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EQUALITY, DIVERSITY AND INCLUSION

Improving mental healthcare access and experience for people from minority ethnic groups: an England-wide multisite experience-based codesign (EBCD) study

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ABSTRACT

Background Long-standing ethnic inequalities in access and mental healthcare were worsened by the COVID-19 pandemic.

Objectives Stakeholders coproduced local and national implementation plans to improve mental healthcare for people from minority ethnic groups.

Methods Experience-based codesign conducted in four areas covered by National Health Service (NHS) mental health trusts: Coventry and Warwickshire, Greater Manchester, East London and Sheffield. Data were analysed using an interpretivist–constructivist approach, seeking validation from participants on their priority actions and implementation plans. Service users (n=29), carers (n=9) and health professionals (n=33) took part in interviews; focus groups (service users, n=15; carers, n=8; health professionals, n=24); and codesign workshops (service users, n=15; carers, n=5; health professionals, n=21) from July 2021 to July 2022.

Findings Each study site identified 2–3 local priority actions. Three were consistent across areas: (1) reaching out to communities and collaborating with third sector organisations; (2) diversifying the mental healthcare offer to provide culturally appropriate therapeutic approaches and (3) enabling open discussions about ethnicity, culture and racism. National priority actions included: (1) co-ordination of a national hub to bring about system level change and (2) recognition of the centrality of service users and communities in the design and provision of services.

Conclusions Stakeholder-led implementation plans highlight that substantial change is needed to increase equity in mental healthcare in England.

Clinical implications Working with people with lived experience in leadership roles, and collaborations between NHS and community organisations will be essential. Future research avenues include comparison of the benefits of culturally specific versus generic therapeutic interventions.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Long-standing ethnic inequalities in mental healthcare exist.
⇒ The pandemic has widened these.

WHAT THIS STUDY ADDS

⇒ Initiatives to reduce inequalities have not delivered expected gains.
⇒ We developed concrete implementation plans for priority actions with stakeholders.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Substantial change is needed to increase equity in mental healthcare.
⇒ Our implementation plans for priority actions present many avenues for testing organisational and service-based changes.

INTRODUCTION

Long-standing inequalities in access to and experience of mental healthcare exist between minority ethnic and white British populations.[1] Individuals from UK minority ethnic groups are more likely to be detained under the Mental Health Act and receive restrictive and coercive interventions.[2] Other inequalities in mental healthcare include failure to discuss cultural or religious factors, or provide accessible information to ensure informed consent on treatment.[1]

In a recent meta-ethnography of 66 studies, Bansal *et al*[3] explored mechanisms underpinning ethnic inequalities in mental healthcare. They found that current models of statutory mental healthcare are experienced as a major barrier for people from minority ethnic groups due to the dominance of a monocultural framework of assessment and treatment. The lack of holistic frameworks in mental healthcare is experienced as epistemic injustice, especially for individuals who attribute their mental illness to experiences of migration, racism and trauma. Cultural stigma, fear of harm and discrimination, and negative experiences within mental healthcare (including direct experiences of racist practice) contribute to avoidance of, and disengagement from, mainstream mental healthcare. The COVID-19 pandemic widened these disparities.[4]

People from minority ethnic groups struggled more with their mental health than white British people during the pandemic, experiencing increased

levels of anxiety, stigma and racism.[5] While the COVID-19 pandemic has placed further pressure on mental health and social care systems, it has also heightened awareness of the importance of reform and evolution of public health systems.[6] The observed pandemic impacts add urgency to the need for appropriately responsive strategies to improve mental healthcare access and experience for those from diverse ethnic groups.

National initiatives to reduce ethnic inequalities in mental healthcare have not delivered expected gains.[3] Lack of progress has been attributed to the absence of authentic and meaningful coproduction, and insufficient adoption of existing recommendations within services.[3] To maximise impact, it is key to ensure significant involvement of service users, carers and front-line staff throughout the research process,[3] to produce relevant and actionable implementation plans. We selected experience-based codesign (EBCD) to develop priority actions based on stakeholder experiences and input across four diverse study sites. Research was embedded in local systems to ensure that local decision makers were part of the process, and priority actions were tailored to the contexts. We then compared priority actions across study sites to draw generalisable insights.

