Creative Pathways to Healing: Arts-Based Interventions and Therapies for Black Young People in the UK with Psychiatric Disorders

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Submitted for the degree of DPhil in Psychiatry, Trinity Term 2026

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Abstract

Black young people in the United Kingdom experience persistent and well-documented inequalities in mental health outcomes, access to care, and quality of services. These disparities are shaped by structural racism, mistrust of formal mental health institutions, and a lack of culturally responsive treatment options within dominant mental health systems. Despite growing recognition of these challenges, there remains limited evidence on how mental health support can be better aligned with the needs and lived experiences of Black youth. This thesis addresses this gap by examining whether creative arts–based interventions may offer culturally congruent, accessible, and effective pathways to mental health support.

Using a multi-level mixed-methods design, the thesis begins with a robust meta-analytic global synthesis of 33 quantitative studies evaluates the effectiveness of creative arts–based interventions for trauma and PTSD in children and adolescents with a focus on non-Western populations. Results show large reductions in symptoms overall, with stronger effects observed in non-Western and Global Majority populations, suggesting that cultural practices play a critical role in therapeutic treatment and effectiveness.

Second, the thesis zooms into an epidemiological analysis of the 2023 OxWell Student Survey examining mental health help-seeking among Black and Mixed Black adolescents in England. Findings demonstrate that Black adolescents are less likely to access formal mental health services and more likely to rely on informal and community-based support, with barriers related to trust and, confidentiality, along with perceptions of care offered in services.

Third, a qualitative study conducted across five NHS Trusts explores how Black young people with psychiatric disorders and clinicians perceive creative arts therapies within UK mental health services. Findings indicate that creative approaches are experienced as emotionally accessible, identity-affirming, and culturally meaningful, but are constrained by

systemic barriers including limited availability, insufficient cultural competence training, and mistrust within clinical encounters.

Finally, a mixed-methods pilot study (Spotlight) examines the feasibility and acceptability of a community-based music intervention delivered outside formal clinical pathways. The pilot demonstrates high engagement and preliminary improvements in wellbeing, while also identifying key ethical and implementation challenges, particularly regarding safeguarding, power dynamics, and support structures.

The findings of this thesis suggest that mental health inequalities among Black young people are not solely a function of access but reflect a deeper misalignment between dominant therapeutic models and culturally grounded ways of understanding and expressing psychological distress. While this thesis focuses largely on UK population data, these patterns reflect broader trends across Western mental health systems where talking therapies are dominant therapeutic modalities that do not seemingly prove effective for Black populations. Creative arts–based interventions offer a promising, culturally responsive methods for these young people but their effective implementation requires structural change, including workforce development, community partnerships, and a rethinking of what constitutes evidence-based care. This thesis contributes a novel, multi-level framework for understanding and addressing mental health inequities through culturally grounded creative interventions.

Declaration

The work reported in this thesis was completed between October 2022 and December 2025, supervised by Professor Morten Kringelbach, Professor Ilina Singh, Professor Olivia Spiegler, & Dr Emma Soneson. The work in this thesis is my own. I declare that the work presented has not been submitted for any other degree, in this or any other university or learning institute.

Acknowledgements

I never imagined that a rainy visit to Oxford in autumn 2021 would lead me to complete the work of my dreams. That day in Peloton, when I met you, Morten, I remember you asking me, "What exactly are you passionate about doing? Because you have the chance to do exactly that over the next few years." I had never been asked so frankly, but in that moment, I knew I had been given the chance of a lifetime to do the work I am most passionate about, with the people who need it most.

After receiving my offer letter, I journeyed back to Oxford with my mother and had the opportunity to meet Hélène, who further solidified the feeling that I would be entering a truly supportive environment where I would be championed to the finish line. I am deeply grateful for the exemplary guidance you have provided me throughout these years, Morten. Thank you for always inspiring me to be bold and to aim higher.

To my mother, my nexus, and the reason why this work exists, I am grateful for the constant lessons you have imprinted on me throughout my life, but especially throughout this DPhil process. "The worst anyone can say to you is no, and is that really so bad?" That phrase has carried me into spaces I once thought unimaginable and given me the confidence to stand firmly in my own understanding. I could not have done any of this without you, and I remain in awe of your strength, and the person you have helped me become.

To my best friends, Janet and Myrrh, all I can say is that I love you, and I am endlessly grateful for your sisterhood. And to my Lord and Saviour, Jesus Christ, thank you for always seeing me through.

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Prologue

This thesis explores the role of creative arts interventions as culturally competent approaches to mental health support for Black young people in the United Kingdom. While the chapters that follow focus on epidemiological evidence, global intervention research, lived experience within NHS mental health services, and applied community intervention, the process of conducting this research was itself shaped by many of the structural, relational, and institutional tensions discussed throughout the thesis.

As a Black woman conducting research on Black mental health within predominantly White academic and clinical institutions, I became increasingly aware throughout the DPhil that the research process could not be separated from the wider systems in which it was situated. Questions of trust, legitimacy, cultural understanding, and institutional power were not only themes identified in participant narratives, but realities that emerged repeatedly throughout the process of designing, implementing, and sustaining the work itself.

My interest in this area began long before the DPhil. My earliest experiences of understanding the relationship between trauma, healing, and creative expression came through witnessing PTSD within my own family and observing how music could provide comfort and emotional regulation in ways that conventional language often could not. These experiences shaped my broader academic trajectory, including prior work with refugee populations in Germany and music-based interventions within inpatient mental health settings in the UK. However, despite this personal and academic foundation, I entered the DPhil relatively unaware of how difficult it could be to operationalise research focused specifically on Black mental health within institutional contexts.

One of the clearest examples of this emerged during the qualitative BLACK-ARTS study. Although the study itself was focused on understanding how Black young people and clinicians perceived creative arts therapies within NHS mental health services, the process of securing ethical approvals and site permissions became unexpectedly prolonged and complex. While the University of Oxford and Health Research Authority (HRA) ethical approval process proceeded relatively smoothly, obtaining approvals across NHS Trusts was much more difficult than anticipated. In total, it took approximately one year to receive full approvals for the study before recruitment could begin.

Not only was it difficult to get ethics clearance for the study, but NHS Trusts were sometimes wary about how the study would be conducted. Particularly memorable was the response from

one NHS Trust site during the governance review process. Recruitment materials originally described Black young people as a "racial minority" group, terminology that was commonly used throughout much of the academic literature at the time the project was initially designed. However, concerns were raised by the Trust that the terminology was inappropriate or potentially harmful, and the study was flagged for language considered potentially racist or culturally insensitive. Luckily, the Trust was sufficiently interested in the study not to dismiss it immediately. I was subsequently asked to attend a meeting with theTrust leadership to discuss the wording and framing of the project.

