

# **Experiences of severe and multiple disadvantage within ethnically diverse communities in Nottingham.**

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## Executive Summary

This is the first research study to specifically document the experiences of severe and multiple disadvantage in ethnically diverse communities in Nottingham. Nottingham is a city with some of the poorest wards in the country and has a rapidly evolving, ethnic diverse community. Severe and multiple disadvantage is the term given to people who are experiencing a combination of problems relating to substance or alcohol addiction, homelessness, mental health or are engaged with the criminal justice system. Previous studies have suggested that these problems tend to affect white men more than other groups. Yet, experience from practice suggests otherwise and women and people from ethnically diverse communities are also affected but tend to not be as visible in the systems of support currently available. The purpose of this research was to understand more about the experiences of people from ethnically diverse communities, to see what services they need and how services can be better equipped to respond.

In this report we document how we approached the problem. First, we wanted to know whether the existing frame of reference for understanding severe and multiple disadvantage was suitable for people from ethnically diverse communities. We interviewed people from a wide range of communities in Nottingham who were already using services in the non-statutory and statutory sectors. We also interviewed professionals from within the services provided locally, many of whom are experts by experience to get an insider perspective on existing provisions. We also conducted analysis on existing service use data to understand whether there was any difference in the chances of accessing a service once a referral had been made.

Firstly, we found that if a person from an ethnically diverse community was referred to a specialist severe and multiple disadvantage service, they were no less likely to be accepted for support. This showed us that the issues to be addressed were further upstream. Whilst there is much overlap in the experiences of severe and multiple disadvantage across the ethnically diverse community in Nottingham, a crucial difference also appeared within the interviews. People from ethnically diverse communities reported that coming from an ethnic minority group resulted in experiences of racism. Racism was often a traumatic experience and the major theme of racial trauma was presented as a significant form of severe disadvantage that should be added to the existing definition.

We also found that services were sensitive to racial trauma with workers in key positions able to show a deep understanding informed by lived experience. However, these were few and our interviews showed how further work is required in staff development, training, and recruitment will help address the needs of people from ethnically diverse communities and recognise racial trauma as a distinct form of disadvantage.

Following this report, we recommend that racial trauma be addressed in all assessments of severe and multiple disadvantage. We propose that the definition for severe and multiple disadvantage be changed to recognise the distinctly severe disadvantage caused by racial trauma. We suggest that services incorporate training on racial trauma into their ongoing equality and diversity strategies making staff aware of the effects of racial trauma within the group of people seeking help for severe and multiple disadvantage.

Our hope is that this report becomes a stimulus for further research and development around severe and multiple disadvantage especially with ethnically diverse communities. We would like to thank all of the people who participated in this research, the participants who we interviewed and attended focus groups, the steering group members and the service managers that facilitated access to participants.

## Introduction

We are pleased to submit this report of our research which investigated the experiences of severe and multiple disadvantage (SMD) within ethnically diverse communities in Nottingham city. The research was commissioned by Nottinghamshire Healthcare NHS (National Health Service) Foundation Trust, NHS Nottingham and Nottinghamshire Integrated Care Board and Nottingham City Council.

Based on the current definition for Severe and Multiple Disadvantage (SMD), researchers have attempted to scope the extent of SMD within the population. The reported levels of SMD are based on estimates in the Lankelly Chase Foundation report *Hard Edges: Mapping severe and multiple disadvantage* (Bramley & Fitzpatrick et al, 2015) and suggests that the number of people experiencing a combination of homelessness, substance misuse and involvement with the criminal justice system in England, reaches around 58,000 people in any one year; they also estimated the number increases to over a quarter of a million when facing just two of these three problems. The Lankelly Chase Foundation report suggests that SMD is unique from other forms of exclusion due to the degree of stigma attached to, directed at, or experienced by people in this group. Those people, according to the report, are most likely to be white men aged 25-44, who have experienced significant childhood trauma that has its roots in family and educational experiences.

Highlighting the effects of stigma and traumatic childhood experiences are important as they orient attention to the social processes involved with the experiences of disadvantage rather than foregrounding the behavioural consequences that locate the problem within individuals. However, whilst Lankelly Chase Foundation Report highlights the unique problems facing people experiencing SMD due to stigma and exclusion, little is offered by way of how and why people may find themselves in the situations resulting in SMD or about the ways that SMD might be experienced differently between different groups of people.

Considering the finding that white men appear to disproportionately experience SMD, a more recent report, *Gender Matters* (Sosenko, Bramley, & Johnsen, 2020) looked specifically into women experiencing SMD. This study presents a nuanced and detailed analysis of hidden groups of men and Black, Asian, and other Minority Ethnic groups. The *Hard Edges* report defined SMD using involvement in the criminal justice system as a form of disadvantage; the *Gender Matters* report, used a definition for SMD that included violence and abuse within the home. This meant women are at least as equally represented as experiencing disadvantage as men, and the overall figures are estimated to rise to approximately 336,000 people (in England) being affected.

As these two reports highlight, there is a need to know more about the experiences of SMD within ethnically diverse communities. Growing by 5.9% in the last ten years, the population of Nottingham is diverse and increasingly multicultural. The Office for National Statistics (2023a) reported on the 2021 Census showing that the population identifying as Black, Black British, Black Welsh, Caribbean or African increased to 10% of the local population up from 7.3% since the last census. The population in Nottingham who identify as being in the White ethnic group fell by 5.6% to 65.9% (down from 71.5% in 2011), people from Asian, Asian British, or Asian Welsh ethnicity increased to 14.9% (up from 13.1%). Those identifying as mixed or multiple ethnic identity fell slightly (by 0.7%) to 5.9%. Added to this, between the 2011 and 2021 Census, the proportion of residents in Nottingham identifying as Muslim increased by almost 50% (up from 8.8% to 12.2%) with fewer people reporting to be Christian and more people reporting to have no religion. As the cultural and ethnic identity of Nottingham's demography changes, understanding the needs within diverse communities is essential for a healthy and more prosperous city; this includes the need to understand how SMD is experienced and constructed within ethnically diverse communities.

Ranked in the lowest 10 percent of local authorities when it comes to population health, according to a report released last year (ONS (Office for National Statistics), 2023b), Nottingham city Health Index scores report the second amount of worsening score for physical health in England. Considering health related to behavioural risk factors, including drug and alcohol misuse, Nottingham scores lower than England as a whole. The picture is also poor when it comes to mental health, crime, and access to housing, all of which remained well-below the national average. Taken together the combination of alcohol or substance misuse, mental health difficulties, homelessness, and being a victim of or involved in the criminal justice system as criteria constituting SMD, there is a strong likelihood that Nottingham has higher levels of people experiencing SMD than many other parts of England.

It is recognised that people experiencing SMD should have a voice in how the concept is defined (Rose & Thornicroft, 2010), the services that are provided and the ways that scholarly work represents them (Sandhu, 2020). To date, voices within ethnically diverse communities have not been sufficiently represented in these ways and this report is intended to give a voice to the experiences of people within ethnically diverse communities who experience severe and multiple disadvantage.

## **The current state of SMD in Nottingham**

The combination of problems referring to SMD has not been static, and definitions have changed over time (Parker & Bullock, 2017). The group of adults currently considered to experience SMD will face issues of alcohol and/or substance misuse, homelessness, mental health problems and being a victim of violence or abuse or being in the criminal justice system. These are

problems that in combination or accumulatively have long been recognised within healthcare as a nexus of complex and challenging needs. In 2014, a Big Lottery funded project named Fulfilling Lives featured a range of partnership projects across England. In Nottingham, this was led by the Opportunity Nottingham project and has since been replaced by the Changing Futures service. Changing Futures has developed its practices incorporating much of the learning from the Fulfilling Lives project evaluations and is currently serving the local SMD population.

Whilst looking into SMD within ethnically diverse communities as part of the Fulfilling Lives funded Opportunity Nottingham project, a report by Everitt and Kaur (2019) suggested that Nottingham might have around 5,348 people experiencing SMD. In the same report, it was acknowledged that this is likely a conservative estimate due to hidden cases attributable to under-detection of SMD in ethnically diverse communities. There are several reasons why this might be the case. One prominent issue is the existing approach to categorising SMD does not reflect or is not sensitive to the ways that disadvantage is experienced within ethnically diverse communities. For example, it is understood that homelessness is experienced differently within Asian communities (Bramley, Fitzpatrick, McIntyre & Johnsen, 2022) or that drug use can be affected by cultural norms depending upon the substance being used. Being able to differentiate between such experiences is an important part of practice in this area. Locally this is the responsibility of the specialist navigator role within Changing Futures. These workers have responsibility for completing assessments and are embedded within ethnically diverse communities often providing an insider perspective. However, having skilled and competent people ‘on the ground’ is helpful only as far as the people who need help are being put into contact with the frontline of service provision.