METHOD

The aims were to identify priority actions, and to codesign local and national implementation plans, to improve access to and experience of mental healthcare for people from minority ethnic groups. We had the following specific objectives:

1. To understand stakeholders' views on priory actions as highlighted by their experiences of mental healthcare before and during the COVID-19 pandemic.
2. To identify stakeholders' top five site-specific priority actions at four different sites.
3. To codesign local implementation plans for the top two-to-three site-specific priority actions, at the four different sites.
4. To codesign national implementation plans for the top two national priority actions jointly chosen by stakeholders from across the four specific sites.

We used multisite EBCD. EBCD is an effective approach for codesigning health service improvements.[7] Adaptations were incorporated for the mental health setting (eg, using 'actors' to develop videos summarising themes from stakeholders' experiences' rather than audiovisual recordings of the interviews) and online delivery (eg, 'breakout rooms' for one-to-one support). The study was conducted in parallel across four geographical areas, each covered by National Health Service (NHS) mental health service providers. Areas were selected to capture ethnic diversity across England and variations in deprivation. The study ran from July 2021 to July 2022.

Use of terminology

As per government guidelines,[8] we selected the term 'minority ethnic' to include all ethnic groups (excluding white British), accepting that preferences on terminology vary, and that we would not be able to include participants from all the ethnicities included under this umbrella term. For example, we were unable to recruit any white Roma participants despite our best efforts.

Participants and recruitment

Participants were recruited using purposive sampling according to the following eligibility criteria:

- Service users: over 18 years old; from a minority ethnic group; used mental health services in the previous 5 years; resides in one of the study areas.
- Carers: over 18 years old supporting a service user (from a minority ethnic group) who has used mental health services in the previous 5 years; resides in one of the study areas.
- Mental health professionals: NHS clinician or senior manager, or community or voluntary sector worker, or commissioner (any ethnicity); works in one of the study areas.

Study sites were selected in different geographical areas covered by NHS mental health trusts (ie, Coventry and Warwickshire, Greater Manchester, East London and Sheffield). Areas were selected to reflect diversity across England including differences in urbanicity/rurality, deprivation and ethnic composition. Each trust provides care to a wide geographical area with large urban populations and also rural (or semirural) areas. As a crude indicator, London is the most ethnically diverse region (57.5% minority ethnic population) followed by Manchester (51.3% minority ethnic population), Coventry (44.7% minority ethnic population) and Sheffield (25.5% minority ethnic population).[9]

Site leads were situated in each of the four study locations and the peer researchers covered two sites each to facilitate recruitment and anchor local people as a key part of the broader research team. The research team worked closely with clinical studies officers at each site to ensure recruitment from a wide range of NHS services and local voluntary organisations. We followed Point of Care Foundation guidelines[10] for the recruitment of participants across the EBCD process (ie, eligible participants who had taken part in preceding stages of the study were invited to take part in subsequent stages of the study). Participant numbers were bolstered through the recruitment of new participants at each stage of the study. We endeavoured to achieve good retainment of participants throughout the three stages of the study through the following processes: regular reminder texts and emails, provision of preparatory materials; prompt payment (shopping vouchers) with thank you letters and regular feedback on study results.

Written (or verbal where restrictions applied) consent was obtained from participants for each activity (ie, interviews, focus groups (FGs), coproduction workshops).