What stood out to me most during that meeting was not simply the discussion surrounding terminology itself, but the broader assumptions underpinning the interaction. Although never explicitly stated, there appeared to be visible surprise when I entered the meeting and introduced myself as the lead researcher. As a Black woman at Oxford University conducting research specifically focused on Black mental health and culturally competent care, I became acutely aware of how assumptions about authority, expertise, and ownership of research can shape institutional interactions. This awareness emerged through the contrast between how the study appeared to be perceived before the meeting and how it was discussed once I introduced myself as a Black woman researcher leading the work. Although nobody explicitly referenced my race, the change in tone of the discussion and visible surprise within the room prompted me to reflect on assumptions surrounding who is expected to conduct research on Black mental health and whose expertise is viewed as legitimate.

Importantly, I do not view the concerns raised regarding language as entirely invalid. In many ways, the experience prompted an important reflexive shift within the project itself. Prior to this interaction, I viewed terms such as 'racial minority' primarily as descriptive categories commonly used within academic literature. Following the discussion, I began to recognise more explicitly that research terminology is not neutral. The words used to describe communities can carry broader histories of power and identity may be experienced differently by participants, institutions, and researchers themselves.

Following these discussions, recruitment materials and study language were revised to use the term "Global Majority" rather than "racial minority," reflecting broader ongoing conversations surrounding race, representation, and deficit-based framing within mental health research. This process reinforced to me that language within culturally focused research is not static or politically neutral, but embedded within evolving histories of identity, power, and representation (Campbell-Stephens, 2021).

At the same time, the experience also highlighted the complexity of conducting equity-focused research within institutional structures that may themselves still be navigating how to engage with race, racism, and representation. While the project aimed to explore culturally competent mental health care, I found myself simultaneously negotiating institutional discomfort around the very discussions of race and inequity the research sought to address.

Another important reflexive decision was taken during participant recruitment for the qualitative study. Early in recruitment, engagement rates across some NHS sites were low, despite extensive outreach through clinical teams and Trust pathways. After discussions with my supervisors, we decided to revise the recruitment materials to include a photograph of myself alongside the study information.

This decision was made intentionally and reflected our growing awareness that representation and trust were likely to influence participant engagement. The rationale was straightforward: potential participants may respond differently when they can see who is conducting the research, particularly when discussing highly sensitive topics related to "race," mental health, and institutional experiences within NHS services.

In my view, the improvement in recruitment was not simply participants being able to see who was leading the study, but specifically because they could see that the researcher was Black. Several participants later spoke about experiences of racism and mistrust within mental health services, and I believe that my visibility as a Black woman researcher may have signaled a greater likelihood of being understood and believed when discussing these experiences. This observation is consistent with literature suggesting that racial concordance can increase trust and engagement within healthcare and research settings, particularly among populations who have experienced discrimination or exclusion within institutions (Alsan et al., 2019; Shen et al., 2018).

In practice, this appeared to make a substantial difference. Following the revised recruitment materials, engagement increased noticeably across sites. While it is impossible to determine precisely why, my interpretation is that participants may have felt more comfortable or reassured knowing that the research was being led by someone who shared aspects of their racial and cultural identity and who might therefore understand some of the experiences being discussed. This assumption was borne out in the findings of the qualitative data itself, where participants repeatedly emphasised the importance of trust, cultural understanding, and relational safety within care settings.

The issue of relational trust became even more visible during the *Spotlight* pilot intervention. Due to delays associated with ethical approvals and governance processes, the

timeline for recruitment was very compressed. Once approval was finally obtained, there was approximately one month available to recruit participants before the intervention began.

Given the limited timeline, recruitment relied heavily on direct relationship-building within the community setting itself. Rather than relying solely on advertisements or digital recruitment, I attended Grounded Sounds sessions in person and spoke directly with the young people about the purpose of the project, my reasons for pursuing the research, and the broader goals of creating culturally meaningful mental health support for Black youth.

These conversations were important for the success of the pilot. In my view, recruitment and retention were strengthened not simply because the programme involved music, but because trust and my personal connection to this work and what it meant to me were established relationally. Young people appeared responsive not only to the intervention itself, but also to the reasons I explained to them for my personal investment in the project. This experience reinforced one of the central findings of the thesis: engagement in mental health interventions cannot be separated from relational dynamics, trust, and perceptions of authenticity.

The Spotlight study also revealed the fragility of community-based intervention work. Although a second cohort had initially been planned, the partner organisation, Grounded Sounds, subsequently lost funding and was forced to cease operations before the second intervention cycle could begin. This highlighted a broader structural challenge within community-based mental health and arts work: many of the organisations most trusted by underserved communities are themselves operating within financially precarious environments and so are temporary.

This experience became another important reflexive insight within the thesis. Throughout the project, creative arts interventions were repeatedly found to be promising and culturally meaningful approaches to care. However, as the Grounded Sounds example showed, the sustainability of these interventions cannot be separated from the material realities facing the organisations delivering them. Community-based mental health innovation often relies on short-term funding structures, overstretched staff, and fragile organisational infrastructures. As such, while community settings may offer culturally safer and more accessible forms of engagement, they are not immune to structural instability.

These experiences fundamentally shaped how I came to understand both the possibilities and limitations of culturally competent mental health research. The process of conducting this work repeatedly mirrored many of the themes later identified within the findings themselves: mistrust, institutional tension, relational safety, power, and the importance of culturally grounded connection.

These experiences also reinforced for me that cultural competence is not simply a characteristic of an intervention or clinician, but relationally negotiated throughout every stage of research and care. Recruitment, governance, institutional engagement, ethical review, and participant trust all became sites where questions of race, identity, legitimacy, and representation were actively encountered.

This prologue is not intended to position these experiences as unique to me, nor to solely criticise individual institutions, but to acknowledge that research on race and mental health is often shaped by broader organisational, cultural, and historical dynamics that require ongoing reflection. In many ways, the process of conducting the research became part of the data itself, illustrating how discussions surrounding Black mental health continue to generate institutional uncertainty, discomfort, and negotiation, even within spaces committed to equity and inclusion.

At the same time, these experiences also demonstrated the profound importance of representation, reflexivity, and relational trust in this area of work. Throughout the DPhil, I became increasingly aware that my positionality as a Black woman researcher shaped not only how participants engaged with the research, but how the research itself was interpreted, questioned, and operationalised within institutional systems.

Ultimately, these experiences strengthened rather than weakened my commitment to the work. They reinforced the central argument of this thesis: that mental health care and mental health research cannot be fully effective without attention to the cultural and structural realities shaping how people experience care.

Chapter 1
Creative Pathways to Healing: Arts-Based Interventions and Therapies for Black Young People in the UK with Psychiatric Disorders

1.1 Introduction

In the United Kingdom, Black ethnic groups represent only 1.1% of the UK population, but suffer stark and persistent inequalities in access to mental health care, the quality of care received, and in outcomes from mental health care (Robertson et al., 2021). In Black populations, disparities have been consistently documented across national reports and research studies but remain insufficiently addressed within policy and practice (NHS Race and Health Observatory, 2023; Office for National Statistics, 2018; Race Disparity Unit, 2019). These are most visible in elevated rates of severe and enduring mental illness (SMI), such as psychosis and schizophrenia, and in poorer service experiences and outcomes following diagnosis (NHS Race and Health Observatory, 2023; Race Disparity Unit, 2019). Black people in the UK experience the lifetime prevalence of 37.8%, the highest rate of PTSD of any other ethnic group (Wilson et al., 2025). Similarly, in common mental disorders, Black men are less likely to self-refer for mental health care, more likely to not have a course of treatment and more likely to drop out of treatment once started in NHS Talking Therapies services (Arundell et al., 2021).