According to the Changing Futures Nottingham interim report, people from Asian and Asian British ethnicity and White Other ethnic groups are very underrepresented within Changing Futures beneficiaries. (Draper 2023)

**Table 1**  
**Demographic Profile of Changing Futures beneficiaries based on ethnicity.**

<b>Ethnicity</b>	<b>Percentage of beneficiaries</b>
White British	71%
Black/Black British	9%
Multi Racial	8%
Asian/Asian British	6%
White Other	3%
Unknown	2%
Other Ethnic Groups	1%

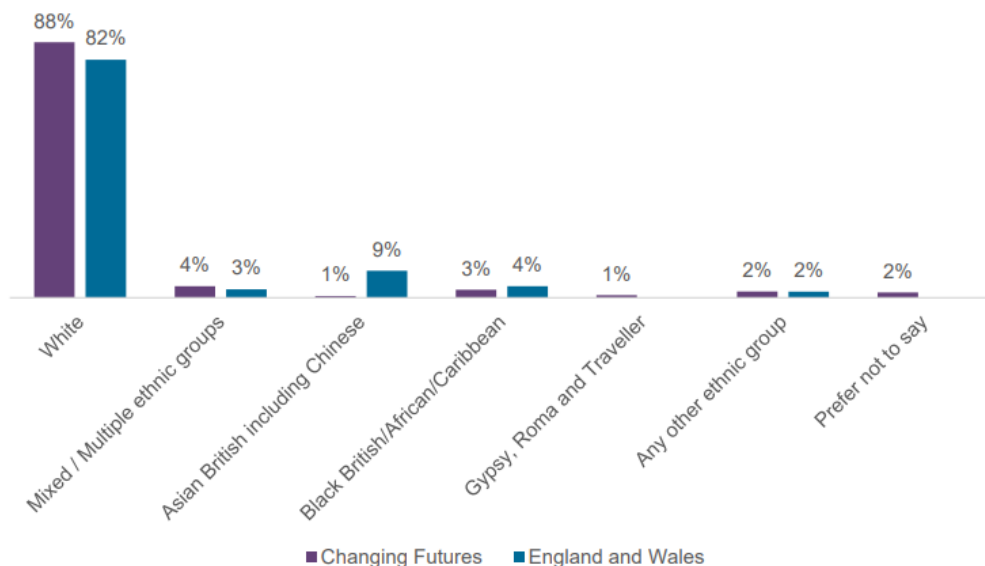
**Table 2.**  
**Ethnic Groups 2021 Census, Nottingham and England**

		<b>Nottingham Number</b>	<b>Nottingham %</b>	<b>England %</b>
<b>All usual residents</b>		<b>323,635</b>	<b>100.0</b>	<b>100.0</b>
<b>White</b>	British	185,580	57.3	73.5
	Irish	2,360	0.7	0.9
	Gypsy or Irish Traveller plus Roma*	1,399	0.4	0.3
	Other White	24,091	7.4	6.3
<b>Mixed or Multiple ethnic groups</b>	White and Black Caribbean	10,129	3.1	0.9
	White and Black African	2,129	0.7	0.4
	White and Asian	3,363	1.0	0.8
	Other Mixed or Multiple ethnic groups	3,442	1.1	0.8
<b>Asian, Asian British</b>	Indian	11,515	3.6	3.3
	Pakistani	21,684	6.7	2.8
	Bangladeshi	2,223	0.7	1.1
	Chinese	4,263	1.3	0.8
	Other Asian	8,532	2.6	1.7
<b>Black, Black British, Caribbean or African</b>	African	18,740	5.8	2.6
	Caribbean	9,339	2.9	1.1
	Other Black	4,136	1.3	0.5
<b>Other ethnic group</b>	Arab	3,673	1.1	0.6
	Any other ethnic group	7,037	2.2	1.6

Source: 2021 Census, ONS Crown Copyright Reserved

Similarly, the baseline report from 2023 by the Department for Levelling Up, Housing & Communities, UK Government, while evaluating the Changing Futures Programme at a national level highlights the following while discussing about the ethnic profile of Changing Futures participants and the 2021 census of the population of England and Wales; (United Kingdom Government, 2023).

## Ethnic profile of Changing Futures participants (base=325) and 2021 census of the population of England and Wales



It is important to note that the underrepresentation of people from minoritised ethnic group may appear less pronounced than it is in reality due to the comparison made with the population of England and Wales as a whole rather than the demography limited to just the Changing Futures areas as a collective.

The reasons for this are important to understand as it is possible people from diverse ethnic communities are more vulnerable to experiencing SMD. For example, there is evidence and well-documented reporting on the higher prevalence of mental health problems in women (McMannus, Bebbeington, Jenkins, Brugha, 2016) and the greater likelihood of engagement in the criminal justice system for men (UK (United Kingdom) Government, 2022) amongst ethnically diverse communities within England.

As the needs of ethnically diverse communities might be greater, so to the challenge to provide adequately accessible forms of services is substantial. Such a challenge would be in line with ‘Hart’s Law’ which, some 50-years after it was first proposed, seems as prescient now as it was then; the law claims that greater disadvantage is inversely related to responses from public services (Hart, 1971) and this is specially the case in areas where there is greater market forces and competition in the provision of services. Applied in this context, it is important to understand whether people from ethnically diverse communities who experience SMD, are benefitting from the services they need and whether services being provided sufficiently understand the needs of the populations they intend to serve.



## **Covid 19 and the impact on SMD in ethnically diverse communities**

Epidemiological studies highlight that Covid 19 disproportionately impacted ethnically diverse and socio-economically disadvantaged communities in the UK, it also exposed multiple areas of inequality in the provision of services. The destabilising effects of the pandemic continue to be felt, further entrenching health, social and economic divides amongst the most vulnerable communities. Immigrant and ethnic minority groups encountered higher rates of infection, hospitalisations, death, serious illness, slower vaccine uptake, in addition to higher rates of job losses and unemployment. This means that the traumatic impact and subsequent destabilising factors will be felt more acutely within these populations (O'Donnell et al., 2023). The data already suggests the pandemic has had a disproportionate impact on groups with lower levels of social inclusion and/or those who traditionally have declined support services (O'Connor et al, 2020), for example (but not limited to) people living in poverty, traveller communities, and people who are homeless, groups where the prevalence of SMD pre-pandemic was much greater.

Studies post-pandemic also highlight the difficulties in reaching members of ethnically diverse communities who are experiencing SMD, one of the consequences of the Covid 19 pandemic was the rise in digital consultations, which further exacerbate the problem of accessibility, trust in services and overcoming communication barriers (Husain et al., 2022). The consequences of the pandemic will continue to impact lives for decades (Katikireddi et al., 2021), it is therefore essential that SMD and its prevalence within Nottingham amongst ethnically diverse communities is understood, with a coherent policy as to how existing statutory and voluntary sector service providers might best serve those impacted.

## **Racial Trauma**

This term encompasses the experience of racial discrimination that is faced by ethnically diverse individuals, or groups, which affect multiple aspects of their lives such as their mental and physical health, education and ability to learn, work and finances, various personal and professional relationships, and even day-to-day interactions and behaviours (Williams & Mohammed, 2013; Dominguez et al., 2008; Epstein, 2005; Gee et al., 2012; Harris & Lieberman, 2015; Hope et al., 2021; Katz & Joseph, 2014; Paradies, 2006; Trent et al., 2019). Such traumatic experiences can and often begin early in life during childhood and result in enduring exposure to the trauma of racial discrimination.

Numerous studies have shown (Carter, 2007; Saleem et al., 2020; Williams, Metzger, et al., 2018) that individuals from ethnically diverse communities rarely identify with only one experience of racial trauma but instead, can base it on 2 categories based on their skin colour which is:

1. **Major racial trauma:** This first category consisted of openly racist remarks by others around them including strangers who they have one-time interactions with or rejections from jobs, access to schools, bank loans etc., that are based on their physical features or characteristics. Additionally, threats or infliction of harm based on an individual's cultural identity (Carter, 2007; Carter et al., 2017; Cénat et al., 2022; David et al., 2019; Hollinsworth, 2006; Kirkinis et al., 2021).
2. **Everyday racial trauma:** This form of racial trauma focuses on daily occurrences of microaggressions and systemic racism that ethnically diverse individuals come to face from living in Western societies. Often this type of trauma is repetitive and detrimental in nature (Nadal, Erazo & King, 2019) and can result in individuals becoming hypervigilant to their surroundings and environment. It is comprised of daily inconveniences, inappropriate comments, and actions or attacks that are racially motivated. (Garcia & Johnston-Guerrero, 2016; Metinyurt et al., 2021; Ogunyemi et al., 2020; Carter & Forsyth, 2010; Cénat et al., 2022; DiAngelo, 2018; Kendi, 2017; Williams, 2020).