Patient and public involvement

The Lived Experience Advisory Panel (LEAP) members were selected from the four study sites on the basis of: (1) having experience of using mental health services and (2) being able to usefully contribute to the study. LEAP members were black, black-Caribbean, African and South Asian. The LEAP was chaired and managed by a coapplicant and peer researcher, both of whom had lived experience of mental health distress as a consequence of racism. Convening six online meetings, the LEAP provided 'critical friend' discussion regarding ethical, recruitment, procedural and acceptability issues. LEAP members were offered the opportunity to contribute to the development of a conference presentation, participate in the filming of the videos summarising themes from stakeholders' experiences,' and share their experiences at dissemination workshops.

Research team

The core research team comprised two peer researchers, three research psychologists (programme manager, research assistants), and a clinical and academic psychiatrist (chief investigator). All researchers received group (ie, PowerPoint presentation by chief investigator with role play practice)

and individual (ie, one-to-one mock interview with the programme manager) interview training. Researchers were provided with an interview checklist and distress protocol, and a script for the FGs. Two researchers (one peer, one psychologist) attended the Point of Care Foundation EBCD training. Researcher team meetings were held weekly to discuss progress, and understandings of emerging findings (eg, themes from the interview data). One peer researcher left the project early but contributed to the analysis of interview transcripts. The wider team included experts in mental healthcare, qualitative methodologies, behavioural and organisational sciences, general practice and social care, and senior lived experience advisors.

Study stages

Figure 1 outlines study stages and includes details on participants. Due to the interactive nature of the study, we took an interpretivist–constructivist approach,[11] directly checking themes with participants, and asking them to validate their priority actions and implementation plans.

Objective 1: interviews to understand stakeholders' views on site-specific (local) priory actions

Trained researchers (three research psychologists and a peer researcher) conducted semistructured one-to-one interviews with service users, carers and mental health professionals to gather their views on priority actions for improving mental healthcare for people from minority ethnic groups. Topic guides covered: (1) experiences of mental healthcare prior to the pandemic; (2) experiences of the impact of the pandemic on mental healthcare; (3) participant's views on priority actions for improvements in mental healthcare and (4) participant's suggestions for improvements in mental healthcare. This paper focuses on priority actions for improvement. Most interviews (n=69) were conducted remotely via MS Teams or telephone. Two participants were interviewed face to face. Interviews were conducted in English, audiorecorded and transcribed verbatim. The data were analysed, and themes identified; these themes became the inputs for the FGs. Details of the analysis are provided later.

Objective 2: FGs to identify stakeholders' top five site-specific (local) priority actions

Two research psychologists and a peer researcher conducted two separate online FGs (service users and cares; mental health professionals) per site to compile eight lists of site-specific priority actions (one from service users and carers; one from mental health professionals). FGs lasted approximately 1.5 hours and were audiorecorded and transcribed. We used a nominal group technique (NGT) within our qualitative FGs. Due to its transferable methods, the NGT has been applied to FGs in different domains,[12] as a useful approach for helping to identify and prioritise outcomes that are important to stakeholders.[13] Further, this approach enabled us to limit the influence of the researchers and encourage equal participation from group members.[14] Sessions proceeded as follows: (1) presentation of priority actions from interview data; (2) participant voting on their top five priority actions and (3) discussion on votes to reach a group decision on the top five local priority actions to take forward. The facilitators guided discussions (eg, offered brief recaps), but were careful not to influence selections. Priority action lists were sent to the LEAP to check for omissions and explore whether priority actions resonated with their lived experiences. Using the local priority action lists, we created four (one per site) videos summarising themes from stakeholders' experiences' to present at the beginning of the first codesign workshop. The videos were created using 'actors' (ie, members of the LEAP and research team) who read verbatim quotes from the stakeholders' interviews to illustrate the priority actions selected at each site.

Objective 3: codesign workshops for the development of site-specific (local) implementation plans

We conducted three joint (service users, carers and mental health professionals) online codesign workshops per site (12 in total) to select stakeholders' two-to-three most pressing local priority actions, and develop detailed implementation plans for these priority actions. Two research psychologists and a peer researcher attended each codesign workshop alongside the chief investigator and/or a behavioural scientist who facilitated the group. We kept a track of group discussions using online slides to organise ideas visually and identify emerging themes. Each workshop was audiorecorded. Before each session, an agenda and summary of the previous week's results was distributed to participants.[10] Following advice from the LEAP, we conducted one-to-one participant feedback sessions using an amended version of the Point of Care Foundation joint-patient-staff-event feedback form[10] to explore whether we were creating space for conversations about racism to surface.

