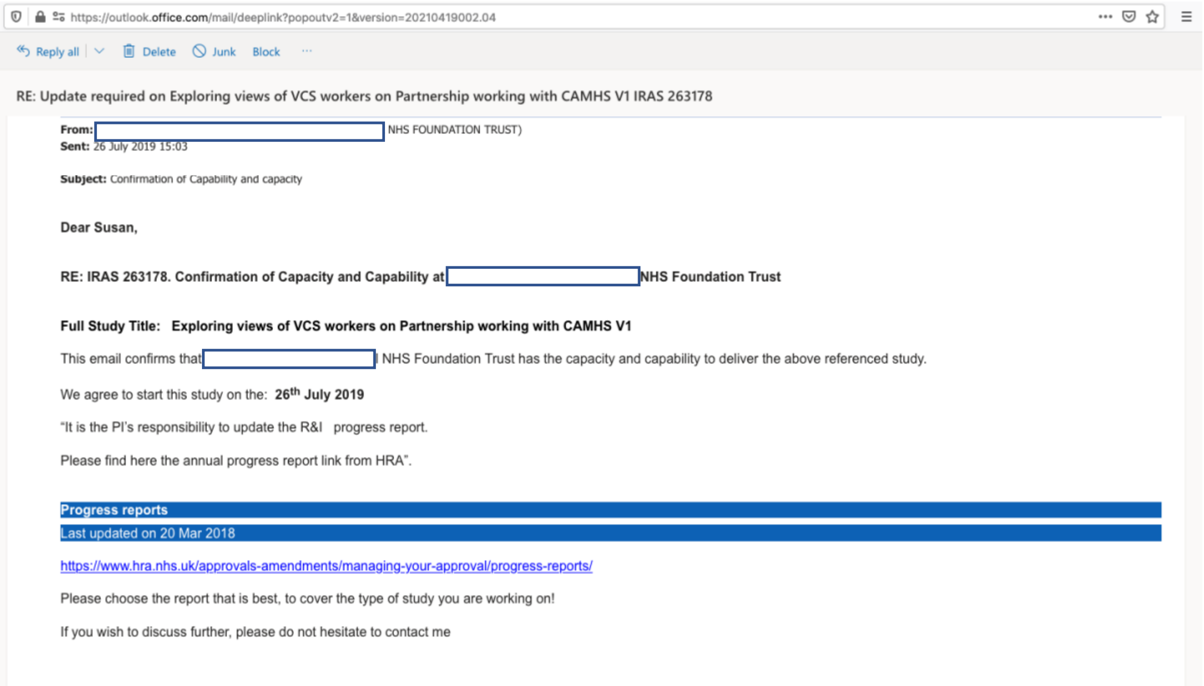
With the Committee's best wishes for the success of this project.

Yours sincerely,

[redacted]

Research Integrity and Ethics Manager
For and on behalf of
Research, Research Degrees and Ethics Sub-Committee (RRDE)
Email: researchethics@uel.ac.uk

Appendix E: Confirmation of Capability and Capacity



RE: Update required on Exploring views of VCS workers on Partnership working with CAMHS V1 IRAS 263178

From: [redacted] NHS FOUNDATION TRUST)
Sent: 26 July 2019 15:03

Subject: Confirmation of Capability and capacity

Dear Susan,

RE: IRAS 263178. Confirmation of Capacity and Capability at [redacted] NHS Foundation Trust

Full Study Title: Exploring views of VCS workers on Partnership working with CAMHS V1

This email confirms that [redacted] NHS Foundation Trust has the capacity and capability to deliver the above referenced study.

We agree to start this study on the: **26th July 2019**

"It is the PI's responsibility to update the R&I progress report.

Please find here the annual progress report link from HRA".

Progress reports

Last updated on 20 Mar 2018

https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/progress-reports/

Please choose the report that is best, to cover the type of study you are working on!

If you wish to discuss further, please do not hesitate to contact me

Appendix F: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

What facilitates partnership working between Voluntary Community Sector workers and Clinical Psychologists? How do such collaborative partnerships influence how families from ethnic minority backgrounds access and engage with child and family NHS services?

Invitation and brief summary

This letter provides information that will help you make a decision about whether to participate in this research study. Before you agree it is important that you understand what your participation would involve.

This study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at the University of East London.
Please take time to read the following information below.

What does the research involve?

This research aims to hear the views of professionals within third sector community organisations who work collaboratively with NHS clinical psychologists in child mental health services. It will explore what facilitates partnership working and collaboration between third sector community organisations and clinical psychologists. I am also interested in understanding how such collaborative partnerships influence how families from ethnic minority backgrounds access and engage with child and family NHS services.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

What would taking part involve?

You have been contacted to participate in this research as you have been identified as a professional working within a community organisation. I am particularly interested in interviewing professionals about their experiences of working in partnership with Clinical Psychologists in child mental health services in [anonymised major UK city].

If you choose to participate I would ask you to meet me for an interview. This would last approximately one hour. The interview will take place at a location that is convenient to you. This could be in a private room at your place of work or within the First Steps team base. The interview will be audio recorded with your permission. Participation in the research is voluntary and you may withdraw at any time if you were to change your mind. Choosing to take part in this study will have no impact on your existing working relationship with any service and is independent of any service evaluation.

Your taking part will be safe and confidential

Due to the ongoing working relationships between participants and NHS services, there is a chance that quotations from the interviews may be read and identifiable by staff within the relevant services. This risk will be reduced by ensuring that all identifiable information, including your name, cultural and service identity are not included in any quotations used within the research.

What will happen to the information that you provide?

All names and identifiable information will be stored on a password protected spreadsheet on a computer login that the researcher has sole access to. The data will be treated confidentially and all names, places and identifiable information will be changed.

UEL is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UEL will keep identifiable information about you for 1 year after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

UEL will keep your name and contact details confidential and will not pass this information to the NHS. UEL will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study.

The researcher will keep identifiable information about you from this study for 1 year after the study has finished. Anonymised data will be kept for up to 5 years in case the study is published.