In the UK there are few research studies that have looked directly at the experience of racial trauma in a mental healthcare setting, homelessness services or substance misuse services. One study explored the role of educational psychologists working with children who experienced racial trauma in schools and explored the school to prison pipeline as a consequence of racial trauma (Agyeman & Lichwa, 2020). Another considered NHS clinical psychologists' experiences of working with clients who had experienced racial trauma. This study found that effects of racial trauma are often underestimated and discussions about how racism impacts mental health can be omitted (King, 2021). A third study explored the experiences of racially minoritised clients disclosing experiences of racial trauma in psychological therapy in the NHS. Participants shared negative responses from their therapist including insensitivity, ignorance or inability to contain their own emotional responses. Some therapists were able to respond constructively leaving clients feeling validated (Samuel, 2023). Finally, an American study showed elevated scores on the race-based traumatic stress scale were predictive of more risky alcohol use among college students suggesting links between racial trauma and other factors associated with severe and multiple disadvantage (Johnson, Chng, & Courtney, 2023).

Any study that is investigating ethnically diverse communities must consider the syndemic effects of racism and racial trauma, especially when considering the experiences of those severely and multiply disadvantaged through substance misuse, homelessness and violence.

## **Towards a new understanding of SMD**

Definitions and policies develop hand in hand. Policies that inform practice will change and morph considering the changing needs within society and the definitions of target problems will change as the society in which services operate also changes post pandemic. The changing demographic of the population in Nottingham might be happening at a faster rate than the ways in which problems are constructed and services become configured. In addition to this, whilst the collection of problems constructed as SMD might be experienced differently within different communities, services need to continually work to both understand and meet the needs of these communities.

There is much to learn from the broad range of ethnically diverse communities within Nottingham, especially those referred to as emerging communities such as the Afghan, Syrian and Roma which, according to Al-Hurrayya's data, are growing within the city. It is evident from the Census 2021 that Nottingham has some of the highest reported levels of deprivation which, when taken together with the changing demographics within the city, provide a clear rationale for this research investigating the experiences of SMD within ethnically diverse communities.

## **Research questions**

Given the starting point of this research study is to challenge the assumption that the existing definition of severe and multiple disadvantage adequately reflects the experiences or needs of people of ethnically diverse communities, we identified the following research questions:

***RQ 1: What are the major forms of severe and multiple disadvantage for people within ethnically diverse communities in Nottingham and how can understanding these enrich and construct a more inclusive definition for the concept of severe and multiple disadvantage?***

***RQ 2: What is the likelihood of people from ethnically diverse communities accessing SMD services following referral compared to people from white ethnicity group?***

***RQ 3: What range of services are currently providing support and how can existing services adequately adapt to support the SMD needs of ethnically diverse communities in Nottingham?***

## Methodology

We answered the **RQ1** and **RQ3** through a combination of interviews, focus groups together with a survey of local service providers working in the SMD space. **RQ2** was answered using quantitative data provided by Changing Futures. In the following section we outline each part of the study's methods and approach to analysing the data.

### *Participant recruitment*

To address the question of defining experiences of SMD (**RQ1**), we conducted an interview based qualitative study. We recruited 20 participants, these were 10 local service professionals and 10 local service beneficiaries. The aim was to investigate their experiences of SMD within ethnically diverse communities. The objective was to generate a rich qualitative data source to help understand the meaning of SMD within ethnically diverse communities.

All the participants for the interview study were recruited with the help of Al-Hurrayaya using a combination of convenience and snow-ball sampling methods. This began by contacting people who have been the community point of contact for this research study across a range of organisations who regularly partner with Al-Hurrayaya.

The 10 service professionals interviewed were drawn from across the following organisations in Nottingham: Ideal Roma; Nottingham Recovery Network; Afghan Resettlement Scheme; New Hope Rehabilitation; Changing futures; East African Association; Evolve Housing; Islamic 12 Step Program - Al-Hurrayaya; POW and Clean Slate. Accessing the expertise and experience within these organisations was key to developing and building an understanding from a wide variety of perspectives of ethnically diverse communities within Nottingham.

These services are at the interface between statutory services and local communities often reaching people who would not access statutory services for a variety of reasons. To recruit these participants, a joint letter from the project partners was sent to the CEO or head of research within each organisation explaining about the study's aims. Together with the letter, we attached an information sheet setting out the study in more detail, explaining what would be required of their participation and what they might expect from the interview. We also provided information about data protection and GDPR (General Data Protection Regulation). Once we received a positive response, we then provided the participant with a consent form. The consent form contained information to assure the research team that participants had read the information sheet and understood its content and were aware of their right to withdraw from the research at any point until the research is published. All the above was carried out in line with the research ethical approval for the study obtained through the University of Nottingham.

Through the interviews with the 10 service professionals, a snowball method was used to recruit a sample of 10 service beneficiaries from across the organisations represented above. Our sampling strategy was to ask the service professionals to propose a suitable service beneficiary for recruitment into the study based on their understanding of SMD within that community. The research team provided a participant information sheet tailored for service beneficiaries that explained the study and requested that the service professional send this to their proposed service beneficiary. If the service beneficiary became interested in becoming a participant, the research team provided the consent form and further information about data security and GDPR to the service professional who passed these to the service beneficiary; the research team was available to answer any questions about the study and, if the service beneficiary wished to participate, made arrangements for the collection of informed consent and scheduled the interview with them.

To answer RQ3 we also recruited participants to the survey and to the focus groups.

#### ***Survey of local organisations recruitment***

To address the question aimed at understanding the level of need for people experiencing SMD we conducted a small-scale survey. The survey data was used to demonstrate the levels of SMD within the sample population who were already seeking help. The survey was sent out to 30 local organisations and 18 organisations returned responses. Responses were received from organisations mainly in the third sector. Eight were registered as a charitable organisation, two as community interest company, two as local authority of central government funded agency, four as private organisations, and two did not disclose their status. The organisations surveyed represented a wide range of service beneficiaries including a focus on children and young people, families, and adults. These were in the target areas ranging from homelessness to drug and alcohol services, working with refugees and asylum seeker groups to sexual violence and those directly facing severe and multiple disadvantage. Just under half (n=8) of the sample exclusively provided a service for the people from diverse ethnic communities in Nottingham.

#### ***Focus group participant recruitment***

We conducted two focus groups to present the findings from the interviews (**RQ1**). The first focus group consisted of members of the project steering committee. This comprised frontline professionals working in the field of SMD in Nottingham representing organisations from the third and statutory sectors. The second focus group was conducted with a small group of service beneficiaries who were attending an Al-Hurraya therapy programme. Within the focus group, we facilitated discussions following a presentation of our findings and recommendations on the major forms of severe and multiple disadvantage for people within ethnically diverse communities in Nottingham. Detailed notes were made and recorded during both the focus groups which were used to conduct a thematic analysis to comprehend a concise outcome for these focus groups that helped us to answer RQ3.

Our sample of participants for this phase of the study were service professionals from a wide range of services within Nottingham city. Al-Hurrayya and University of Nottingham used a convenience sampling method by drawing from connections and existing networks of contacts within the field of SMD-related services and from the project Steering Group. In the first instance, we provided an information sheet directly to contacts within existing networks. When a potential participant expressed an interest in being involved in the study, we invited them to attend the focus group and requested a consent form be completed by them. We also provided information about data management and protection and GDPR notices were also given.

### **Data collection and analysis**

All the interviews were conducted by two members of the research team. One from the University of Nottingham and one from Al-Hurrayya. Both interviewers were experienced qualitative researchers previously working with people from marginalised and ethnically diverse backgrounds in a therapeutic capacity. Both researchers are from a South Asian ethnic background, and both are currently living in Nottingham.

Minimally structured interviews ranging from forty-five minutes to one hour each were conducted with all the twenty participants at Al-Hurrayya's office in Nottingham. The data was collected using a digital recording device to capture the audio of the interviews. The recordings were downloaded and saved to a UoN (University of Nottingham) SharePoint created specifically for the project and safe storage of research data. Once the audio files were transferred to the SharePoint the original recordings were deleted from the device. The audios were transcribed using the UoN auto transcription service.

Except for wanting to understand people's lived experience of SMD via some predetermined questions, the interviews were allowed to unfold organically and were led by the participant's lived experience. Taking the approach of minimally structured interviews has been useful within the context of the study to address specific themes related to experiences of SMD in ethnically diverse communities and avoiding the risk of themes being determined by pre-existing assumptions about SMD. In this research, it was our intention to leave room for the participants to be in charge with spontaneity and flexibility to add onto our exploration.

A process of thematic analysis has been used to analyse and interpret data collected in the interviews and focus groups. Thematic Analysis is a research method that involves the identification, examination, and interpretation of recurring themes within qualitative data. This approach to data analysis offered flexibility in terms of research inquiries, sample sizes, and data collection methods. By determining the key themes and associated research questions, thematic analysis facilitates the identification of patterns in participants' lived experiences, perspectives,

behaviours, and practices. This enabled us to gain insights into participants' thoughts and emotions and explore the patterns of personal and social significance related to the lived experience of SMD.