Black patients are more likely to experience more adverse care pathways and service experiences, which include higher rates of sectioning under the Mental Health Act (Coelho et al., 2022) and tend to access services more regularly via the police and criminal justice system (Coelho et al., 2022; Halvorsrud et al., 2018). They are also more likely to receive medication rather than recommendation of psychological therapies from clinical staff (Catalao et al., 2025), are often prescribed incorrect dosages (De Freitas et al., 2022) and report difficulties in accessing services that meet their needs and are culturally informed (Jensen et al., 2021; Kovandžić et al., 2011).

Black populations are less likely to seek treatment for psychiatric conditions and often underrepresented in research and reporting due to lower prevalence in seeking mental health treatment (Bignall et al., 2019; Dyer & Gilbert, 2019). Black populations have been reported to have less access to relevant support for their mental health (Wessley, 2018), and experiences

and outcomes for Black individuals are often less effective and, in some circumstances, cause harm (Rabiee & Smith, 2013; Sewell et al., 2021).

These inequities reflect systemic and structural racism within health services, which continues to shape patterns of access, diagnosis, and treatment across NHS mental health care (Robertson et al., 2021).

Barriers to accessing mental health services among Black people include cultural stigma around mental illness (Kovandžić et al., 2011), fear and mistrust of care systems, and experiences or perceptions of discrimination from healthcare providers (Halvorsrud et al., 2018; Mclean et al., 2003). Together, these factors often deter individuals from seeking help when needed, leading to delayed intervention and reinforcing existing inequalities in mental health outcomes (Halvorsrud et al., 2018).

The NHS Race and Health Observatory (2023) has identified institutional bias and a lack of culturally responsive care as key drivers of these disparities (Robertson et al., 2021). Within clinical encounters, stigma surrounding mental illness, fear of racial discrimination, and the lack of culturally competent clinicians further reduce engagement and retention in treatment (Coelho et al., 2022).

The next chapters therefore examine how Black British young people with psychiatric disorders and NHS clinicians understand and experience creative arts therapies in practice, exploring the cultural meanings, relational dynamics, and structural constraints that shape their use within UK mental health services.

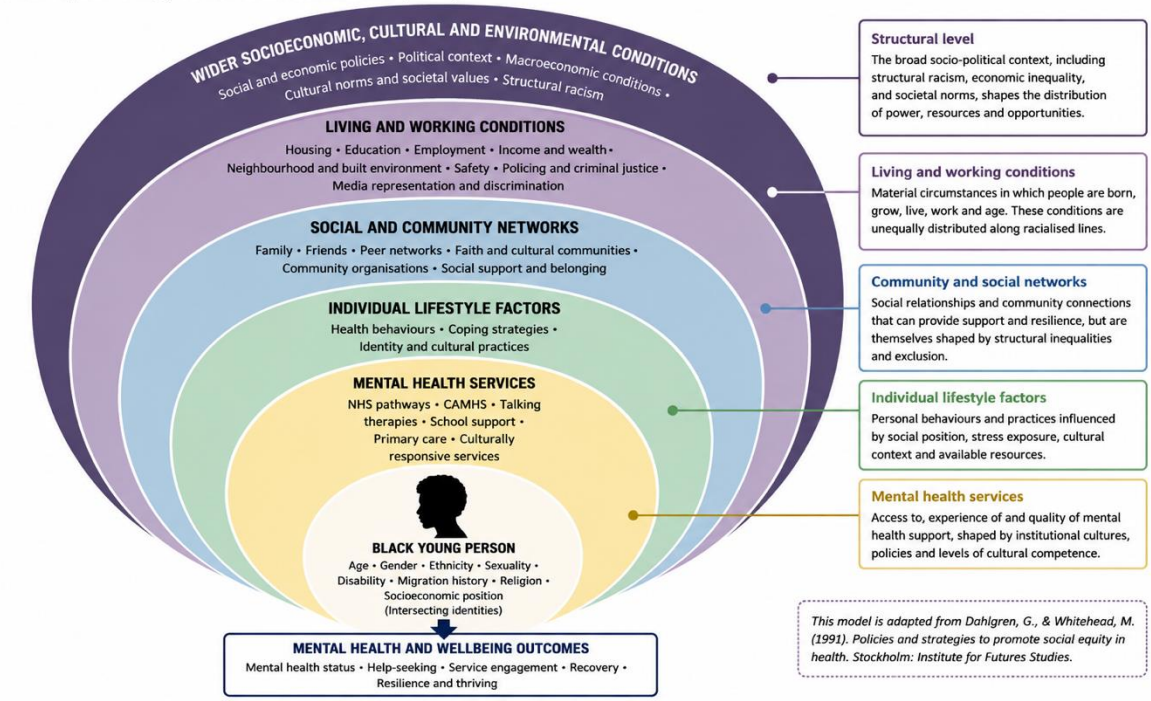
1.2 Conceptualising Black Mental Health Through a Social Determinants Framework

Mental health inequalities experienced by Black young people cannot be understood solely through individual characteristics, psychological vulnerabilities, or service-level experiences. Public health models increasingly recognise that health outcomes are shaped by a complex interaction of social, economic, environmental, and structural influences that operate across the life course (Marmot, 2020; Whitehead & Dahlgren, 1991). These determinants influence not only exposure to adversity and stress, but also access to resources, opportunities, support networks, and healthcare services.

This thesis adopts a social determinants perspective to understand the mental health experiences of Black young people in the United Kingdom. As illustrated in Figure 1.1, mental health outcomes are shaped by multiple interacting layers of influence, ranging from wider socioeconomic, cultural, and political conditions to community relationships, living conditions,

and experiences within mental health services. These layers do not operate independently; rather, they interact to influence both mental health outcomes and engagement with care.

Figure 1.1 Social determinants of Black young people's mental health: An adapted Dahlgren and Whitehead model (1991)



Note. This adapted model illustrates how multiple layers of social, economic and structural factors interact to influence the mental health and wellbeing of Black young people. Intersectionality is represented at the centre, recognising that overlapping identities shape experiences at every level.

Within Black communities, these determinants are further shaped by processes of racialisation and structural racism. Structural racism refers to the ways in which historical and contemporary systems, institutions, policies, and social practices produce and maintain racial inequalities across domains such as education, employment, housing, healthcare, and criminal justice (Nazroo et al., 2020). From this perspective, mental health inequalities are not simply the result of individual experiences of discrimination but emerge through broader social structures that shape life opportunities and exposures over time.

This framework is also consistent with ecosocial approaches to health, which emphasise how social and structural conditions become embodied and expressed through physical and mental health outcomes across the life course (Krieger, 2024). In this sense, the elevated rates of mental health difficulties observed among Black populations should not be understood solely as clinical phenomena, but as outcomes that are influenced by broader social, economic, and political conditions.