You can find out more about how we use your information by contacting us below.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:
Susie Haynes

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Amy Bartlett, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: a.l.bartlett@uel.ac.uk
or
Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)
or
Ms Catherine Hitchens, Research Integrity and Ethics Manager, Graduate School, University of East London, EB1.43, Docklands Campus, 4-6 University Way, London, E16 2RD (Email: researchethics@uel.ac.uk)

Appendix G: Consent Form

CONSENT FORM

What facilitates partnership working between Voluntary Community Sector workers and Clinical Psychologists? How do such collaborative partnerships influence how families from ethnic minority backgrounds access and engage with child and family NHS services?

Name of Researcher: Susie Haynes

Please initial box

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these 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. ☐

3. I agree to take part in the above study. ☐

______________	______________	______________
Name of Participant	Date	Signature
______________	______________	______________
Name of Person taking consent	Date	Signature

Appendix H: Debrief Sheet

UNIVERSITY OF EAST LONDON

Debrief Sheet

Thank you for taking part in this research study. We hope that the information you gave today will help to develop a better understanding of the views of community organisations working in partnership with NHS child and family mental health services.

If you have any questions or comments after the interview has commenced, you are very welcome to contact me by email:

I am aware that some of the topics we spoke about today, such as partnership working, cultural differences and accessing support may have been difficult or upsetting for some people. If you feel you would like to talk to someone further, I have included some details of organisations that you may find helpful for support:

Samaritans:
Telephone 116 123
Email jo@samaritans.org

Mind:
Telephone 0300 123 3393
Email info@mind.org.uk

Appendix I: Semi Structured Interview Schedule

Preamble:

- Introductions
- Explain purpose of interview and clarify the definitions of “partnership working” for the purposes of this research, as this term may not be familiar to all.
- Consent
- Confidentiality
- Right to withdraw
- Any questions

Experience of partnership working

- Can you tell me about how you started partnership working with service x [insert appropriate service]?
- How would you describe the current working relationship?
    - Prompt: Do you notice any similarities or differences in the way that you work?
- What do you think are the key ingredients to effective partnership working?
    - Prompt: How were roles and responsibilities negotiated?
- How do you see the partnership working in the future?

Engagement with services

- What do you think are the priorities in helping to improve access and engagement?
- What do you think are the difficulties that impact on community members engaging?
- How do you think that working together has improved access and engagement for service users within your community?
    - Prompt: Can you give any examples?
- Is there anything that can be learnt from working in this way?

Is there anything else you would like to say?

Debrief and time for questions

Appendix J: Transcription Key

[   ] square brackets include contextual information, including interactional features of the dialogue that were important, e.g. [laughter]

(.) pause

(.3) signifies length of pause in seconds

Italics used when words were emphasised by the speaker

Appendix K: Excerpt from Reflective Journal

Interview X

Feelings before

- Slightly nervous
- Nice to see X again and hear how they had been doing
- Aware that there was lots of noise in the room next door – we discussed the option of moving rooms if necessary