Table 3 sets out the process followed for conducting thematic analysis.

**Table 3. Phases of thematic analysis**

Phase	Description of the process
1	Familiarising yourself with your data: Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2	Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5	Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6	Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

#### *Data analysis for RQ2*

We requested that data from the Changing Futures dataset be used to answer the question regarding the equity of access to SMD services based on ethnic group (**RQ2**). The lead evaluator from Changing Futures completed the analysis on behalf of the research team. This meant that no individual beneficiary level data was shared but only the results of the analysis.

The analysis that was carried out was a logistic regression. The outcome variable was whether a beneficiary had been accepted into the Changing Futures service following assessment. The predictor variable was whether the beneficiary was in the ‘White’ ethnicity group or the ‘diverse

ethnic communities' group. The diverse ethnic communities' group was a variable constructed by the Changing Futures evaluation team for the purpose of this analysis and included all other ethnicities than 'white' listed in their assessment dataset.

## Findings RQ1, RQ2 and RQ3

Within this section, we present the findings RQ1, RQ2 and RQ3. RQ1 focuses on what the major forms of SMD were present for the ethnically diverse individuals residing in Nottingham. RQ2 focuses on the equality of access to specialist SMD services. RQ3 will highlight the range of services which are needed and explores how existing services can adequately adapt to support the SMD needs of ethnically diverse communities in Nottingham.

**Table 4. A detailed demography and context of the interview study participants**

<b>Total Number of participants</b>	20
<b>Service Professionals</b>	10
<b>Service Beneficiaries</b>	10
<b>Men*</b>	15
<b>Women*</b>	5
<b>Participants from Black/African/Caribbean background</b>	5
<b>Participants from South Asian background</b>	10
<b>Participants from Mixed race background</b>	4
<b>Participants from other ethnic background</b>	2
<b>Participants who are UK citizens</b>	13
<b>Participants who migrated to the UK or are asylum seekers</b>	7

*\*Please note that during the interview, none of the participants mentioned or stated that they didn't identify with the gender that was assigned to them at birth. Hence, we will be operating with the standpoint that all participants are cisgendered at the time of conducting the interviews.*



## Findings RQ1

***RQ1: What are the major forms of severe and multiple disadvantage for people within ethnically diverse communities in Nottingham and how can these enrich and construct a more inclusive definition for understanding the concept of severe and multiple disadvantage?***

Through our studies conducted with service beneficiaries and service professionals with lived experience one major recurring theme emerged regarding the experience of SMD within ethnically diverse communities. The title given to this theme is '***Racial Trauma***'. This overarching theme reflects a myriad of ways in which racial trauma is experienced both historically and contemporaneously and how this interacts with the other defining characteristics of SMD.

Within this single major theme, there were 8 distinct but related themes identified, representing various descriptions of their experience of racial trauma in the context of SMD. These experiences are nuanced and represent distinct experiences of racial trauma from within the frame of reference of the range of ethnically diverse communities of the participants.

Below, we provide a thorough unpacking of each of the 8 smaller subsections to identify their relationship to racial trauma as well as how they affect each other. The phenomenon of racial trauma was experienced within the range of diverse ethnic communities represented in our interviews. To show how the 20 participants shared their experiences and knowledge of others' experiences, racial trauma has been further broken down by the ways in which it is recognized. This covers topics such as the impact of discrimination based on physical traits, the length of exposure to discrimination, and internalised racism. Based on the foundations of racial trauma, the following 8 sub themes were identified

### **(a) Disadvantaged by racial stereotyping from service professionals.**

One of the main experiences that participants reported was when they were trying to engage with local services to access support for problems related to SMD, they encountered racial stereotyping from service professionals, this is a widely acknowledged but under researched phenomenon (Weng & Clark, 2018). These stereotypes were of different forms, depending on their unique contexts. Below are some examples of racial stereotyping experienced by the participants.

Participants reported experiencing service professionals who assumed that family support was available to the beneficiary. This was expressed frequently, but was not limited to, the way that professional's preconceived notion the beneficiary had access to greater sums of money, privilege, and social support from family based on their ethnicity. One interviewee reported

being told, “You're Asian, you can't have any problems.” Or “You're Asian, you don't need any support.”

Even when entering a service, beneficiaries were offered support they felt lacked a client-specific focus and did not consider different races, cultures, and experiences. Rather, all ethnically diverse individuals were categorised into one group, which was labelled as ‘BAMER’. Beneficiaries felt this needed to be addressed as, if they are trying to get support for SMD but do not experience their ethnic identity being recognised, they would be less likely to engage with the service.

Due to this type of grouping together of ethnic identities, along with other forms of stereotyping by service providers, beneficiaries understood there to be a substantial lack of trust in professionals. This was particularly apparent within the Roma community.

### **(b) Disadvantaged by loss due to forced migration and seeking asylum**

The second of the effects of racial trauma experienced by service beneficiaries stems from experiencing loss after being displaced due to various social and political circumstances (Luci, 2020). Due to the influence of colonial zeitgeist societies, there has been a significant increase in political instability and civil unrest in many parts of the world, which directly impact the lives of those who are native to the country. This often results in many individuals being forced to flee or migrate to other stable countries such as the UK, Canada, Europe, etc. in search of safety and a better life.

However, once there, their lives are usually put on pause waiting for immigration and visa papers to clear. This can take months or more often years to be processed and during that time, the dispersed individual has no recourse to public funds or access to paid employment. They are provided with the essentials to survive. This includes accommodation in a shared hostel, which often does not offer privacy or stability, limited access to the Internet, and a stipend of around £40 every 2 weeks. With the cost-of-living crisis and many individuals resorting to getting multiple jobs to meet the demands, refugees and asylum seekers have no access to work permits until their visa documents have cleared which leaves them with limited access to funds or opportunities to support themselves and better their lives.

This form of post migratory stress can also be considered to fall within the theme of racial trauma (Morgan, Melliush & Welham, 2017). Specifically, it can contribute to further high-risk behaviours including alcohol and substance misuse, committing, or becoming a victim of crime, homelessness and mental health problems, experiences more commonly associated with SMD. Here, this kind of racial trauma can be seen to underpin the potential for multiple and severe disadvantage to occur.

### **(c) Disadvantaged by a literacy gap in understanding rights and access**

The third theme frequently mentioned by service providers, is the literacy gap in understanding of rights. It was stated in interviews there exists substantial lack of knowledge in the ethnically diverse communities about available resources and the means to access those resources available. Examples include visa and immigration information, how to access healthcare via the NHS, pathways to setting up small businesses to make a living, and how to access educational opportunities. A service provider within the Afghan community stressed how because teachers for ESOL classes often do not speak the native language of the individuals attending, it was hard for classes to be interactive or effective in learning the language with a contextual understanding.

There is a significant disadvantage for those experiencing gender-based violence who also lack trust in statutory services (Goodson, Darkal, Hassan, Taal, Altaweel & Phillimore, 2020). As noted above, a lack of trust can arise due to experiencing racial trauma when contacting statutory services; however, the gap in literacy, knowledge of rights and the disparity in access to legal aid (Burrige & Gill, 2017) can further compound this experience and place further disadvantage on people in ethnically diverse communities. The lack of access to knowledge affects the ability to flourish in accessing education, barriers in accessing mental health support and healthcare more generally (O'Donnell, Higgins, Chauhan et al., 2007) and opportunities for using trade skills as a potential source of income were also highlighted by participants. A clear example of the effects of the disadvantage exacerbated by a literacy gap was presented by the Roma community (Morris, 2016) Many within this community were not aware of changes to visa regulations post-Brexit. This resulted in women being charged over £700 for hospital services after finding out that they were not registered citizens within the NHS registry. This was happening especially with younger mothers.

### **(d) Disadvantaged through justice administered through own cultural systems**

Interviews highlighted some specific cultural practices which create a form of disadvantage. This was referred to as 'take matters into their own hands' and referred to dealing with difficulties within the enclosure of the community. One example of this was the creation of intra-community justice systems which rely upon the guidance of elders or respected individuals in the community. The role of the elders was to bring a conclusion to disputes or problems. In other words, a self-governing community is created, and this is overseen by local bodies that have been elected by the local people and are responsible for the management of the affairs of those within the community. An example highlighted in the findings was, 'Stabor', a form of self-governing and justice system within the Roma community. A desire to keep issues within the community, coupled with the lack of trust in statutory services, means that individuals reported paying money they do not have to have their concerns addressed. Within the Roma community, we were told about individuals struggling to manage their families, having to pay up to £1000 to £2000 to receive guidance from their local courts, not recognised by the UK legal system. Whether this can be considered a form of exploitation and racial trauma is not entirely clear and

needs further exploration. Participants were willing to go to the Stabor courts rather than the official legal system in their country of residence, nevertheless, it can most certainly be considered a form of severe disadvantage for some communities.