An intersectional perspective further strengthens this framework by recognising that structural determinants do not affect all Black young people in the same way. Experiences of

mental health are shaped not only by race, but also by the interaction of age, gender, socioeconomic position, migration history, religion, disability, and other dimensions of identity and social location (Crenshaw K., 1991; Hill Collins & Bilge, 2020). Throughout this thesis, intersectionality informed the recognition that Black young people are not a homogeneous group and that experiences of help-seeking, stigma, trust, and service engagement vary across different social positions and contexts.

Importantly, the findings presented throughout this thesis suggest that creative arts interventions should not be viewed as solutions to structural inequalities in themselves. Rather, they represent one potential response operating within a wider system of determinants that influence mental health. Creative arts interventions may help address some of the relational, cultural, and service-level barriers experienced by Black young people; however, improving mental health outcomes ultimately requires attention to the broader social and structural conditions in which distress emerges and recovery becomes possible.

The following sections therefore examine several key determinants that have been identified as influencing mental health outcomes among Black populations in the UK, including employment, structural racism, stigma, cultural beliefs, and pathways into mental health care.

1.3 Health Determinants Affecting Black Mental Health

A multitude of different factors influence the mental health outcomes of Black people in the UK ranging from employment inequities, structural racism, adverse pathways to mental health care, lack of psychoeducation, and associated stigma surrounding mental health care . Research has shown that Black people considered their mental health problems as exacerbated by adverse life experiences including traumatic experiences, discrimination, inadequate income, and a loss of their home culture (Eliacin, 2013; Morgan et al., 2017; Schofield et al., 2019).

1.3.1 Employment

Employment disadvantages were factors identified as influencing mental health outcomes for Black patients in comparison to White patients, in both the time of admission, and at follow up (Devonport et al., 2023; Lawrence et al., 2021). A recently published systematic review exploring the mental health of Black African-Caribbean communities in the UK found in included studies that unemployment rates were the highest for people from a Black background (26%) in comparison with their White counterparts (11%) (Kapadia et al., 2018; the SELCoH study team et al., 2011). Additionally, Black Caribbean women were more likely (32.9%) than

White women (18.9%) to be in the lowest household income quartile (Hackett et al., 2020; the SELCoH study team et al., 2011).

1.3.2 Racism

In 2020, The Black Lives Matter movement generated renewed attention to the ongoing discrimination and systemic racism that black people continue to face and recent scholarship following the movement has highlighted the ubiquity of systemic racism in the UK. (L. Henry & Ryder, 2021; Phoenix et al., 2020)

Structural racism has been consistently cited as a main factor affecting the mental health outcomes of Black people in the UK, namely in both physical and mental health systems like the NHS (NHS Race and Health Observatory, 2023), contributing to higher rates of psychosis, psychological distress, and overall poorer mental health functioning (the SELCoH study team et al., 2011; Wallace et al., 2016).

Long-term exposure to chronic racism and racist experiences has been associated with longer hospital admissions in Black populations (Edge & Grey, 2018; Gazard et al., 2015). Racism when accessing mental health services has been consistently reported across the UK, with Black service users reporting racial abuse, leading to mistrust of the overall system when seeking support, leading to feelings of hopelessness of getting better, poor adherence, fear of treatments not working as effectively (Adams et al., 2015; Chakraborty et al., 2011; Cooper et al., 2013; Devonport et al., 2023; Gazard et al., 2015; Karadzhov & White, 2020; Morgan et al., 2017; Rabiee & Smith, 2013; Schofield et al., 2019).

A study exploring how equitable psychological services are in the UK found that Black patients felt unheard when advocating for their mental health needs with mental health service providers and challenging psychiatric decisions and negotiating their treatment in comparison to White counterparts (Morgan et al., 2017).

Qualitative discoveries showed an overall theme of White British patients feeling that recovery from a mental illness is possible, with 93.3% identifying this way in focus group narratives, however none of the Black Caribbean patients recorded this narrative (Lawrence et al., 2021). There have been Black parents narratives about preparing their Black children for racialised society, hinting at the emotional labor and anticipatory stress for their young ones in the UK (L. Henry & Ryder, 2021; Phoenix et al., 2020).

1.3.3 Stigma and Cultural Beliefs

Stigma has often been cited as a contributing factor towards Black service users not seeking out mental health support, and being labelled with a mental disorder acting as an overall barrier to recovery and care (Karadzhov & White, 2020; Kular et al., 2019). Religious and spiritual practices have also been consistently cited in research as first-line to care avenues for Black patients, and Black patients seeing religious leaders about their mental health related problems instead of formal mental health services (Fernández De La Cruz et al., 2016).

Religious and spiritual frameworks were frequently implicated in shaping perceptions of mental illness and help-seeking, acting as barriers both to early recognition of difficulties and to engagement with mental health services (Fernández De La Cruz et al., 2016; Schofield et al., 2019). Qualitative studies have reported the use of stigmatizing language by some Black service users when describing mental illness and psychiatric care settings, reflecting broader concerns within family and community environments (Kular et al., 2019). These perceptions were often linked to spiritual beliefs, including interpretations involving possession or supernatural causation, which may contribute to heightened anxiety around diagnosis and exacerbate the perceived consequences of mental health service involvement (Rabiee & Smith, 2013).

1.3.4 Mental Health Care Pathways

Black patients have been reported to enter mental health care pathways through the police or criminal justice system more frequently than those for White service users (Brown et al., 2014; Mann et al., 2014; Morgan et al., 2017; Rabiee & Smith, 2013). Fear of coercive treatment was commonly reported, including concerns among Black Caribbean patients and their families about involuntary hospitalization and restraint (Brown et al., 2014). Black African individuals are two times more likely to be involuntarily sectioned and experience a short-term detention; they are more than four times more likely to have compulsory treatment orders compared with White individuals (Bansal et al., 2014). Similarly, Black African women are more likely to be involuntarily admitted under the Mental Health Act than White British women (Singh et al., 2014) and Black African and Black Caribbean patients experience more frequent and longer hospital admissions, with admissions more likely to involve police and compulsory detention (Morgan et al., 2017).

Importantly, several studies indicate that limited engagement may reflect difficulties accessing appropriate services rather than reluctance to seek help (Bhavsar et al., 2021; Das-

Munshi et al., 2018; Jankovic et al., 2020; Rabiee & Smith, 2013). Barriers identified at the level of service provision include failure to recognise the severity of mental health difficulties in primary care, reduced referral to secondary services, lack of out-of-hours support, and poor continuity of care for psychological therapies (Rabiee & Smith, 2013). In some cases, Black service users reported bypassing primary care pathways and accessing psychiatric services via emergency departments, either due to limited knowledge of alternative routes or perceived inadequacy of primary care responses (Rabiee & Smith, 2013).