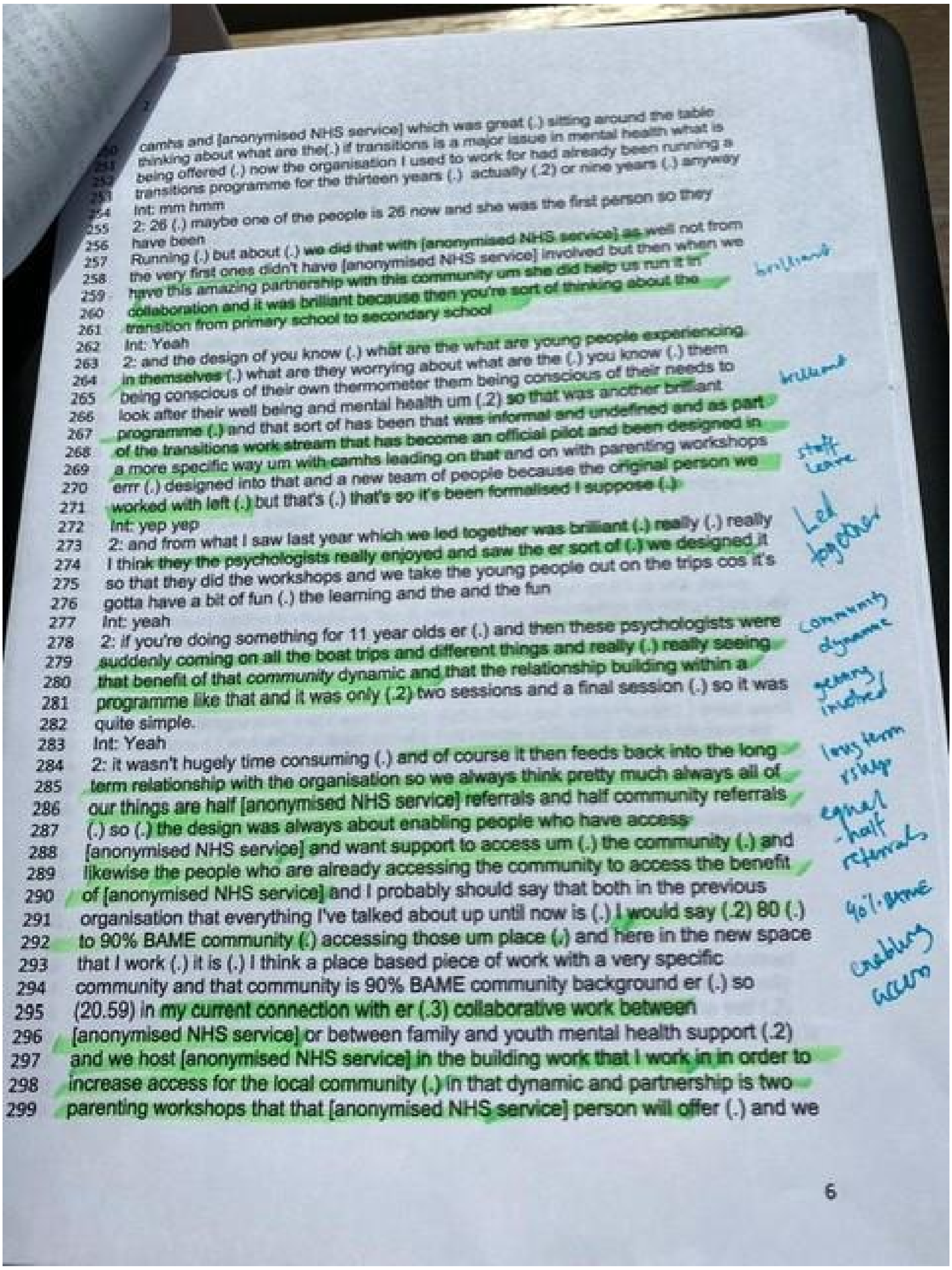
During Interview/ Process

- Powerful impact of sharing personal as well as professional experiences regarding difficulties accessing children and young people services
- Streams of consciousness – less bound by questions – you could see the participant formulating meaning during the interview and really engaging with questions and ideas and what this means
- They seemed to go off track/ forget the questions regularly and then name this
- I felt like I struggled with finding the balance of not wanting to be directive or scaffold the conversation in any way but did this impact how they were able to answer the questions – did the questions feel too open?
- Participant was weary to use names until I clarified again that this was ok as all identifiable information would be removed. This appeared to enable them to relax and the dialogue to flow much more easily after this
- Would it be helpful to provide time estimates in the future or check in half way through as participant spent a lot longer on first half and seemed slightly fatigued by second half
- Participant asked if they could keep a copy of the questions and email me with any further thoughts. I paused to consider but said I would be unable to do this to ensure the research process was consistent with all participants and this hadn't been offered

Reflections whilst transcribing

- Noticed how the participant expressed feeling bad for not sharing a good enough version of [anonymised Child and Adolescent Mental Health Service] – as if they had made too many critical comments - I didn't notice this at the time of the interview but suggests my presence presents pressure to provide positive feedback?
- Made me think about the complex definition of "community" as didn't really explore cultural community in the same as the first interview and how this may mean different things to different participants
- Very long relationship with service and borough
- No mention of power interestingly
- Felt this interview was very rich at time but when typing up it feels scattered and like the questions were not always really answered – interesting contrast

Appendix L: Initial Codes/ Highlighted Transcript



camhs and [anonymised NHS service] which was great (.) sitting around the table thinking about what are the(.) if transitions is a major issue in mental health what is being offered (.) now the organisation I used to work for had already been running a transitions programme for the thirteen years (.) actually (.2) or nine years (.) anyway

Int: mm hmm

2: 26 (.) maybe one of the people is 26 now and she was the first person so they have been Running (.) but about (.) we did that with [anonymised NHS service] as well not from the very first ones didn't have [anonymised NHS service] involved but then when we have this amazing partnership with this community um she did help us run it in collaboration and it was brilliant because then you're sort of thinking about the transition from primary school to secondary school

Int: Yeah

2: and the design of you know (.) what are the what are young people experiencing in themselves (.) what are they worrying about what are the (.) you know (.) them being conscious of their own thermometer them being conscious of their needs to look after their well being and mental health um (.2) so that was another brilliant programme (.) and that sort of has been that was informal and undefined and as part of the transitions work stream that has become an official pilot and been designed in a more specific way um with camhs leading on that and on with parenting workshops err (.) designed into that and a new team of people because the original person we worked with left (.) but that's (.) that's so it's been formalised I suppose (.)

Int: yep yep

2: and from what I saw last year which we led together was brilliant (.) really (.) really I think they the psychologists really enjoyed and saw the er sort of (.) we designed it so that they did the workshops and we take the young people out on the trips cos it's gotta have a bit of fun (.) the learning and the and the fun

Int: yeah

2: if you're doing something for 11 year olds er (.) and then these psychologists were suddenly coming on all the boat trips and different things and really (.) really seeing that benefit of that *community* dynamic and that the relationship building within a programme like that and it was only (.2) two sessions and a final session (.) so it was quite simple.

Int: Yeah

2: it wasn't hugely time consuming (.) and of course it then feeds back into the long term relationship with the organisation so we always think pretty much always all of our things are half [anonymised NHS service] referrals and half community referrals (.) so (.) the design was always about enabling people who have access [anonymised NHS service] and want support to access um (.) the community (.) and likewise the people who are already accessing the community to access the benefit of [anonymised NHS service] and I probably should say that both in the previous organisation that everything I've talked about up until now is (.) I would say (.2) 80 (.) to 90% BAME community (.) accessing those um place (.) and here in the new space that I work (.) it is (.) I think a place based piece of work with a very specific community and that community is 90% BAME community background er (.) so (20.59) in my current connection with er (.3) collaborative work between [anonymised NHS service] or between family and youth mental health support (.2) and we host [anonymised NHS service] in the building work that I work in in order to increase access for the local community (.) in that dynamic and partnership is two parenting workshops that that [anonymised NHS service] person will offer (.) and we