Furthermore, the interviews revealed the impact of cultural norms and gender roles in the implementation of ‘constitutional matters,’ the heteronormative narratives in collectivist culture can frequently determine the responsibility of the community’s pride in women and instil the community’s moral safeguarding on men, which determines who gets to do what within a cultural sphere and how much power they can have. Participants reported that women within ethnically diverse communities are at a higher disadvantage because many of these communities are collectivist cultures whose value structure is rooted in conformity to traditional roles and norms, which, can leave women feeling restricted in their roles and disempowered.

#### **(e) Disadvantaged by social exclusion and isolation**

Being disadvantaged through social exclusion and isolation both by one’s own community and from the wider community was another theme to emerge. Often exclusion occurred due to someone’s engagement in behaviours that would bring shame upon the family and community, such as being homeless or engaging in substance misuse. The shame and stigma associated with the problems of SMD is already understood. However, within some ethnically diverse communities the extent of exclusion can be so significant it is considered here to be a severe form of disadvantage.

The perceived loss of anonymity, lack of trust in the confidentiality of services, and fear of stigma within the community poses a barrier that results in avoidance in accessing services within the wider community. There is a lack of trust reported both within service providers (with lived experience) and service beneficiaries towards statutory organisations that lead them to not engage with services as they believe that it is not structured or made for them. The exclusion and isolation from support systems is a major source of disadvantage. The lack of trust is multifactorial but some common threads to the interviews pointed to intergenerational trauma as a potential underlying cause.

Language can be exclusionary as a means of recreating intergenerational trauma. The impact of language on people, particularly within the black community, was presented by service professionals as a concerning source of disadvantage. Our interviews highlighted how language is often used to cause suffering and oppression and the colonial aspect of language is deeply ingrained, leading to linguistic classism and stereotypes. An example by one service professional highlighted how, during the COVID-19 pandemic, the messaging of the vaccination programme was being perceived and understood using the word ‘injection’ within the African-Caribbean community. The effect of this made it extremely hard for services to reach communities and the

reluctance to have a vaccination was interpreted as resistance. Intergenerational trauma as a form of racial trauma can lead to fear of accessing services, compounding the impact of SMD.

In line with previous research, participants expressed concerns about the potential for exclusion due to gender within ethnically diverse communities. Several participants expressed frustration with their own community for not doing more to address the issue of gender inequality and suggest that survival and maintaining the status quo become the priority. The reported disproportionate lack of recognition of the effects of gender inequality as severe disadvantage can exacerbate the experience of SMD for women and leads to the next theme of seeing racial trauma as an intersectional construct.

#### **(f) Disadvantage of racial trauma as an intersectional construct**

In considering the definition of SMD Parker and Bullock (2017) stated that disadvantage is typically severe when it is multiple and when there are multiple disadvantages it is naturally severe for the individual. Within the concept of racial trauma, it is possible to see this statement being evidenced when taking an intersection lens to consider experiences reported in the interviews.

The impact of a colonial mindset on traditional values leaves little room to stray from the norms. This is particularly the case when it comes to people expressing their sexuality, gender identity or not conforming to assigned gender roles. In one interview, a service beneficiary from a mixed-race Jamaican family shared how his mother stopped speaking to him when he was open about his sexual orientation. Further, he also expressed how prevalent colourism towards him from within his community was as a person of mixed heritage.

Additionally, women reported facing further disadvantages within ethnically diverse communities as speaking about certain things remains 'taboo.' For example, important biological and health aspects for women, such as talking about menstruation, or menopause are not understood or taken into consideration when thinking about wellbeing. Furthermore, in addition to the hidden harms of colourism and homophobia, women and sometimes men experience domestic violence or gender-based violence within ethnically diverse communities, further facilitating the decline in mental health. These harms are often hidden and a significant source of disadvantage for women because their existence is kept within the community. This makes it hard for statutory organisations to track such experiences. But also due to a lack of knowledge about and trust in services within communities it is difficult for women to seek support via existing services. Marginalised groups and individuals have an added layer of racial trauma and therefore vulnerability to factors of SMD when they are being excluded by the wider community, as well as by their own communities.

**(g) Disadvantaged by the differences between and the needs within generations of ethnically diverse communities**

For some time, there has been a trend within ethnically diverse families (South Asian and Roma communities for example) who migrate to the UK where the children or young people and their parents are going through different processes to adapt to this significant change. Parents who bring their children to a new country usually approach a process of integration whereas children approach a process of assimilation. There is a distinction between these processes, whilst the process of integration entails individuals being able to simultaneously adopt practices from the host country without diminishing the practices from their home country, assimilation is the process of not wanting to maintain their previous identity or culture and being inclined towards day-to-day interaction with the host's culture instead.

Service providers noted that children from some communities are often ashamed of their parents and try to give themselves a new cultural identity to better adapt to the new environment, however, parents only adopt certain values from the host country that they identify with whilst still balancing their own cultural needs and values. For example, participants belonging to Afghan communities shared their experiences of not being taken seriously and their intelligence being questioned by their children due to their lack of proficiency in English. This can cause tension in the home and can lead to issues for all members of the family. One participant recalled an instance of children and young people being isolated at home after rejecting their traditional values. Parents are also sometimes unaware of the child or young person's life outside the home. When a young person might be confronted by the authorities and the parents are notified either directly or indirectly through other community members, parents can be 'shamed' or become ostracised within the community.

Participants reported a considerable lack of communication within families in relation to bridging the generation gap. This aspect is deemed important as collectivist cultures may be more responsive to holistic support, one that not only engages with the individual but their wider family system and community.

**(h) Disadvantaged by internalised racism**

Finally, the disadvantage faced by ethnically diverse individuals is their own internalised racism. Pyke (2010, p. 553) described this as "The internalisation of the racist stereotypes, values, images, and ideologies perpetuated by the white dominant society about the individual's racial group". This can be seen in many service beneficiaries as not associating with or even rejecting one's own culture and heritage in a prejudicial way towards themselves. This can also be seen in many children and young people within ethnically diverse communities who are assimilating into the UK, especially once they start school. Sandhu (2020) discusses the significant role of shame in severe and multiple disadvantage in young people, it is not known about the ethnicity of her sample as there is no reporting of these details. As many beneficiaries reported instances of

shame felt individually or within their family and the community, this is an important aspect of internalised racism.

Additionally, service beneficiaries and service users who have had lived experiences also shared how they are “okay with racist situations” as they use this to fit into the dominant cultural network and create their own identity within the wider community. For example, one service provider with lived experience and a service beneficiary both shared how they were accepting of being known by derogatory racial terms within the wider community, whilst having to conceal that side of themselves within their social networks to avoid shame or criticism.

### **Findings for RQ2**

#### ***RQ 2: What is the likelihood of people from ethnically diverse communities accessing SMD services following referral compared to people from white ethnicity group?***

The aim of this part of the study was to understand more about the accessibility to the specific and specialist SMD service by users from ethnically diverse communities. The purpose was to consider whether, having been referred to a service, there was an equal likelihood of accessing the service regardless of ethnic group.

The sample consisted of referrals made to Changing Futures for consideration of access to this specialist SMD service in Nottingham city. At the time of the analysis, there were N=361 referrals with adequate data for the analysis. Of these, n=260 belonging to the ‘white’ ethnicity group and n=161 belonging to the ‘ethnically diverse communities’ ethnicity group. Of the N=361 referrals made, n=234 were rejected and n=137 were accepted to the service. The difference between the two groups was as follows.

**Table 5. Accepted/Rejected by ethnic group.**

<b>Group</b>	<b>N Referrals</b>	<b>Accepted (%)</b>	<b>Rejected (%)</b>
<b>White ethnicity</b>	260	98(37.69)	162(62.31)
<b>EDC ethnicity</b>	101	39(38.61)	62(61.39)

*EDC = Ethnically Diverse Communities*

Table 3 above shows the difference between the rates of accepted or rejected by ethnic groups at the point of assessment is in the region of just 1 percent. This difference was non-significant. The finding is important for informing both the potential service beneficiary and the professionals. What this tells us is that if potential beneficiaries within ethnically diverse communities can be referred, they have an equal chance of being accepted into the service.

Whilst this does not provide the sensitivity of looking at the different effects within the ethnically diverse communities and whether this might be different for different groups.

Similarly, whilst Changing Futures data suggests that for some ethnicities the number of referrals made reflects well and is consistent with the population of Nottingham of specific ethnic groups, it does not tell us the scale of the problems of SMD within the range of diverse ethnic communities in Nottingham. As stated above, for this a further study quantitative study using the network scale-up method would be advised.