1.4 Children and young people

Young people from racial and ethnic minority backgrounds are particularly vulnerable to these inequities. Around one in five children and young people aged 8 to 25 in the UK experience a probable mental disorder in the UK (Booysen et al., 2019) and 50% of all psychiatric conditions begin by age 14 (Gronholm et al., 2017; Sadler et al., 2018). Yet Black children and adolescents are less likely to access early mental health support (Sadler et al., 2018), and when they do, they show high rates of disengagement (Kim et al., 2019). A recent study found Black Caribbean boys are more likely to suffer with a diagnosable mental health condition than their White peers (Gutman et al., 2015).

Research indicates that Child and Adolescent Mental Health Services (CAMHS) are significantly underutilised by Black young people, despite their overrepresentation in crisis care and compulsory admissions, and the fact that they are more likely to be referred to CAMHS by social services than their GP. In the UK, 5.6% of Black racial minority children have a mental disorder with a typical age of onset between 5 to 19 years of age (Lavis, 2014).

In Black university school students, many Black students experienced feelings of isolation, both from their communities and within the university setting (Stoll et al., 2022). This lack of belonging was exacerbated by stigma surrounding mental health issues, leading to further distress (Arday, 2018; Crittle, 2018; Jones, 2017; Myrie & Gannon, 2013; Stoll et al., 2022),access to mental health support was identified as crucial, yet many Black students felt that university services were inadequate and often racially insensitive (Stoll et al., 2022).

However, there are large gaps in the literature concerning the treatment outcomes of Black children and young people living with mental health problems. Reasons for the data gap are varied, but often studies of young people have few participants and given the poor representation of Black young people both in services and in research studies, the choice is

often made to collapse categories of ethnicity into larger groups encompassing several ethnic identities, representing a heterogenous group of people that experience inequality due to their race or ethnicity (Dogra et al., 2012). These frequently include using the generic 'Black, Asian, and minority ethnic (BAME)' category. However, this approach further obscures within-group differences, limiting the understanding of specific barriers faced by Black youth in the UK (Dogra et al., 2012).

To address this gap, the present thesis focuses specifically on the experiences of Black young people, recognising that understanding their individual perspectives is essential for developing more culturally competent and equitable mental health services.

While this thesis is grounded in the UK context, the inequalities described are not confined to the NHS. Across Western mental health systems, including in the United States, Canada, and Europe, Black populations consistently experience poorer access to care, lower engagement with services, and worse mental health outcomes, despite comparable or greater need (Burkett, 2017; Cloos & Bilsen, 2021; Fante-Coleman & Jackson-Best, 2020; Gaston et al., 2016; Harrell et al., 2011). These patterns are shaped by structural racism, mistrust of institutions, and the dominance of therapeutic models that are often culturally misaligned with the lived experiences of minoritised communities. As such, the challenges faced by Black young people in the UK should be understood not as isolated system failures, but as part of a broader global issue in which Western mental health care models have limited cross-cultural validity.

This global perspective has important implications for how mental health care is conceptualised and evaluated. Evidence-based practices developed within Western contexts are often assumed to be universally effective, yet emerging research suggests that culturally grounded approaches may be more effective in contexts where they align with local modes of expression and meaning-making (Adams et al., 2015; Arundell et al., 2021; Rabiee & Smith, 2013; Schaeffer & Borduin, 2005). This thesis therefore adopts a multi-level and globally informed perspective, drawing on both UK-based and international evidence to examine whether creative arts–based interventions can offer more culturally congruent and accessible pathways to mental health support for Black young people.

1.5 Culturally Competent therapies

Cultural competence in mental health care refers to the ability of practitioners and systems to deliver services that are respectful of, and responsive to, the cultural identity and values of service users (Chu et al., 2022). The ultimate goal of culturally competent care is to promote

health equity by using approaches at the micro (individual) level and the macro level of organizations and communities (Pacquiao et al., 2021).

Although cultural competence remains widely used within mental health policy and research, the concept has been subject to substantial critique. Some scholars argue that focusing on culture risks obscuring the role of racism, discrimination, and structural inequalities in shaping mental health experiences (Fernando, 2014). Others suggest that an emphasis on individual cultural knowledge may be insufficient without attention to broader social and institutional contexts that shape health outcomes (Metzl & Hansen, 2014).

Within this thesis, cultural competence is therefore conceptualised not simply as knowledge of cultural differences, but as the ability of services and interventions to recognise and respond to the social, relational, and structural realities shaping Black young people's experiences of mental health and care.

In recent years, the literature has identified a need for culturally competent mental health treatments for minoritized groups. A recent systematic review proposed a novel conceptual framework for considering cultural adaptations to care and particularly noted the importance of organisational-level adaptations to assist adapting psychological services for global majority patients (Arundell et al., 2021). Researchers found that flexibility in the timing of sessions, or location, use of interpreters, having creche facilities during appointments proved to be effective cultural adaptations (Arundell et al., 2021). Although several psychosocial interventions have been developed for ethnic minority youth in the United States (J. A. Cohen et al., 2004; Huey & Polo, 2008; Schaeffer & Borduin, 2005), such as Trauma-Focused CBT and Multisystemic Therapy, evidence of their efficacy and applicability in the UK remains limited. In the UK, cultural competence training is often limited to superficial awareness of cultural differences, without addressing power, privilege, or institutional racism (Bhopal, n.d.; Sewell et al., 2021). However, a few key studies have focused on cultural competent therapies for Black people in the UK taking into account these critical factors.

Studies focused on Black mental health have found that the use of patient-centred communication styles was an effective way for Black service users to articulate their experiences and perspectives more fully (Adams et al., 2015; Hui et al., 2021). This approach was viewed as helpful in creating open discussion of racialised identities and engagement with religious, spiritual, and cultural beliefs that shape mental health understanding and treatment outcomes (Fernández De La Cruz et al., 2016; Karadzhov & White, 2020; Rabiee & Smith, 2013). One particular researcher highlighted the need for this approach cautioned that dismissing service users' lived experiences and identities may contribute to disengagement

from mental health services, whereas attentiveness to these experiences was associated with greater uptake and adherence to patient-centred treatments, such as talking therapies, rather than reliance on medication or watchful waiting (Adams et al., 2015).

Many studies explored the use of culturally adapted interventions and highlighted their usefulness for Black populations (Edge & Grey, 2018; Jensen et al., 2021). Edge et al. created a culturally adapted family intervention (CaFI) for African-Caribbean individuals diagnosed with schizophrenia. This intervention adopted a collaborative psychoeducational model in which therapists, service users, and family members shared experiences and knowledge, supporting more effective management of difficulties associated with psychosis within the family context(Edge & Grey, 2018). Cultural adaptation in this case involved explicitly addressing beliefs about mental illness, offering alternative explanatory models, and fostering conditions conducive to behavioural change (Edge & Grey, 2018).

Several studies also reported that Black service users perceived clinicians from similar ethnic backgrounds as more likely to understand their concerns and perspectives (Edge & Grey, 2018; Rabiee & Smith, 2013; Sancho & Larkin, 2020). This preference may reflect broader experiences of racialised discrimination within predominantly White societies, specifically the UK, which can shape wariness toward treatment and care systems (Chakraborty et al., 2011; Edge & Grey, 2018). Increasing the diversity and visibility of Black mental health professionals within the workforce has therefore been proposed as one strategy to enhance trust and signal institutional recognition of the social and cultural contexts shaping Black service users' mental health experiences (Lawrence et al., 2021). However, workforce diversification alone is unlikely to be sufficient; it should be accompanied by system-wide training to promote patient-centred communication and culturally responsive practice across all levels of service provision.