Objective 4: codesign workshop for the development of the national implementation plan

We conducted one national codesign workshop. Two research psychologists, the chief investigator and lead behavioural scientist (who facilitated) attended the online cross-site codesign workshop to identify national priority actions. Participants from all four sites attended (figure 1).

Theoretical framework and analytical approach

Interview data

Data were analysed using NVivo V.12 Pro. Rapid framework analysis was used to develop priority action themes for the FGs. Framework analysis is not aligned with a particular theoretical approach. We selected the framework approach as it facilitates data analysis with a large number of participants in a rigorous, transparent and logical process, and is especially suited to research with a limited time frame and specific questions.[15] Further, we were able to use the framework matrix (ie, grid organising participant by row and subtheme by column) to compare and contrast responses from different stakeholders and sites.[16] This enabled us to compile site-specific priority action lists. CW developed the code book in parallel to data collection to enable sharing of emerging findings with the research team, and provide a basis for the rapid analysis.[17] We adopted an inductive approach through the development of data driven (open) codes, assigning labels to meaningful units of text. Codes were organised under main categories aligning with the interview topic guide.[17] A proportion (~10% each) of transcripts were independently coded by two research psychologists and two peer researchers to check for omissions, and refine code book definitions following group discussion. In the second stage of the process, CW developed four separate matrix tables (organised into participant×priority themes) to enable rapid qualitative analysis.[18]

Figure 1. Overview of study structure and process including objectives, sample characteristics, and key outputs (MH= mental health; F=female; M=male)