### **Findings for RQ3**

#### ***RQ 3: What range of services are currently providing support and how can existing services adequately adapt to support the SMD needs of ethnically diverse communities in Nottingham?***

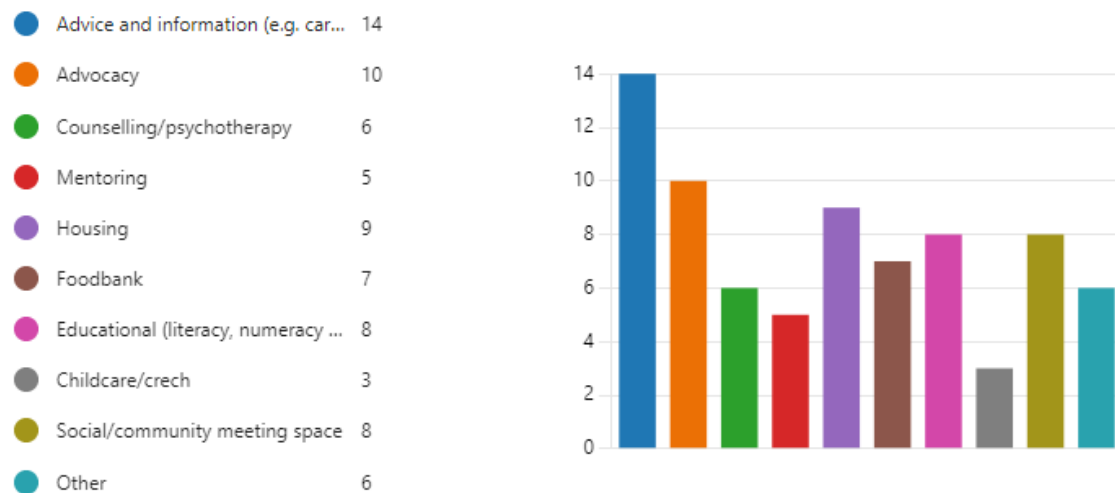
We used a survey, interviews and focus groups to answer RQ3. Below we have set out first the findings from the survey. These are then followed by findings from the interviews which were pertinent to research question 3 and finally from the focus groups.

We set out with the objective to understand the experiences of SMD within ethnically diverse communities in Nottingham and provided an analysis of experiences of or barriers experienced accessing services. We have heard how many people from ethnically diverse communities do not perceive that services available in the statutory sector are relevant to their needs, ‘for them’ as it is often said. The lack of trust in services was reported to be often based on experiences of encountering structurally racist systems within society. As noted in the Changing Futures attempts to increase accessibility by amending the NDT assessment tool, there are concerns about the appropriateness of the tool and its cultural sensitivity. In addition to the analysis by Draper (2023), we wanted to know whether potential beneficiaries from diverse ethnic communities referred to Changing Futures were any more or less likely to gain access to the service than people from the white ethnicity group. The reason for doing this analysis was to understand whether any implicit bias was operating within the assessment processes affecting access. The disparities in access to mental healthcare across racial and ethnic groups is well recognised (McGuire & Miranda, 2008).

All organisations considered themselves to provide services for people experiencing SMD using the existing definition. The types of support for people varied and the chart below shows the frequency of each type of support provided.



## Type of support provided for people experiencing SMD across organisations



The data provided by some organisations was incomplete and, on a few occasions, where a specific number was requested, the respondent provided a range. In these instances, we took the lower end number so that we made only the most conservative claims about the scale of SMD problem. We asked all 18 organisations to tell us how many people they had provided services to in the 12-month period August 2022 to July 2023 and how many of these were from ethnically diverse communities. 15 organisations provided data estimating that 5,271 people had accessed a service. Of those, it was estimated that 3,674 (70percent) were from ethnically diverse communities.

To be experiencing SMD, using the existing definition requires a minimum of at least three areas of disadvantage. In our survey, 14 organisations provided information indicating an estimated 554 people were experiencing SMD. As the number of people supported in each organisation varied and not all organisations responded to this item, we have estimated this to mean 15% of service users were experiencing SMD in the 12-month period August 2022 to July 2023.

This survey asked organisations to respond to a question about changes in the levels of service user experience of SMD prior and since the pandemic. We asked services to tell us how many service users they supported in the 12-month period January 2019 to December 2019 experienced three or more forms of disadvantage. Only 4 organisations responded meaningfully to this question, as many said they did not have access to the data required to answer. Two organisations said there had been no change and 100% of their service beneficiaries experienced SMD in the specified period. Two organisations said they had supported more people in the year before the pandemic compared to 2022-23 period. One indicated this was as high as a fivefold difference going down from 25 in 2019 to 5 in 2022-23. The other organisation indicated they supported 150 in 2019 and only 50 in 2022-23 for SMD.

It is difficult to know exactly why there might have been such a drop-off in the numbers of people experiencing SMD being supported within these two organisations. One explanation might be that as there now exists an organisation in Nottingham exclusively dedicated to supporting people experiencing SMD, those previously seeking help across a wider spread of organisations are now appropriately attending the specialist SMD service.

### Understanding racial trauma

A key finding from the main part of this research study was to understand experiences of SMD in ethnically diverse communities. What this research showed us is that experiences of racial trauma are central to experiences of SMD within ethnically diverse communities. Hence, we have proposed the need to situate racial trauma within the field of SMD. To further understand the situated nature of racial trauma within the field of SMD, we have asked organisations about their perception of the status of existing knowledge about racial trauma within their organisations, the prevalence of racial trauma in service beneficiaries experiencing SMD, the impact on organisational operations of its inclusion in recognising SMD and, on their perceived need for training in the field of racial trauma for all staff in their organisations. The description of the findings is presented below in a series of charts.

We asked about the level of knowledge of staff about racial trauma.

Most responses indicated staff to range from quite to very knowledgeable.

Overall, using the definition of 'racial trauma' given above, how would you describe the level of knowledge about the concept of 'racial trauma' amongst your staff team?

[More Details](#)

● Not at all knowledgeable	0
● A little bit knowledgeable	4
● Quite knowledgeable	9
● Very knowledgeable	5



We asked respondents to estimate the proportion of people from ethnically diverse communities experiencing SMD and accessed their service who also report experiencing racial trauma. Half of organisations indicated that between 0-20% of service users from ethnically diverse communities experienced racial trauma.

17. Please estimate the proportion of service beneficiaries from ethnically diverse communities and have sought help for severe and multiple disadvantage also reported experiencing racial trauma.

[More Details](#)

[Insights](#)

- 0 - 20% reported experiencing r... 9
- 21 - 40% reported experiencing ... 3
- 41 - 60% reported experiencing ... 2
- 61 - 80% reported experiencing ... 3
- 81 - 100% reported experiencin... 1



We next asked organisations to tell us how much impact on the level of service use changing the definition of SMD to include experiences of racial trauma might have. The findings indicated that all organisations thought it would have some impact with half of them saying this would be a small impact and a further five thought it would have a moderate impact. Four organisations said it would have a high or very high impact.

18. If racial trauma is included and recognised as a form of severe disadvantage, what impact would this have on the proportion of service beneficiaries from ethnically diverse communities considered to be experiencing SMD?

Remember, SMD would mean experiencing at least three of the following five areas of disadvantage:

Substance/alcohol misuse problems

Homelessness

Involved with the criminal justice systems

Mental health problems

Racial Trauma

[More Details](#)

[Insights](#)

- No impact at all 0
- A small impact (0-25% increase) 9
- A Moderate impact (26-50% inc... 5
- A large impact (51-80% increase) 2
- A very large impact (81-100% in... 2



In the context of situating racial trauma in SMD we wanted to know whether services thought they could cope with any additional demand on their services. Given that half of organisations estimated this would have quite a small impact it was important to understand whether this could be absorbed into existing staffing capacity. Six organisations said they had zero capacity for an increase in demand for support for people experiencing SMD under the new definition whereas

only two thought they could cope easily with up to a 100% increase in demand. Most organisations reported they had some capacity reaching up to a 25% increase in demand.

19. What capacity does your service have to cope with additional demand in the number of service beneficiaries from ethnically diverse communities seeking help for SMD?