brilliant

brilliant

staff leave

Led together

community dynamic

getting involved

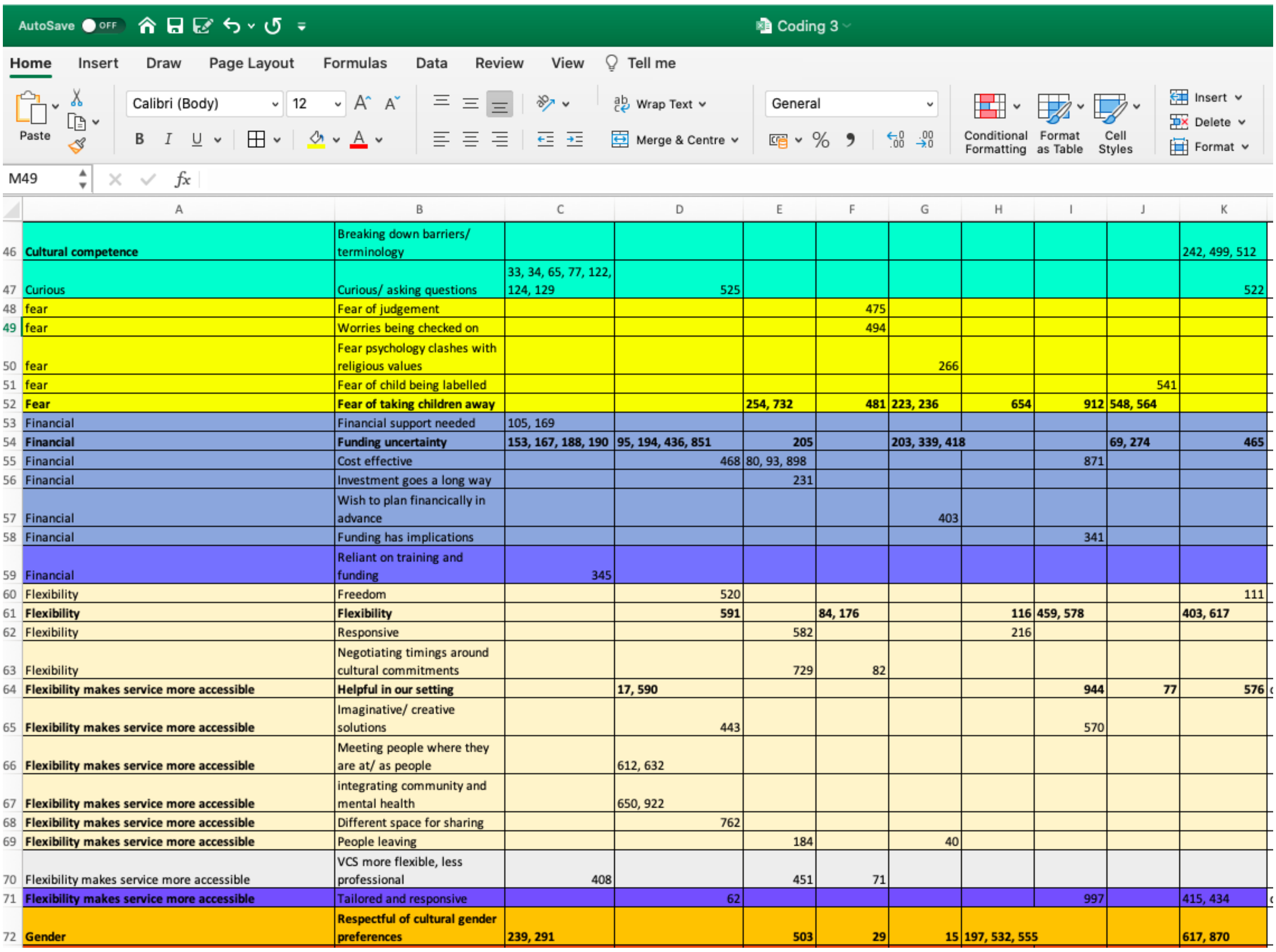
long term r'ship

equal - half referrals

90% BAME

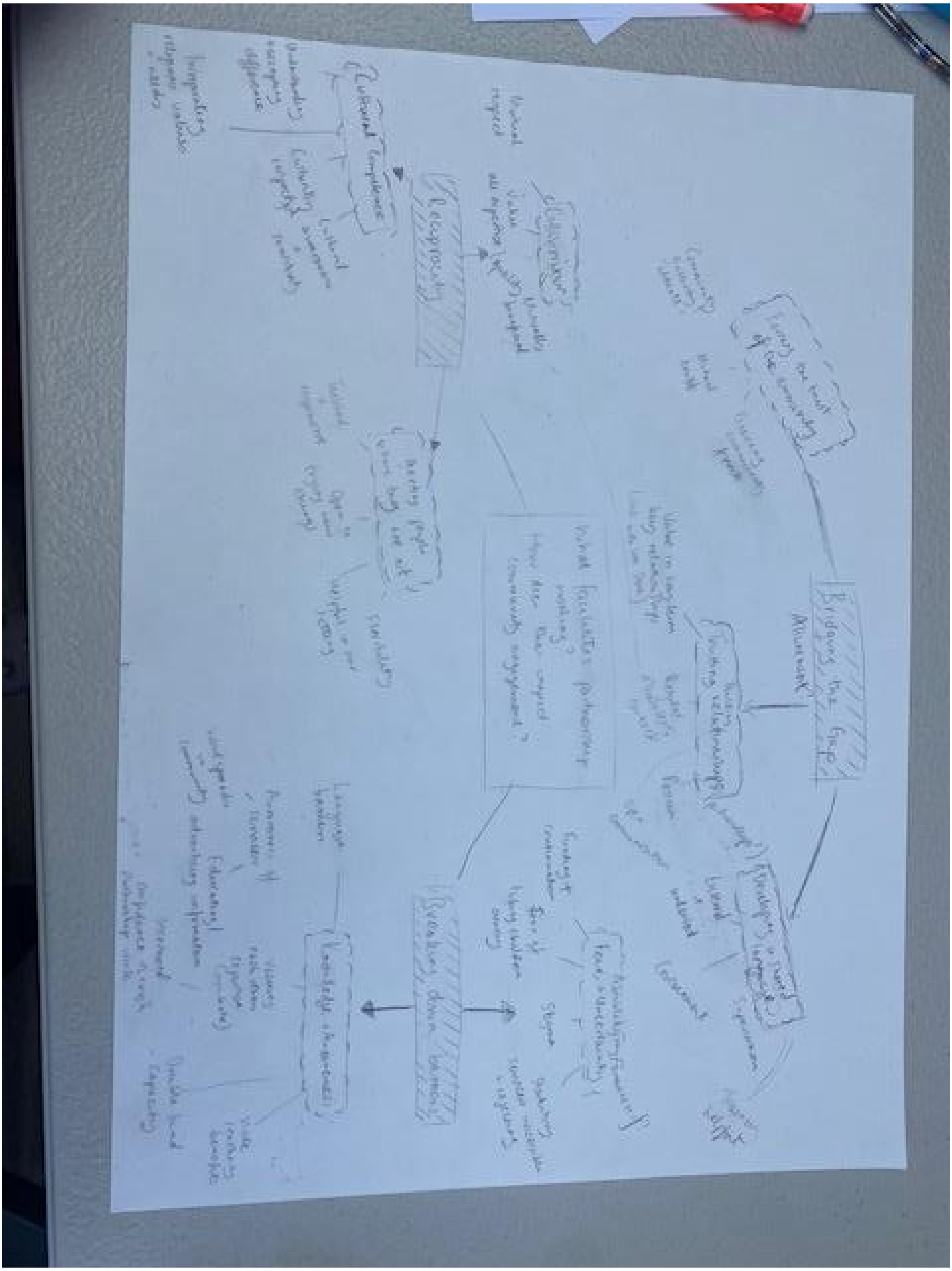
enabling access

Appendix M: Excerpt from Coding Spreadsheet

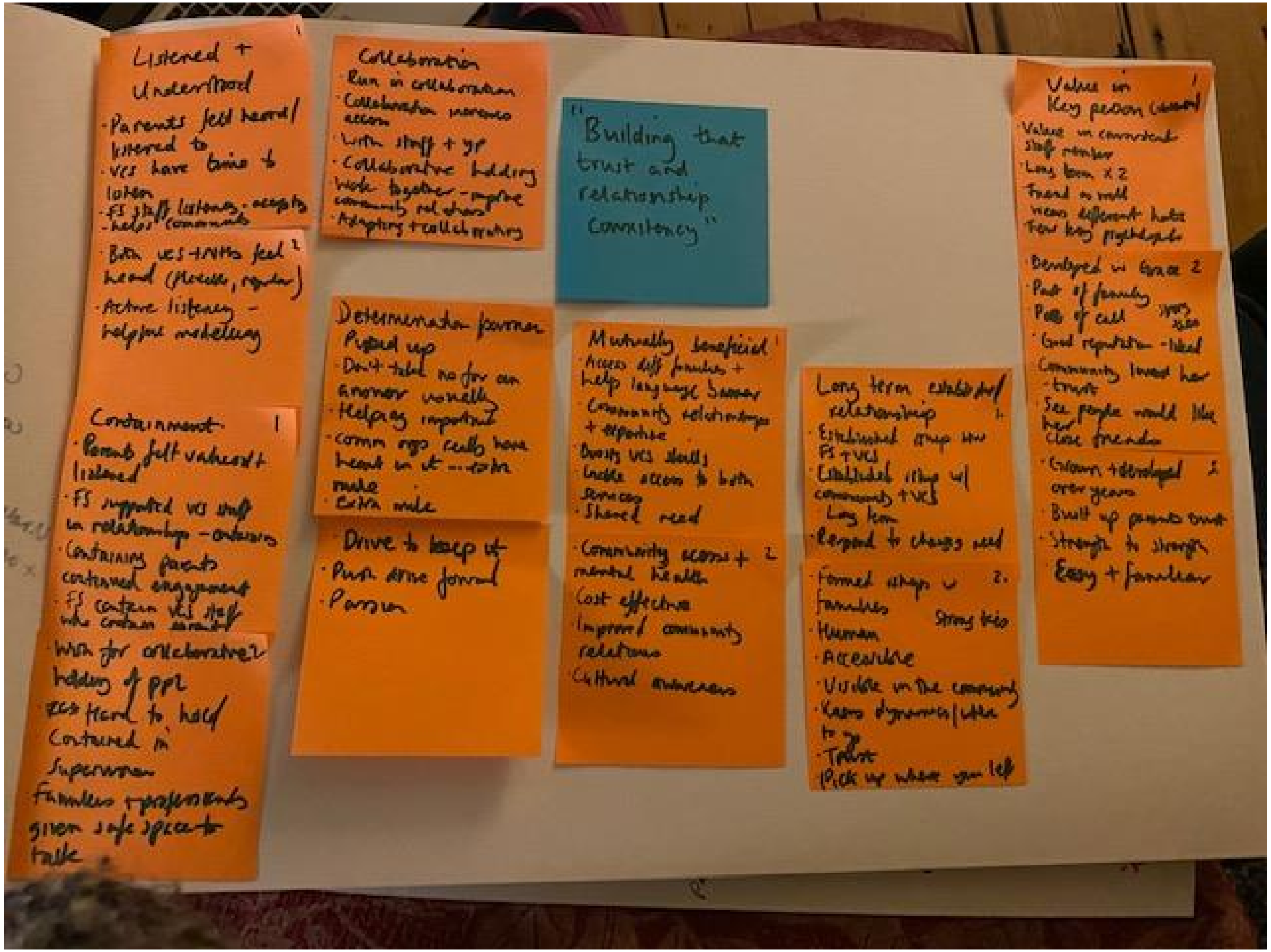


	A	B	C	D	E	F	G	H	I	J	K
46	**Cultural competence**	Breaking down barriers/ terminology									242, 499, 512
47	Curious	Curious/ asking questions	33, 34, 65, 77, 122, 124, 129	525							522
48	fear	Fear of judgement				475					
49	fear	Worries being checked on				494					
50	fear	Fear psychology clashes with religious values					266				
51	fear	Fear of child being labelled								541	
52	**Fear**	**Fear of taking children away**			**254, 732**	**481**	**223, 236**	**654**	**912**	**548, 564**	
53	Financial	Financial support needed	105, 169								
54	**Financial**	**Funding uncertainty**	**153, 167, 188, 190**	**95, 194, 436, 851**	**205**		**203, 339, 418**			**69, 274**	**465**
55	Financial	Cost effective		468	80, 93, 898				871		
56	Financial	Investment goes a long way			231						
57	Financial	Wish to plan financially in advance					403				
58	Financial	Funding has implications							341		
59	Financial	Reliant on training and funding	345								
60	Flexibility	Freedom		520							111
61	**Flexibility**	**Flexibility**		**591**		**84, 176**		**116**	**459, 578**		**403, 617**
62	Flexibility	Responsive			582			216			
63	Flexibility	Negotiating timings around cultural commitments			729	82					
64	**Flexibility makes service more accessible**	**Helpful in our setting**		**17, 590**					**944**	**77**	**576**
65	**Flexibility makes service more accessible**	Imaginative/ creative solutions		443					570		
66	**Flexibility makes service more accessible**	Meeting people where they are at/ as people		612, 632							
67	**Flexibility makes service more accessible**	integrating community and mental health		650, 922							
68	**Flexibility makes service more accessible**	Different space for sharing		762							
69	**Flexibility makes service more accessible**	People leaving			184		40				
70	Flexibility makes service more accessible	VCS more flexible, less professional	408		451	71					
71	**Flexibility makes service more accessible**	Tailored and responsive		62					997		415, 434
72	**Gender**	**Respectful of cultural gender preferences**	**239, 291**		**503**	**29**	**15**	**197, 532, 555**			**617, 870**