1.6 Creative arts-based interventions and therapies

As noted by Arts and Health Glossary by Davies & Clift (2022), art therapies are a form of psychotherapy, that involve a therapeutic relationship between a qualified therapist and an individual who engages in creative activities for diagnostic or remedial purposes(Davies & Clift, 2022). Creative arts therapies (CATs) are treatment interventions that involve art activities within therapy sessions and delivered by a trained creative arts therapist (NCCATA, 2019). Using creative arts therapeutically can either refer to trained therapists using creative arts methods in their sessions or community-based creative arts interventions administered by community-based creative arts instructors with no mental health or therapeutic training. The National Coalition of Creative Arts Therapies Associations (NCCATA) defines Creative Arts

Therapists as, "human service professionals who use distinct arts-based methods and creative processes for the purpose of ameliorating disability and illness and optimizing health and wellness (NCCATA, 2019).

For this thesis, we define CATs as music, visual art, dance movement, poetry and drama therapy facilitated by a trained creative arts therapist and creative arts-based interventions as any intervention utilizing music, movement, visual arts, poetry or drama with the interventions carried out by a trained facilitator.

Creative arts-based interventions may provide novel solutions and alternative options to existing psychotherapies with variable success. Specifically, creative arts are unique therapeutic modalities that have the potential to overcome language barriers by utilizing predominantly nonverbal modalities that allow for the emotional expression of complex feelings in a nonverbal format (Grasser et al., 2019). Creative arts-based interventions can also be viewed as a therapeutic strategy that may mitigate stigma surrounding mental health treatments (Gaiha et al., 2021), as they are not traditional talking therapies, which have been implicated in lacking engagement specifically with minoritized populations. In traditional talking therapies, these patients have reported feeling unwelcomed in services and stigmatized (Halvorsrud et al., 2018; Synergi Collaborative Centre, 2017).

NICE already recognises CATs as effective adjunctive treatments for psychosis and schizophrenia (NICE, 2013) yet their cultural adaptation for Black populations remains largely unexplored.

In African and Caribbean cultures, creative expression through music, art, and dance plays a central role in community life, identity, and healing(Brennan, 2012; Humphrey, 2018; Mbaegbu, 2015; Mpofu et al., 2006). For Black youth, these modalities are both familiar and empowering, potentially providing a culturally congruent framework for mental health support.

Music therapy (MT) has been shown to yield positive impacts on people with mental health problems by reducing symptoms of depression (Heise et al., 2013), anxiety and OCD (Nezgovorova et al., 2022), Anorexia Nervosa (Applewhite et al., 2020; Krishna Priya et al., 2021) and Autism Spectrum Disorder (Applewhite et al., 2022), and overall and fostering greater emotional well-being. For example, when received as an adjunct to standard treatment, active MT (which involves the service user creating or playing music themselves) and receptive MT (which involves listening to music for relaxation or to change a mood), are associated with significant reductions in major depressive disorder (Lee et al., 2015).

Music and dance are closely linked, and the two art forms create an emotional quotient complementing one another (Sievers et al., 2013). In many Black racial minority groups,

specifically African and Caribbean cultures, dance can serve as a powerful form of cultural identity (Humphrey, 2018); and is used as a ceremonial rite of passage in different life events and phases including birth, and death (Onwuekwe, 2009). It has been argued that African diasporic dance uses movement to communicate history, combat negative stereotypes, and present political and social commentary on the struggles of the African diasporic people (Onwuekwe, 2009).

Dance movement therapy (DMT) has been linked to positive outcomes in different psychiatric conditions such as depression and schizophrenia (Karkou et al., 2019; Lee et al., 2015) and has also been shown to improve optimal brain performance (Zilidou et al., 2018), reduce stress (Lee et al., 2015), and improve social, emotional, and motor functions (Foster Vander Elst et al., 2023; Hanna, 2017; Nahum et al., 2013; Ramanoël et al., 2018).

Beyond their cultural relevance, creative arts therapies may be effective because they engage core neurocognitive mechanisms underlying perception, emotion and action (Vuust et al., 2022). Music perception is a predictive process in which the brain continuously generates and updates expectations about rhythm, harmony and melody (Vuust et al., 2022). Musical engagement therefore represents a form of embodied predictive regulation, linking movement, anticipation and emotional experience and such mechanisms may help explain why creative arts–based approaches can feel emotionally accessible particularly for young people who experience verbally dominant therapeutic models as alienating.

1.7 History of Creative Arts in Black British Culture

The creative practices of Britain's African and Caribbean diasporas have shaped British cultural life since the Windrush generation arrived in the mid-20th century, carrying musical, performative and ritual traditions that quickly rooted and transformed within urban Britain. Early Black migrant communities brought calypso and ska, which fostered a new sound in Black British reggae culture; these forms provided communal spaces for sociality, political expression and cultural continuity in the face of racism and marginalization (Walker et al., 2017).

From the 1970s after the settling of the Windrush generation, distinct genres emerged out of these diasporic roots. Lovers rock developed in South-East London as a distinctly British, reggae that fostered community spaces and became an important vehicle for identity and emotional expression among young Black Britons (Palmer, 2011). UK-born hybrid genres, like jungle, grime and garage, drew on reggae and dub sounds, invented a new club culture to

produce new sites of belonging and intergenerational cultural work in inner-city communities (W. 'Lez' Henry, 2012).These musical forms have repeatedly functioned as arenas for creativity, resilience and political voice.

Performative and embodied practices beyond music, notably dance, carnival and theatre, have been equally central. Notting Hill Carnival, evolving from Caribbean postwar carnival traditions, became a major public forum for cultural celebration, community solidarity and assertive cultural visibility in Britain (Ferdinand & Williams, 2018). African and Caribbean dance traditions and the growth of Black British theatre from the 1960s onward have provided formal and informal spaces for storytelling, intergenerational knowledge-transfer, and the collective processing of trauma and exclusion (Ferdinand & Williams, 2018).

These cumulative traditions matter for mental-health practice because they foreground embodied, non-verbal modes of expression, relationality and community-based meaning-making, processes that are often attenuated or absent in verbally dominant clinical models. Music, dance and other creative forms in Black British life are not merely recreational, they are sites for identity formation, emotional regulation, mourning and joy, and political resistance. This historical embeddedness helps explain why creative arts–based approaches, when delivered in culturally congruent, community-grounded ways, hold promise as accessible, trust-building modalities for young Black people in the UK.

Scholars have argued that Black British identity is formed within a national context in which Britishness has historically been racialised, positioning Black individuals as belonging to British society only with conditions, rather than being automatically recognized (Phoenix et al., 2003). Within this landscape, cultural production has functioned as a means of negotiating their identity and contesting this exclusion. The centrality of creative practices within Black British life therefore reflects more than aesthetic tradition; it reflects an ongoing process of belonging-making within a racialised nation. Understanding this broader socio-cultural context is essential when considering why creative arts–based approaches may hold particular resonance for Black British young people in therapeutic settings.