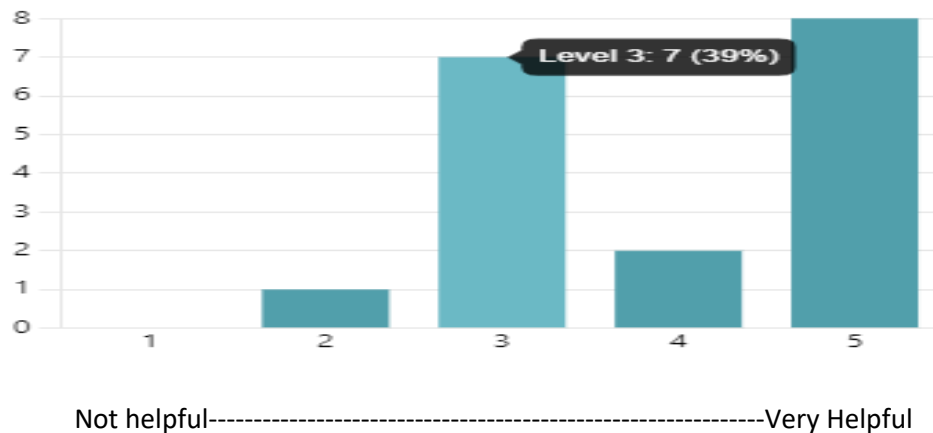
[More Details](#)

[Insights](#)

- No capacity – we would need ex... 6
- Some capacity – we could cope ... 10
- Moderate capacity – We could c... 0
- A large capacity – we could cop... 0
- A very large capacity - we could... 2



Finally, we asked respondents to tell us how much they think that staff within their organisation would benefit from further training about racial trauma in the context of identifying this as a feature of SMD. 56% of respondents suggested that this would helpful or very helpful.



### **Bridging the gap between service beneficiaries and providers**

In the section below, we present findings for RQ3 that were generated through the interviews. The main understanding across both service users and providers is that the services set up have not been designed to meet the needs of culturally diverse individuals. The importance of understanding the diverse makeup of society and providing services that meet the needs of diverse cultural backgrounds has been repeatedly emphasised. Therefore, in the future, services need to consider the follow aspects:

Community learning and self-learning were identified as one of the most effective ways to support and empower the community. Following from this, another point that emerged was the importance of engaging individuals and investing in their education and small businesses as strategies to address mental health issues and enable them to access resources which would help them flourish. To avoid slowing down the process of an individual integrating into the community, access to healthcare and medication should be improved for individuals with different immigration statuses and again, they should be educated on the rules and regulations within the UK. It was also suggested that an establishment of a support network run by women for the women of the community to meet the needs of marginalised individuals within a community is required. It is critical that influencing organisations create spaces that will empower women from ethnically diverse communities and educate their community about breaking taught gender roles.

Furthermore, there was an expressed need for organisations to invest in conducting public outreach and awareness programs especially for people from ethnically diverse backgrounds that would allow them to cover the knowledge gap and be able to reach out for help from statutory organisations. For example, if an individual wants to help tackle SMD within their community and become the middle person to share knowledge with statutory services, they need to better understand how to get involved as they will play an integral role in assisting to bridge the gap between the services and community.

There is also the need for a holistic approach to mental health, beyond just medication, which incorporates the understanding of individuals from collectivist cultures. The involvement of extended family members in the recovery process is highlighted as an advantage not understood by statutory services. Moreover, the collaboration of multiple agencies and organisations is deemed essential to provide comprehensive support in education, mental health, and business development for the community. The participants, specifically service beneficiaries, stressed that there must also be a way to pass on knowledge about the communities between the services such as relevant cultural competence in relation to working with a specific community. There should also be a collaboration between services and agencies that can come together to create an efficient multi-agency support plan for the client with relevant support workers, liaison officers, etc. involved rather than individuals having to set the context for their support worker when they meet different organisations and services.

The development of a maturity matrix to assess community engagement was also mentioned by service providers, who emphasised the need for rigorous training and competency in healthcare systems to address the needs of ethnically diverse individuals.

Again, when exploring how organisations and services can appropriately train their staff on how to work alongside ethnically diverse individuals who are struggling with SMD, the need to have cultural competency and cultural awareness/sensitivity training within staff as well as treatment

plans and care packages which are rooted in cultural competency was deemed essential. Cultural competency is ingrained in the historical and political context of a particular cultural dimension. In other words, cultural competency can support a service provider in addressing the impact of colonialism on a person's culture as well as how that has impacted their personal life, for example understanding generational trauma and the impact of that on the individual's present experience.

The interviews acknowledge the historical oppression faced by individuals coming from enslavement, empire, and colonialism. The interviewees act as an advocate for disadvantaged individuals, emphasising the importance of rights and dignity. This helps us understand that there is also a need for service providers to take up this role of advocacy for their clients more seriously with extreme rigour. Furthermore, there also needs to be advocacy for robust structures within statutory and non-statutory services to challenge negative stereotypes and provide better service provision. Whistleblowing and addressing poor practice are seen as essential for improving service provision and ensuring the needs of all individuals who are trying to access the service are met.

Trust in the system is lacking, and the interviewees discuss the responsibility and values that come with their role, emphasising the need to do the right thing and be consistent. Collaboration with multiple agencies is mentioned, with recognition of potential bias and lack of understanding regarding the distress faced by an individual from an ethnically diverse community. For example, one interview with a service provider highlighted the issue of vaccine hesitancy within minority communities rooted in intergenerational trauma, despite the disproportionate impact of COVID on these communities.

### **Therapeutic Interventions such as counselling and support groups as a tool of rehabilitation**

As one service provider describes, "counselling plays a crucial role in reconnecting with one's true self and navigating a new way of life." Throughout the interviews there is a substantial emphasis on the transformative power of counselling in recovery journeys.

However, to ensure that there is effective communication and understanding between counsellors and clients, various service providers stressed the need for cultural-specific counselling services with individuals who can understand the cultural context of the client with more ease.

Furthermore, peer-led support groups were mentioned by several service providers, especially those with lived experience. They spoke about how being in a space where they are understood and 'seen' then enabled them to be honest and share their experiences with the wider group. They all stressed how accurate representation of their cultures within these settings matters and positively impacts their recovery process.

## **Representation of diverse community experiences throughout organisational structures**

Service providers have discussed how diversity and representation within the organisation should be prioritised before implementing support and outreach initiatives. They believe that challenging the unequal distribution of power and promoting inclusivity at a structural level is necessary. Discrimination and structural problems should be acknowledged by statutory services and understood as existing across different social classes and communities. The diversity represented within the NHS has been a mentioned example as a model to understand accurate representation throughout organisational structures within an organisation by one service provider.

Additionally, a recommendation made by a lived experience service provider who assists in housing individuals with SMD, was those other individuals within similar context, such as lived experience and ethnically diverse, need to be given opportunities to work as service providers in statutory organisations and placed throughout organisational structures in management rather than just on the front-line. Furthermore, there is also a need for physically present translators who have been appropriately trained regarding SMD, which includes understanding of body language, social cues, and cultural nuances. Diverse staff with contextual understanding are required to understand the client's individual context as well as their cultural context.

There is a theme of service providers being frustrated with the lack of change and progress within the support and rehabilitation field. Senior individuals in positions of power are reluctant to give up their positions and make necessary changes which then impacts the support being given to the various diverse communities. It was noted that the problem is deeply rooted in the systematic imbalance and power dynamics of politics and society. There was criticism in relation to the hiring practices and suggested that organisations should actively seek out individuals from marginalised communities. It was constantly reiterated by both interview groups that they feel that the system is set up to maintain the status quo and that those in power are comfortable and resistant to change. One service provider also calls for recognition of the contributions and displacement of people of colour in building institutions and industries. Understanding the historical context of racism is deemed essential. Genuine inclusivity and cultural sensitivity by service providers are emphasised, rather than just 'token gestures' such as incorporating and hiring a few 'BAMER specialist workers' within the workplace to meet the needs of various ethnically diverse individuals.

In the section below, we present the findings for RQ3 that were generated through the focus groups.

Once the interviews were completed, 2 focus groups were held separately, one which included only service providers and another which included only service beneficiaries. These focus groups

helped the researchers understand whether the needs and experiences of all the participants had been accurately captured or whether further changes needed to be recognized.

There was a range of feedback from the groups, with few participants feeling that the problem remained with how the implementation of the NDTA (New Directions Team Assessment) by staff and other service providers was the main issue rather than the NDTA itself. The New Directions Team Assessment (NDTA) scored individuals in 10 areas using 5-point scales: engagement with frontline services (0-4), intentional self-harm (0-4), unintentional self-harm (0-4), risk to others (0-8), risk from others (0-8), stress and anxiety (0-4), social effectiveness (0-4), alcohol / drug abuse (0-4), impulse control (0-4) and housing (0-4). These were summed to create the total score, of which the maximum was 48, with a lower score indicating lower needs. The threshold set for eligibility for the New Directions Team Assessment was 22 out of 48.

There were questions around having an automatic ‘tick box’ if an individual from a diverse ethnic background approached the service and how that would feel for the individual if they were not able to identify the impact of racial trauma on their lives.

The general consensus remained that the impact of racial trauma was not ‘surprising’ however, there seems to be an additional layer of trauma for those not having a visa or their asylum claim processed. They are understood to be at a bigger disadvantage regarding safe housing or accessing income for their basic needs. Additionally, they can be seen as more at risk of experiencing violence and abuse within the walls of their community or home without knowing where and who to reach out to for support. Moreover, it was repeatedly expressed that there does not need to be a conversation understanding whether racism exists or not, but more in regard to how it is actively being addressed and acknowledged throughout support work from services.