Appendix N: Mind Map



Appendix O: Post-it Notes



Listened + Understood 1
- Parents feel heard/listened to
- VCS have time to listen
- FS staff listening - accepting
- helps communities

- Both VCS + NHS feel heard (process, regular) 2
- Active listening - helpful modelling

Containment 1
- Parents felt valued + listened
- FS supported VCS staff in relationships - ondrawing
- Containing parents continued engagement
- FS contain VCS staff who contain [illegible]

- Wish for collaborative holding of ppl 2
- VCS Hard to hold
- Contained in supervision
- Families + professionals given safe space to talk

Collaboration
- Run in collaboration
- Collaboration increases access
- With staff + GP
- Collaborative holding
- Work together - improve community relations
- Adapting + collaborating

"Building that trust and relationship Consistency"

Determination journey
- Picked up
- Don't take no for an answer usually
- Helping important
- Comm orgs really have heart in it - extra mile
- Extra mile

- Drive to keep it
- Push drive forward
- Passion

Mutually beneficial 1
- Access diff families + help language barrier
- Community relationships + expertise
- Boosts VCS skills
- Widens access to both services
- Shared need

- Community access + mental health 2
- Cost effective
- Improved community relations
- Cultural awareness

Long term established/relationship 1
- Established relationship btw FS + VCS
- Established relationship w/ community + VCS
- Long term
- Respond to changes need

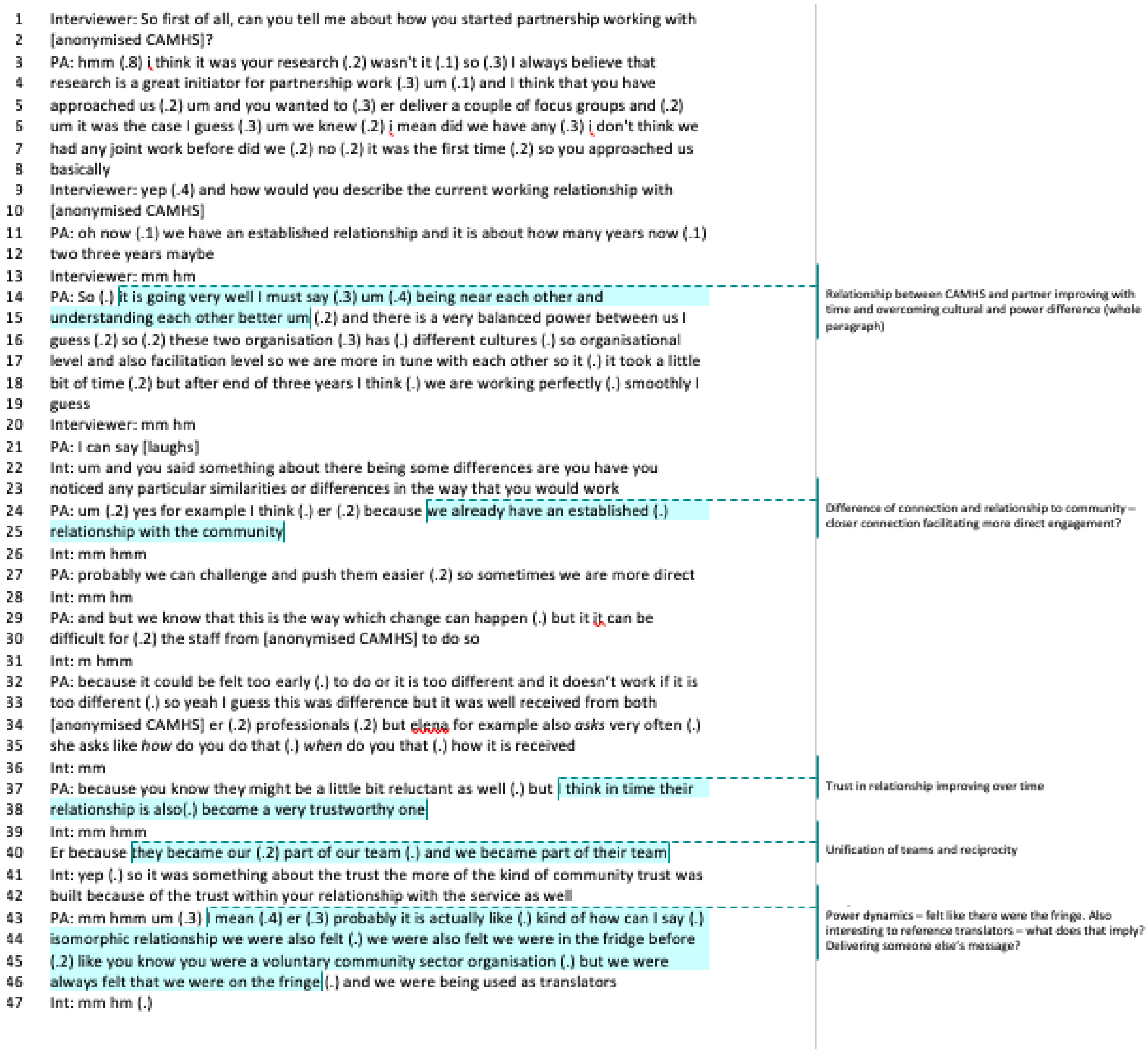
- Formed relationships w families 2.
- Strong ties
- Human
- Accessible
- Visible in the community
- Knows dynamics/who to go
- Trust
- Pick up where you left

Values in Key person (consistent) 1
- Values in consistent staff member
- Long term x 2
- Friend in need
- Wears different hats
- Few key psychologists