However, this thesis does not conceptualise Black young people as a culturally homogenous group. Throughout this thesis, the term "Black" is used as a socially and politically constructed category rather than a biological description. Contemporary understandings of Blackness have emerged through histories of racialization political movements and continue to be contested across different national and historical contexts (Andrews, 2018, 2022; Campbell-Stephens, 2021). The increasing use of the capitalised Black reflects recognition of a shared social and political identity shaped by experiences of racialisation, while also acknowledging that the

meaning and scope of the term remain dynamic and context dependent (Campbell-Stephens, 2021).

Accordingly, the cultural relevance of creative arts–based interventions should not be understood as reflecting a singular or essentialised "Black culture." Rather, the potential effectiveness of these approaches may emerge through multiple intersecting mechanisms, including familiarity of creative practices within specific communities, opportunities for non-verbal expression, identity affirmation, collective meaning-making, relational trust, and the reduction of stigma associated with traditional psychiatric services. These mechanisms are likely to operate differently across groups and individuals depending on their social positioning, cultural background, and lived experiences.

This thesis therefore adopts an intersectional perspective, recognising that mental health inequalities among Black young people cannot be understood solely through race in isolation, but through the interaction of multiple social, structural, and cultural identities that shape both vulnerability and access to care.

1.8 Intersectionality

This thesis is informed by an intersectional perspective, which recognises that experiences of mental health, help-seeking, engagement with services, and experiences with creative arts cannot be understood through race alone. Originating in Black feminist scholarship, intersectionality was developed by Crenshaw (1998, 2013) to describe how systems of power and inequality interact to shape the experiences of individuals occupying multiple social positions simultaneously (Crenshaw K., 1991, 2013). Rather than viewing characteristics such as race, gender, class, migration status, religion, or age as separate and additive influences, intersectionality examines how these identities and social locations interact to produce distinct experiences of marginalisation, privilege, and opportunity.

Intersectionality is particularly relevant to mental health research involving Black young people because experiences of psychological distress and engagement with care are shaped not solely by racialisation, but also by broader social, cultural, and structural contexts. Black young people do not constitute a homogeneous population, and experiences vary across ethnic background, gender, socioeconomic position, migration history, family structure, religion, and community context. An intersectional perspective therefore challenges simplistic or essentialised understandings of Black identity and instead foregrounds diversity within Black populations while recognising the structural inequalities that may be shared across groups (Bowleg, 2012; Collins, 2015; Crenshaw K., 1991).

Although this thesis did not set out to conduct a formal intersectional analysis, intersectionality informed several aspects of the research design and interpretation of findings. First, in the OxWell chapter, Black African, Black Caribbean, Black Other, Mixed White-Black African, and Mixed White-Black Caribbean adolescents were analysed separately rather than being collapsed into a single ethnic category. This approach was adopted to acknowledge heterogeneity within Black populations and to avoid obscuring potentially important differences in experiences of help-seeking and service engagement. While the study was primarily concerned with racial inequalities, this decision reflected an awareness that experiences of mental health support are shaped by multiple dimensions of identity and social context.

Second, the qualitative BLACK-ARTS study demonstrated how participants' experiences of care were shaped by more than race alone. Young people frequently discussed how age, experiences of stigma, cultural expectations, family relationships, and perceptions of institutional power interacted with their racialised experiences within mental health services. Similarly, clinicians reflected on the challenges of supporting young people whose experiences were shaped by multiple and overlapping forms of marginalisation. These findings reinforced the importance of understanding mental health care as occurring within broader social and structural contexts rather than through a single-axis focus on race.

Finally, the reflexive account presented within this thesis was itself informed by an intersectional understanding of positionality. My experiences as a Black woman conducting research on Black mental health were shaped not solely by race, but also by my position as an early-career researcher operating within predominantly White academic and clinical institutions. The interactions described throughout the prologue highlight how questions of race, gender, authority, legitimacy, and expertise were often experienced simultaneously rather than independently, reflecting the core insight of intersectionality that social identities and power structures are mutually constitutive rather than discrete categories of analysis.

Intersectionality therefore serves as an important conceptual lens throughout this thesis. While the primary focus remains on racial inequalities experienced by Black young people, the thesis recognises that these experiences are shaped through the interaction of multiple identities, social positions, and structural conditions. Understanding these complexities is essential for developing mental health interventions and services that are responsive to the diversity of experiences within Black communities.

1.9 Study Rationale and Thesis Research Question

The evidence reviewed above points to a persistent mismatch between the needs of Black British young people and the dominant models of mental health care currently available within the UK. While culturally adapted talking therapies and patient-centred communication approaches have shown promise, their reach and impact remain limited, particularly in contexts characterised by mistrust, stigma, and coercive care pathways. This suggests a need to consider not only how existing therapies are adapted, but whether alternative modalities may offer more culturally congruent points of engagement.

Creative arts therapies represent a particularly relevant avenue for exploration in this context. For many Black British young people, creative expression through music, movement, and visual art is embedded within everyday cultural practices, identity formation, and community life. Unlike verbally dominant therapeutic models, creative arts therapies foreground non-verbal expression, embodied experience, and relational meaning-making, which may be especially salient for young people who find traditional clinical settings alienating or unsafe.

Importantly, the potential relevance of creative arts therapies for Black British youth lies not solely in symptom reduction, but in their capacity to support agency, identity affirmation, and emotional regulation within culturally familiar frameworks. Existing evidence suggests that creative arts interventions may be particularly effective in non-Western and Global Majority populations, yet there remains a significant gap in UK-based research examining how such approaches are experienced by Black British young people and how they might be delivered ethically within both clinical and community settings.

This thesis therefore focuses on creative arts therapies not as a replacement for conventional mental health care, but as a complementary and potentially transformative modality through which issues of access, engagement, and cultural safety may be addressed for Black British youth.

How might creative arts–based approaches contribute to more culturally competent, accessible, and effective mental health support for Black British young people in the UK?

2.0 Thesis structure

This thesis is organised into six main empirical chapters. Following the present introduction, chapter two explores the use of creative arts-based interventions with a particular psychiatric disorder affecting Black people in the UK most widely, PTSD. The chapter explores the present global evidence of creative arts therapies for PTSD and their effectiveness in this disorder particularly in non-Western and West African populations.

Chapter three provides an epidemiological analysis of the 2023 OxWell Student Survey, examining ethnic differences in mental health support use, perceived helpfulness of services, and barriers to care among Black adolescents compared with White British peers.

Chapter four reports a multicentred qualitative study conducted across five NHS Trusts, exploring the perspectives of Black young people with psychiatric disorders and clinicians regarding the use and cultural relevance of creative arts therapies within NHS mental health services.

Chapter five presents a mixed-methods pilot study of a community-based music intervention delivered in partnership with a South London charity. This chapter examines feasibility, acceptability, participant experience, and exploratory patterns of change in mental health and wellbeing outcomes.