It was discussed that although it might be uncomfortable to talk about racial trauma, especially within the workplace, it is an integral aspect of training that needs to be discussed and understood by staff. Within the community, however, there was a discussion on how this would be translated appropriately for individuals who are struggling to access help and how service providers could help them understand what encompasses racial trauma. It was agreed that more community engagement was needed to facilitate this process of translating to the community.

There was an overall understanding amongst all participants that the current environment failed to be inclusive of individuals from ethnically diverse backgrounds and that systems needed to change to meet the needs of marginalised individuals and communities. However, as stated in the focus group, this also shows that there is a need to ‘move away from the current system operation such as validating an individual’s experience of severe and multiple disadvantage before allowing access to support and recognize that one size doesn't fit all.’

It was discussed how the study may have been limited to understanding the experiences of the individuals who are struggling. However, in many collectivist cultures where an individual’s



family and other social circles are engaged, it is worth inculcating their experiences while understanding SMD amongst ethnically diverse backgrounds.

The need for agencies (both statutory and non-statutory) to have extensive engagement with ethnically diverse communities after developing at least basic understanding of their cultural framework to be able to translate the relevant knowledge and resources around issues like addiction, domestic abuse, etc into the host cultural framework. The need for agencies to have the qualities of willingness to learn, to adapt and to listen to the ethnically diverse communities were raised should they wish to really inculcate the experiences of ethnically diverse people with SMD.

There was an emphasis on service providers understanding the idea of ethnically diverse communities operating as a united front in understanding various forms of SMD and how it impacts the members of their community to better support the individuals who are struggling with SMD in their communities instead of isolating them.

The value of identifying various stakeholders in ethnically diverse communities such as religious leaders or any other people who are well respected in the community was discussed. It was discussed how bringing members from the target communities can benefit not only understanding the nuances of experiences inside the community but would also help agencies to design outreach and to support the ethnically diverse communities based on insider's knowledge. The need for religious leaders and other respected people to be trained and educated with various aspects of SMD can help them advocate better as they have the advantage of having the trust of the communities. "Imams leading for change" for example is one such initiative by Al-Hurrayya.

Participants expressed the urgency of organising and arranging rallies, marches, and other forms of public outreach programs to bring the existence and narrative of racial trauma into general awareness within the larger population. However, it was also discussed that to do so, the ethnically diverse communities affected by SMD need to take up more responsibility as a united front, in the same way as the LGBTQ+ communities have managed to do.

People in this focus group also shared their repeated experiences of reliving their racial traumas during in-takes with both statutory and non-statutory agencies where they have been forced to repeat their traumatic experiences repeatedly. They spoke about how such insensitive and inconsiderate behaviour from such agencies affects their rehabilitation process, where it often makes it harder for them to get better.

## Conclusions, Limitations and Recommendations

### Conclusions

In conclusion to the study, we set out to understand the experiences of severe and multiple disadvantage within ethnically diverse communities. Taking the starting point as one of challenging the construct of SMD as it is currently defined, we remained open to the possibility that a new definition might emerge, one that reflects the experiences of ethnically diverse communities. What we heard within the interviews was that in many instances SMD does provide at least a partially accurate heuristic for describing the unique and distinct collection of disadvantages experienced by people. The disadvantages currently describing SMD are all focused on ‘situations’ or ‘behaviours’ in which people are disadvantaged. For example, this includes people expressing the following: “I have problems with my housing; I have problems using substances; I have problems with mental health; I have problems due to crime/violence.” In speaking to people within ethnically diverse communities, we hear them say that disadvantage can be experienced not so much for what they do or the situations they are in, but “because of who I am, how I look or where I am from.” These factors have often been a source of racially motivated incidents creating the experience of racial trauma.

We heard how racial trauma is a distressing experience. This needs to be understood in the context of SMD. Racial trauma might be considered an underlying causal factor leading people into the ‘situations’ or ‘behaviours’ describing severe and multiple disadvantage. It might also be considered a multiplying factor in the experiences of severe and multiple disadvantage. Whilst distress is relative, it also needs to be considered whether two people in the same ‘situation’ engaging in the same ‘behaviours’ can have different experiences. Some of which will make it worse or harder to change. Racial trauma due to being from a diverse ethnic community, is a source of disadvantage that should be factored into all mechanisms for understanding those presenting for SMD assessments and services.

One aspect that we heard participants talk about was how trust in existing services was lacking. The reasons for a lack of trust were many and contrasting across the range of ethnically diverse communities we interviewed. A key point mentioned was the perception participants shared that ‘services were not for [them].’ Accounts of intergenerational racism were shared, direct experiences of structural racism, stereotyping by frontline workers, lack of knowledge and information were all factors reported in interviews and serve to corroborate other reports of racial trauma in the UK when seeking help and psychological support (King, 2021; Samuel, 2023).

Existing policies aimed at addressing SMD are based on ameliorative top-down approaches (The NDTA criteria for example); paradoxically such strategies within ethnically diverse communities solidify disparities as they do not address the individual needs of the most vulnerable groups.

The advancements in SMD, both at the local and national levels, have surpassed what is typically seen in the collaborative planning of services and support, distinguishing themselves from traditional 'top-down' approaches. It is crucial to emphasize that this initiative should be expanded, particularly by prioritizing individuals over their issues. The advancements made in the SMD field already exceed typical expectations. Approaches that are strengths-based and person-centred, along with increased contact time and longer-term engagement, as well as consideration of past experiences, are uncommon in most public service delivery. This is not to imply that these practices are firmly established within the SMD domain, although they receive more attention here than is generally observed in broader practice.

### **Limitations**

Our initial intention had also been to assess the extent of SMD within ethnically diverse communities in Nottingham, however, this proved to be beyond the scope of this project. We had originally proposed the following research question:

RQ 2: Based on a new and more culturally sensitive definition of severe and multiple disadvantage, what is the extent of SMD-related need within Nottingham's ethnically diverse communities?

This question required the use of methods to answer it which would involve a large-scale survey of particularly hard to reach communities. In our consideration of this question, we have determined that the most effective way to answer this question would be to conduct a network scale-up survey (Bernard, Johnsen, & Killworth et al., 2010). This method involves conducting a survey of randomly selected participants from the general population. Respondents are asked to report the number of people they know who engage in the behaviours or are in the situations of interest. In the case of SMD this would mean the number of people a respondent knows within their community who has a combination of SMD problems. Using an equation that accounts for factors such as size of population and size of social network an estimate can be made about the size of a hidden population. We recommend further study to carry out such a survey in Nottingham would be valid.

## Recommendations

Key findings	Recommendations	Recommendation for:
<p><i>Key Finding 1: Racial Trauma is a source of severe and multiple disadvantage for people from ethnically diverse communities.</i></p>	<p><i>Statutory and non-statutory services engaging with beneficiaries associated with any form of severe and multiple disadvantage need to be sensitive to and alert for experiences of racial trauma when assessing, referring, and working with service beneficiaries. Racial trauma needs to be recognised within a new definition of SMD</i></p>	<p><i>All services and parties involved in commissioning, strategy and planning / local leadership associated with severe and multiple disadvantage.</i></p>
<p><i>Key Finding 2: Trust in local services within ethnically diverse communities is low due to a perceived lack of understanding about racial trauma and its effects on individuals and communities.</i></p>	<p><i>Develop and ensure the reach of appropriate training focusing on racial trauma for all staff in local services (both statutory and non-statutory organisations). This training should develop knowledge for recognising racial trauma, adding to cultural competency, and unconscious bias.</i></p>	<p><i>All key partner organisations in Nottingham such as Changing Futures and leadership bodies in the Place Based Partnership.</i></p>
<p><i>Key Finding 3: Changing Futures works well in supporting service beneficiaries' access. Not enough is known about the level and correlation between SMD and experiencing of racial trauma within ethnically diverse communities not just in Nottingham, but also nationally.</i></p>	<p><i>Further research is required that can inform commissioners of the actual scale of the problem of SMD in Nottingham within ethnically diverse communities.</i></p>	<p><i>Nottingham City Place Based Partnership to consider next steps.</i></p>
<p><i>Key Finding 4: Representation of diverse community experiences throughout organisational structures is essential.</i></p>	<p><i>Services to support diversification of staff throughout organisational structures who also have a contextual understanding of the demographic they are working alongside.</i></p>	<p><i>All services in any of the related fields of severe and multiple disadvantage.</i></p> <p><i>All local services including those organisations responsible for commissioning services locally.</i></p>

<p><i>Key Finding 5: Therapeutic Interventions such as counselling and peer led support groups are a tool of rehabilitation.</i></p>	<p><i>Facilitating community spaces with investment and support for services to incorporate culturally sensitive therapeutic interventions.</i></p>	<p><i>All services in any of the related fields of severe and multiple disadvantage.</i></p> <p><i>All local services including those organisations responsible for commissioning services locally.</i></p>

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