- Developed in trust 2
- Part of family
- Port of call
- years
- Good reputation - liked
- Community invest her trust
- See people would like her close friends

- Grown + developed over years 2
- Built up parents trust
- Strength to strength
- Easy + familiar

Appendix P: Independent Coding Excerpt



Interviewer: So first of all, can you tell me about how you started partnership working with [anonymised CAMHS]?
PA: hmm (.8) i think it was your research (.2) wasn't it (.1) so (.3) I always believe that research is a great initiator for partnership work (.3) um (.1) and I think that you have approached us (.2) um and you wanted to (.3) er deliver a couple of focus groups and (.2) um it was the case I guess (.3) um we knew (.2) i mean did we have any (.3) i don't think we had any joint work before did we (.2) no (.2) it was the first time (.2) so you approached us basically
Interviewer: yep (.4) and how would you describe the current working relationship with [anonymised CAMHS]
PA: oh now (.1) we have an established relationship and it is about how many years now (.1) two three years maybe
Interviewer: mm hm
PA: So (.) it is going very well I must say (.3) um (.4) being near each other and understanding each other better um (.2) and there is a very balanced power between us I guess (.2) so (.2) these two organisation (.3) has (.) different cultures (.) so organisational level and also facilitation level so we are more in tune with each other so it (.) it took a little bit of time (.2) but after end of three years I think (.) we are working perfectly (.) smoothly I guess
Interviewer: mm hm
PA: I can say [laughs]
Int: um and you said something about there being some differences are you have you noticed any particular similarities or differences in the way that you would work
PA: um (.2) yes for example I think (.) er (.2) because we already have an established (.) relationship with the community
Int: mm hmm
PA: probably we can challenge and push them easier (.2) so sometimes we are more direct
Int: mm hm
PA: and but we know that this is the way which change can happen (.) but it it can be difficult for (.2) the staff from [anonymised CAMHS] to do so
Int: m hmm
PA: because it could be felt too early (.) to do or it is too different and it doesn't work if it is too different (.) so yeah I guess this was difference but it was well received from both [anonymised CAMHS] er (.2) professionals (.2) but elena for example also *asks* very often (.) she asks like *how* do you do that (.) *when* do you that (.) how it is received
Int: mm
PA: because you know they might be a little bit reluctant as well (.) but I think in time their relationship is also(.) become a very trustworthy one
Int: mm hmm
Er because they became our (.2) part of our team (.) and we became part of their team
Int: yep (.) so it was something about the trust the more of the kind of community trust was built because of the trust within your relationship with the service as well
PA: mm hmm um (.3) I mean (.4) er (.3) probably it is actually like (.) kind of how can I say (.) isomorphic relationship we were also felt (.) we were also felt we were in the fridge before (.2) like you know you were a voluntary community sector organisation (.) but we were always felt that we were on the fringe (.) and we were being used as translators
Int: mm hm (.)

Relationship between CAMHS and partner improving with time and overcoming cultural and power difference (whole paragraph)

Difference of connection and relationship to community – closer connection facilitating more direct engagement?

Trust in relationship improving over time

Unification of teams and reciprocity

Power dynamics – felt like there were the fringe. Also interesting to reference translators – what does that imply? Delivering someone else's message?

PA: we weren't acknowledged because of our qualifications (.2) so we were most of the time we were approached because just because other (.) er (.) organisation needs to access our (.) *target* groups so but (.) our partnership with er [anonymised CAMHS] was totally different (.) you know it was like (.) there was always mutual respect

This is so powerful! Suggests history of being undervalued, and partnership did something to challenge this

Int: mm

PA: and then also like joint and equal er partnership work

Int: mm hmm

PA: so we didn't feel that we were at the fringe or that we are supporting you it felt we are (.) we are sharing the work (.) so It shifted our (.) organisations position I guess (.) like other like camhs (.) now sees us as a as a partner organisation to [anonymised CAMHS]

FELT shared

Int: yep

PA:so (.) and it is also a shift in *our* parents position (.2) er in their relationship with your organisation (.) so it is more *balanced* I guess they are more *aware* that (.) they are *listened* (.) they can be understood (.) by someone who are different from them

So beautiful

Int: mm hm

PA: so yeah in that sense

Int: yep and how do you think that balance has been (.) how have you got there (.) how has the balance come to be (5.23)

PA: um (.10) I mean I think it was [anonymised CAMHS] (.3) er (.5) curiosity (.3) you guys (.) you and elena and also the managers they were always trying to understanding our approach (.2) try to find better ways of you know um (.2) *engaging* with our community

Curiosity facilitating a relationship that challenges power imbalance

Int: mm hmm

PA: its not (.) your question was always like *your* engagement not you weren't focussing on *their* engagement to your service (.) so you try to in tune and you actually followed our sometimes our lead as well

Int: mm hmm

PA: so I think that helped and (.3) yeah obviously we just saw (.3) um (.5) that our ideas were [laughs] valued um (.4) and ideas also can be practised so (.) you were very you means like you elena whomever we facilitated with you were very open to try new things (6.43)

Openness and willingness as facilitating a relationship that challenges power imbalance

Int: yeah

PA: I mean yeah I think its about curiosity (.) being natural (.2) um not having any prejudice (.3) or you know assumptions (.) I think it was because also facilitators are trained as psychologists clinical psychologists so it helps as well

Int: mm

PA: it might be a different story if a background (.2) had been different (.3) I guess

Int: um so I suppose we just talked about this a little bit but what do you think are the key ingredients to effective partnership working

PA: (.4) hmm (.8) being in constant contact I guess (.3) um and also I mean organisational level we have relationship but then facilitator levels we have very close relationship (.3) we kind've become close friends you know (.)