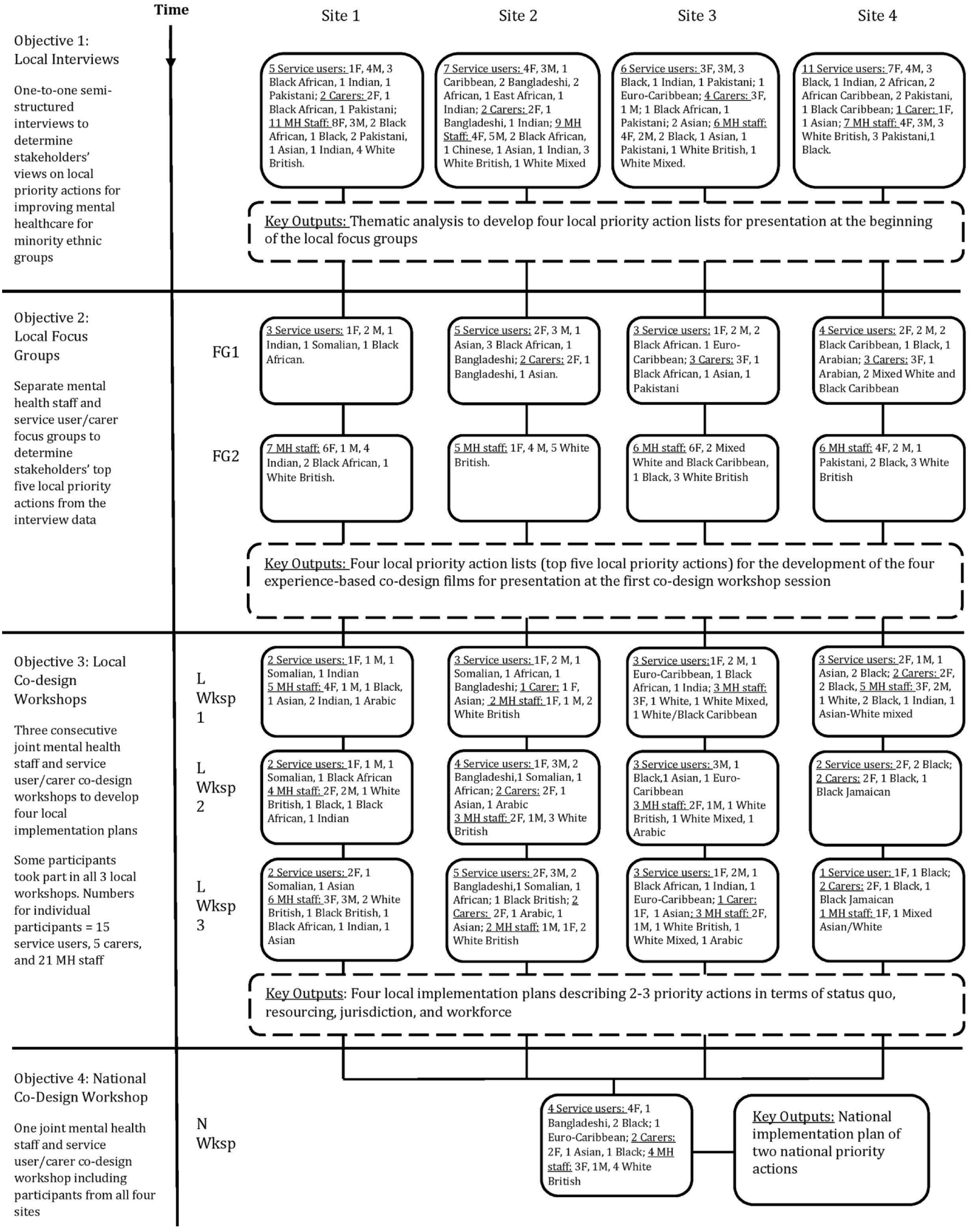

Figure 1 Overview of study structure and process including objectives, sample characteristics and key outputs.

Table 1 Local priority actions from the interview data selected in the separate focus groups

Local priority actions derived from the interviews (sites reporting specific priority actions in interviews)	Focus group selections							
	Site 1		Site 2		Site 3		Site 4	
	SUs/carers	MHPs	SUs/carers	MHPs	SUs/carers	MHPs	SUs/carers	MHPs
Increasing staff diversity across all roles (1, 2, 3, 4)		√	√	√		√	√	√
Greater involvement of lived experience and community groups to improve care (1, 2, 3, 4)	√				√	√	√	√
Training to increase awareness and knowledge of ethnicity and cultures (1, 2, 3, 4)		√	√*		√	√	√	
Enabling open discussions about race, ethnicity and culture (1, 2, 3, 4)						√	√	√
Reducing preconceptions, prejudices and discriminatory actions (1, 2, 3, 4)	√		√*			√		√
Early education to increase awareness and reduce stigma (1, 2, 4)	√	√	√	√			√	
Providing opportunities for minority ethnic service users to engage in peer-support (1, 2)		√	√	√				
Reaching out to communities to improve awareness and reduce stigma (1, 2)	√	√	√	√				
'Not forgetting the person' (person-centred care) (1, 3)	√				√			
Exchanging knowledge with community groups (4)								
Working and communicating with carers and families (3)					√			
Increasing community groups and services in accessible areas (4)								
Including ethnicity and personal narratives in clinical assessments and care (4)								√
Providing culturally sensitive care and assessments (2)			√*	√				
Increasing collaboration with primary care (2)								
Increasing resources for inclusivity (3)								

*Three priorities had the same number of votes, so participants elected to merge them into one all-encompassing priority action.
†Some of the selected priority actions had changes in wording following group discussion.
SUs, service users; MHPs, mental health professionals.

FGs and codesign workshops

Priority actions from interview data were presented in FGs at a local level at the four different sites. Participants then discussed the priority actions, were asked if any were missing, and were invited to reframe priority actions to accurately represent local needs. Following the FGs, the agreed priority actions were sent to all participants for review. The priority actions were reviewed in codesign workshops, and developed into implementation plans for the top 2–3 selected priority actions. At the end of each codesign workshop, the tasks completed during the session were presented to the participants online for verification. Following each codesign workshop, a summary of results was emailed to participants, offering an opportunity for comment and amendment. Final implementation plans (four local, one national) were sent to each participant for verification and were discussed in detail at the dissemination workshops.

RESULTS

We present the results of the study sequentially aligning with our four research objectives described above: (1) to understand stakeholders' views on priority actions; (2) to identify stakeholders' top five site-specific priority actions; (3) to develop site-specific implementation plans for the top two-to-three site-specific priority actions and (4) to identify national priority actions and related implementation plans.

Objective 1: stakeholders' views on site-specific (local) priority actions at four different sites

Local priority action themes are presented in column 1 of table 1. There was considerable overlap in priority actions across areas, and some site-specific priority actions. We observed five common priority action themes across sites: (1) greater involvement of lived experience; (2) increasing staff diversity across all roles; (3) training to increase awareness and knowledge of ethnicity and cultures; (4) enabling open discussions about racism, ethnicity and culture and (5) reducing preconceptions, prejudices and discriminatory actions.

Greater involvement of lived experience

Mental health professionals described the importance of codesigning services.

> Whilst we're making a little bit of headway with how we support staff; I think with service users we're so far behind and that's because we're not including them in conversations about how we're shaping services. (Professional_p16, site 1)

Service users felt that their views and experiences could help improve access and mental healthcare.

> I feel like if people were to understand why we don't reach out for that help, and why we don't feel as though we can reach out, or why it's such a bad thing, maybe they'd be more understanding on both sides. (Service user_p16, site 4)

Increasing staff diversity across all roles

Mental health professionals and service users highlighted the need for more diverse staff teams, including in senior positions.

> So, I think more Asian staff, having a more multicultural staff. We are all very white from [area name removed.] (Professional_p1, site 3)
> We've got a woman Chief Executive at last but before that it was all white male. Still, if you look at all the finance departments, the forensic departments, it's all white. (Service user_p1, site 4)

Training to increase awareness and knowledge of ethnicity and cultures

Mental health professionals, service users and carers described the importance of carefully planned training to provide in-depth knowledge and noted that current NHS training was 'generic' and 'tokenistic.'

> I think there are huge gaps in training. I think they're more a tick box exercise—you get the notification on the hub, and you can skip

> right to the end and fill out your questions without even reading anything. I think if trusts and NHS generally are serious about making changes to accessing healthcare for ethnic minorities, and improving the work environment for BAME colleagues, I don't think that an exercise, a tick box activity really captures the nuances of the experiences these people go through. (Professional_p18, site 3).

Enabling open discussions about racism, ethnicity and culture

Service users described feeling uncomfortable discussing issues pertaining to racism and ethnicity within the mental health setting.

> I only felt brave enough to briefly mention it and I know she was apologetic….so I didn't….It is hard to bring up these things because you get shut down so much when you bring those things up… "Are you sure though…" and the fact that it was so below her consciousness (Service user_p19, site 4).

Mental health professionals also highlighted barriers to discussing ethnicity and racism within the healthcare setting.

> When I've trained and when I've had colleagues, that's been stuff that white health professionals traditionally find really difficult to ask, because people don't want to offend, people don't want to harm. (Professional_p4, site 4)

Reducing preconceptions, prejudices and discriminatory actions

Mental health professionals, service users and carers described the importance of challenging stereotypes and prejudices and resisting the tendency to 'lump' different ethnicities together.

> I think again for me it's really just imploring the experts not to bundle people into groups, so you know, 'this is typical of this group' or 'this is typical of this group'… (Carer_p11_site 1).
> …. staff members are still quite far behind in terms of thinking about anti-racist practice. So, there's a lack of accountability in the trust and in terms of the practitioners, how we work (Professional_p16_site 1).