Partnership going beyond organisational level

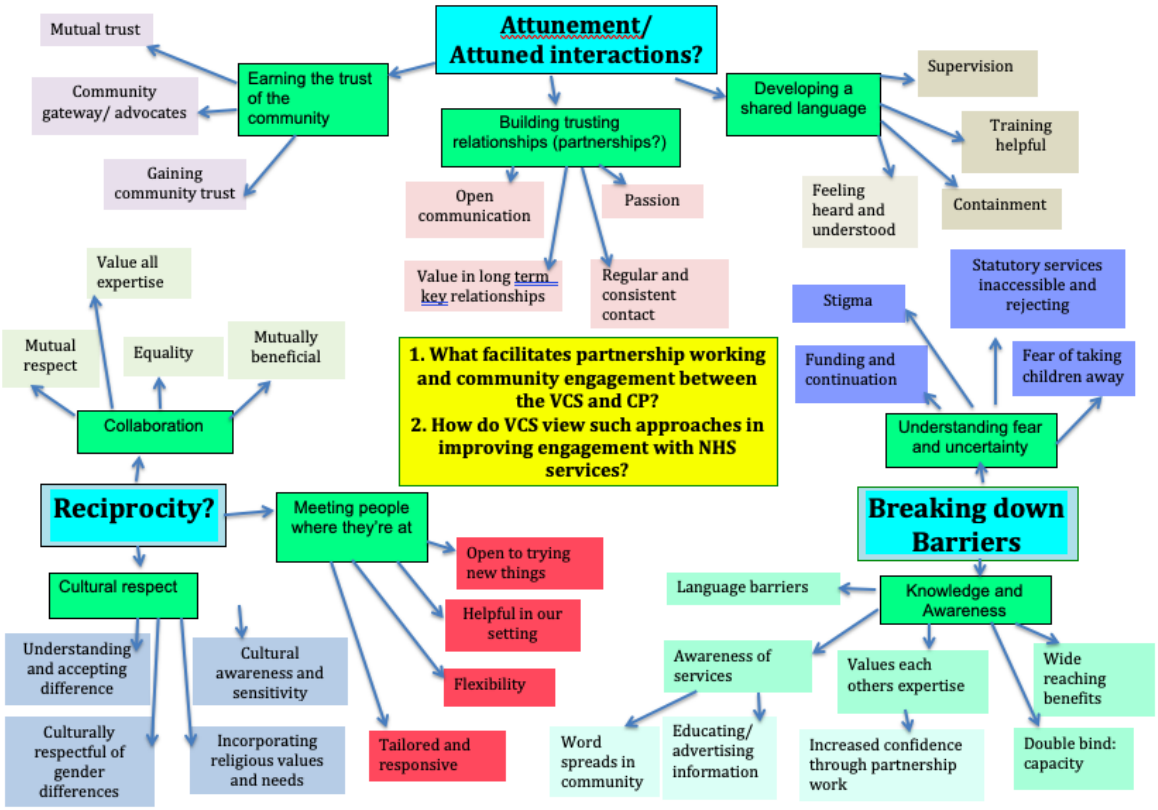
Int" mm hmm

PA: and we were available to each other at all times um (.3) and we gave each other some opportunities to get more ideas about our organisations (.) I had some joined some meetings at [anonymised CAMHS] and also other community organisations so there were like networking meetings which were very helpful (2) to discuss how we are working with what works well what doesn't work and then elena and you also came here (.) with elena we have lots of er (.1) meetings as well

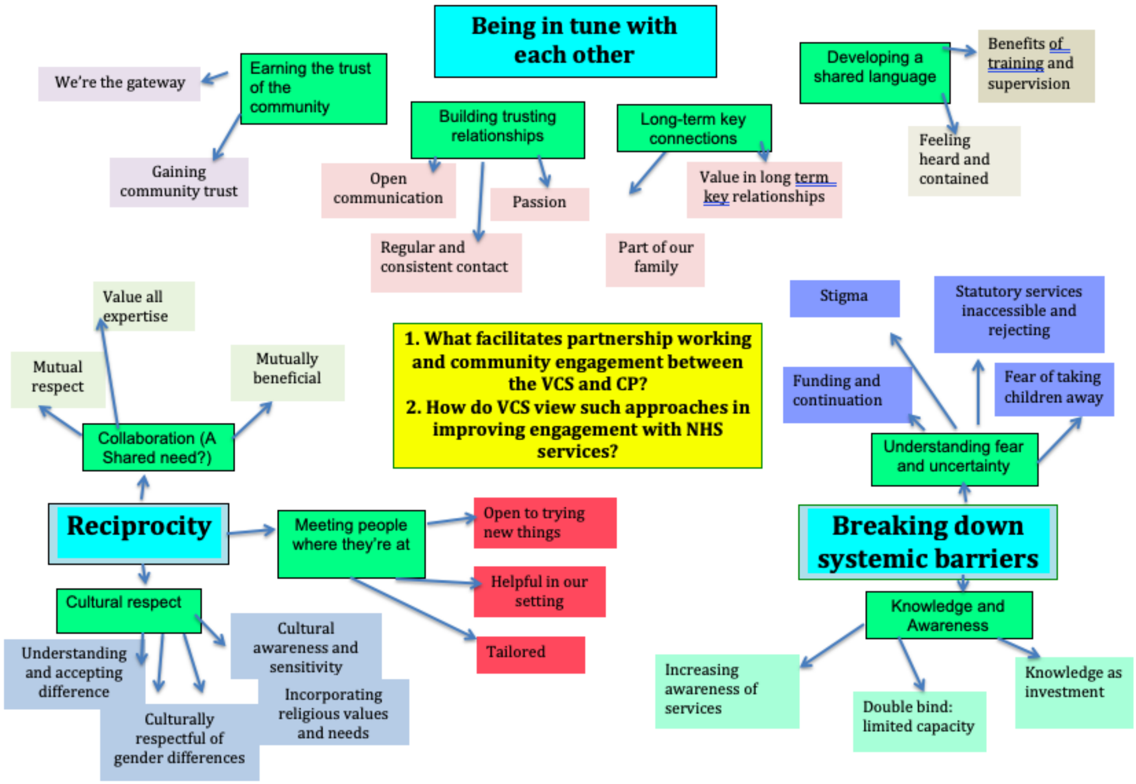
Actual contact time recognised as important

Appendix Q: Provisional Thematic Maps

Thematic map 1



Thematic map 2



Appendix R: Final Thematic Map