Objective 2: stakeholders' top five site-specific (local) priority actions at four different sites

FG selections for each site are shown in columns 2–9 of table 1. The most commonly selected priority actions were increasing staff diversity across roles (n=6), greater involvement with lived experience and community groups (n=5), training to increase awareness and knowledge of ethnicity and cultures (n=5), reaching out to communities to improve awareness and reduce stigma (n=4), reducing preconceptions, prejudices and discriminatory actions (n=4) and early education/working with schools to increase awareness of mental health and reduce stigma (n=4).

Feedback on site-specific priority actions from the LEAP

The LEAP did not highlight any important omissions in the local priority action lists. Four priority actions particularly resonated: (1) providing opportunities to engage in peer support; (2) increasing staff diversity across roles; (3) greater involvement with lived experience and (4) enabling open discussions about racism, ethnicity and culture. It was noted that being asked about experiences of racism and discrimination was 'validating' and 'cathartic', and that 'talking about the elephant in the room' is crucial for an authentic treatment experience. The panel discussed the importance of improving recruitment processes (eg, including people from minority ethnic groups on recruitment panels) and providing mentoring and enhanced support (eg, training on how to tell your story).

Objective 3: site-specific (local) implementation plans developed for the top 2–3 site-specific priority actions

Full local implementation plans are provided in online supplemental tables 1–4. We identified three overlapping priority action themes across sites: (1) reaching out to communities and collaboration with third sector organisations; (2) diversifying the mental healthcare offer to include more culturally appropriate therapeutic approaches and (3) enabling open discussions on ethnicity, culture and racism through the creation of safe spaces. Study sites 1, 2 and 3 discussed community initiatives including the development of 'community-centred networks,' 'hubs' or 'community safe spaces.' Community-centred actions included educational campaigns (sites 1 and 2) for youths and their families to promote mental well-being and help-seeking with a focus on cross-cultural approaches 'irrespective of colour, gender or race' to encourage integration. Diversification of the mental healthcare offer included the provision of information and resources on non-pharmacological peer-led treatments (site 2) and increasing diversity across staff teams including in leadership roles (site 4). Participants envisioned the NHS and community groups working together to share information and resources (eg, training, venues). It was suggested that community 'hubs' could act as mediums for integration between agencies to develop common initiatives through shared budgets. Participants described actions to promote open discussions on ethnicity, culture and racism including educational campaigns (site 3) and the introduction of more effective diversity and inclusion training (site 4).

Participant feedback on the local codesign workshops

Seven out of eight of the participants interviewed felt that they were able to speak freely about their experiences of discrimination and racism during the first workshop session.

> I felt very comfortable discussing my feelings on racism and discrimination, easily. You know, it was quite a mixed group, and everyone was being open and honest. It was quite easy to talk about.' (Service user_p1, site 4).

One participant described censoring their speech regarding tackling racism for fear of being 'argumentative.' In subsequent workshops, the facilitator tried to further encourage open discussions around racism and discrimination.

Objective 4: national implementation plan developed for the national priority actions

Participants described the need for a radical approach. It was stated that: 'there is nothing wrong with going for the big issues,' and to change the system, we need to 'go for the throat' and 'open Pandora's box.' Participants agreed on two actions: (1) co-ordination of a national hub bringing together existing organisations (eg, Royal colleges) and agencies (eg, Synergi Collaborative Centre) to facilitate system level change; and (2) recognition of the centrality of service users and communities in the design and provision of services. The national implementation plan is presented in online supplemental table 5.

DISCUSSION

The consistency of key priority actions offers valuable generalisable insights. However, most actions were site-specific and even consistently reported priority actions, such as reaching out to communities, will vary in their delivery according to local context.

Community outreach requires the development of place-based partnerships between minority ethnic third sector organisations and NHS provider services to bridge relationships where trust is eroded.[19] The inception of the NHS Integrated Care Pathways can help facilitate these partnerships.[20] Implementation plans should include knowledge of a rapidly changing third sector landscape, and consideration of the most appropriate funding arrangements and of jurisdiction for managing risk and accountability. These plans should be mindful of the tension between bureaucratic constraints and relational processes (eg, importance of trust building in community engagement work).[21] Community engagement would increase understanding of local needs, centrality of lived experience, and creativity in reshaping the care system.[22]

Diversification of mental healthcare was envisaged to have to focus on increasing staff diversity, particularly in managerial roles and on provision of non-pharmacological, culturally sensitive treatment options.[3] Inequalities in leadership and professional development within the NHS[23] could be reduced through regulated supervision, reverse mentoring, redefinition of lived experience roles and anti-racist policy. Plans to enable open discussions on racism, inequalities and ethnicity centred on the provision of interactive diversity and inclusion training, and educational campaigns for communities and professionals. Mental health professionals and service users observed an overemphasis on 'correct phrases and terminology,' leading to self-censoring and uncomfortable conversations or a 'watering down' of discussions.[24] Dialogical 'safe spaces'[25] could encourage reflections on discrimination and racism, and the language and structures that can maintain them.

The national codesign workshop proposed a system level change spearheaded by a social movement bringing together national-level agencies and organisations and key grassroots organisations (eg, Synergi[26]) to ensure the centrality of communities and lived experience within the movement. This social movement could influence socio-political climate[1] and NHS reforms. However, it will be important to retain independence from local and national political cycles to benefit from longer term stability and to be guided by community priorities and needs and evidence, rather than ideology.

Study strengths include the multisite design enabling development of specific implementation plans created from multiple stakeholder views and the lived experience component which was embedded within our design. By selecting four case study sites in different parts of England, we were able to make generalisable conclusions considering priority action overlaps developed at each individual region.

The study has limitations. While we endeavoured to recruit a full range of ethnicities covered by the umbrella term 'minority ethnic, most service user and carer participants identified as having black or South Asian heritage and were recruited in urban areas. Therefore, the extent to which findings are transferable to other ethnic backgrounds including Romany and Chinese, or rural areas is unclear. Previous studies indicate that individuals from other minority ethnic communities (eg, Roma, Chinese) experience similar barriers to those from black and South Asian backgrounds including poor mental health awareness, stigma and distrust.[27 28] Indeed, during the interviews, mental health professionals reported similar themes (concerning access and engagement) in their work with Romany and Chinese ethnic groups indicating that findings (in terms of priority actions) are also relevant to these groups. Despite sourcing interpreters for our study, we were unable to recruit any participants who were not fluent in English. It should be acknowledged that language is a key barrier to service access and engagement. Group work to develop priority actions could have deterred some participants from taking part. By conducting one-to-one interviews first, we collated a broad range of views to take forward to group discussions. Most interviews and groups were conducted virtually. This might have hindered some conversations (eg, impacted on building trust), but also increased access and convenience. We were only able to recruit White British mental health professionals for the FGs and codesign workshops at site two. Those professionals had more senior positions than professionals from the other three sites, which could reflect a lack of diversity in senior positions across the NHS, otherwise referred to as 'snowy white peaks'.[29]

Stakeholder-led implementation plans for priority actions highlight that substantial change is needed to increase equity in mental healthcare in England. Some priority actions (eg, collaboration with third sector organisations) might also be relevant to physical healthcare where stark inequalities still exist.[30] Working with people with lived experience in leadership roles to facilitate authentic and meaningful coproduction,[3] and collaborations between the NHS and community organisations will be essential elements in bringing about change. Knowledge gaps remain regarding what constitutes culturally appropriate interventions for people from minority ethnic groups. In view of service user demand for non-pharmacological interventions, we need more randomised controlled trials involving ethnically diverse samples. Promising avenues for testing include the use of nature and creative therapy as antioppressive approaches,[3] and narrative therapies such as the 'Tree of Life' model to provide a more holistic model of care.

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