The sixth and final chapter integrates findings across all studies, discussing theoretical, clinical, and policy implications, and outlining directions for future research and service development aimed at reducing mental health inequalities among Black British young people.

2.1 Personal Connection to this Research

When I was seven years old, my mother, my only parent, was deployed to the Iraq war eight months after 9/11. When she left, I immersed myself in the one thing that brought me peace of mind, the piano. This new form of expression helped me process the powerful emotions I could not make sense of. I knew that this was my only way to cope with her absence and after 13 months, mom was home safe and sound. Physically she was there, but emotionally, she was detached. Mom suffered from severe PTSD. The only thing that seemed to soothe her troubled mind was my neophytic tinkering of the piano keys. Looking back, I realized that mom needed me more than ever, and my new hobby seemed to be one of the only things to provide her with tranquillity.

While my passion for piano persists unyieldingly, my interest expanded into the field of psychiatry, specifically into the mental health of ethnic minorities and their acquisition of

adequate psychological care. As a Black woman, my mother faced considerable stigma in our community surrounding her mental disorder and seeking out psychological care whilst fearful of being judged made it more difficult. Impassioned to create change, I sought to address these stigmas in mental health within the Black community whilst pursuing my Bachelor of Science in Psychology at Howard University. I joined Dr. Jules Harrell's lab on the impact of stress and trauma on ethnic minorities and as a research assistant, I assisted in the development of culturally competent therapies for these individuals.

In 2017 as a Fulbright research award recipient, I examined alternative methods of recovery from PTSD with the Syrian refugee population in Berlin, Germany. Utilizing narrative therapy, I hypothesized that individuals would have a greater sense of emotional well-being over time retelling their experiences in comparison to their initial experience of war-induced distress. Given that space to turn their experiences into stories, my research showed an increase in life satisfaction and psychological resilience after therapy.

For my master's thesis at King's College London, I explored the attitudes surrounding music with inpatients at an eating disorder unit in south London. I found overwhelmingly positive interest in the use of music therapy as an adjunct to patients' current treatment and an overall increase in eating behaviours on the ward when patients would participate in a bi-weekly music group led by me.

I have seen firsthand the profound effects that music and creative arts can have on one's life, and with my previous experiences, I sought to answer if creative arts interventions can have those same positive effects in Black British young people struggling with their own mental health, and later, propose if these interventions can be scalable as a global solution to effectuate positive change in communities that need it most.

Chapter 2

Creative arts-based interventions for the improvement of PTSD symptoms in young people: a meta-analysis with a focus on non-Western populations

Chapter Summary

To begin this thesis, this chapter turns to the question of creative arts intervention effectiveness. If conventional service pathways and therapeutic models are not meeting the needs of Black young people globally, it is critical to examine whether alternative approaches have empirical support, particularly for populations who are underrepresented in Western clinical research.

There is an integral focus on post-traumatic stress disorder (PTSD) in this chapter as the lifetime prevalence of PTSD is highest in Black Britons at 37.8%, more than any other ethnic group in the UK (Wilson et al., 2025).

Creative arts-based interventions, including music, dance, visual art, and drama, have increasingly been proposed as complementary or alternative approaches to mental health care for children and adolescents (NCCATA, 2019). These interventions foreground non-verbal expression, embodied experience, and relational engagement, characteristics that may be especially relevant for young people who experience traditional talking therapies as inaccessible or culturally misaligned.

This chapter presents a meta-analysis of 33 quantitative studies (N= 4,587) examining the effectiveness of creative arts-based interventions for reducing PTSD and trauma-related symptoms in children and adolescents, with a specific focus on differences across Western and non-Western contexts. Overall, creative arts-based interventions led to a significant reduction in PTSD symptoms (Hedge's g = 0.85, 95% CI: [0.70, 1.00]). Strong effects were observed in participants with a PTSD diagnosis and in those with general trauma symptoms. Subgroup analysis revealed large effects in West African and Middle Eastern samples, but no significant effects in Western populations. Creative arts-based interventions show promise in reducing PTSD symptoms in non-Western youth. More culturally focused and high-quality studies are needed, particularly in Western contexts with non-Western youth.

By synthesising global evidence, this chapter evaluates whether creative arts interventions demonstrate consistent mental health benefits and whether cultural context moderates their effectiveness. The chapter also explores if creative arts can be culturally grounded solutions for different global populations.

2.1 Background

Posttraumatic stress disorder (PTSD) is a chronic and debilitating mental health disorder that develops after exposure to a traumatic event(Kessler et al., 2017). According to recent estimates, approximately 320 million people or 3.9% of the world population have had PTSD at some point in their lifetime (Kessler et al., 2017). The reasons for such a high prevalence of PTSD point largely to direct or indirect exposure to traumatic incidences such as physical violence, sexual trauma, serious injuries, natural disasters, and death (Bryant et al., 2008). It is estimated that 25% percent of children and adolescents around the world will experience a traumatic event before reaching adulthood (Ammar, 2006; Chen et al., 2004; Nelson et al., 2002; Takazawa, 2015). In a United States epidemiological study, the prevalence of PTSD in adolescents aged 13-17 was 4.7% (McLaughlin et al., 2013). PTSD can cause significant distress in a child's life and could result in functional disabilities which could impair social, academic, and occupational functioning if these chronic traumas are left untreated (Mavranezouli et al., 2020).

Current therapeutic strategies to treat PTSD in children and adolescents include trauma-focused cognitive behavioural therapy (TF-CBT), CBT for PTSD, group trauma-focused CBT, and eye movement desensitisation and reprocessing (EMDR) for persistent PTSD symptoms (NICE, 2018). Pharmacological interventions are not recommended for children and adolescents with PTSD(NICE, 2018). Despite CBT and EMDR being offered for the alleviation of PTSD symptoms in children and adolescents, nonresponse to CBT in both individual and group settings has been reported to be as high as 50% (Bryant et al., 2008; Schottenbauer et al., 2008). Recent evidence for the use of EMDR has found no significant difference between EMDR and other psychological treatments like CBT in reducing PTSD symptoms(Wright et al., 2024), further highlighting the variability of treatment efficacy. While TF-CBT has been suggested to be effective in Western populations (Cusack et al., 2016; Kar, 2011), there is little research concerning its efficacy in non-Western populations. To address the unique language and cultural needs of these populations, culturally adapted CBT (ca-CBT) was created (Naz et al., 2019) and preliminary evidence has shown ca-CBT to be effective in refugee and asylum seeker populations with trauma (Menon et al., 2024). In it, the main

elements of CBT have been preserved; however, the language, metaphors, techniques and examples used in CBT have been adapted to be culturally specific (Naz et al., 2019).

Despite attempts at culturally adapted talking therapies, ethnic minority groups in Western countries are less likely to access therapies for their psychiatric disorders (Baker, 2018). They also are less likely to have good outcomes in therapy and are more likely to report negative experiences in therapy, compared to white majority service users (Baker, 2018; Crawford et al., 2016; Mercer et al., 2019). Furthermore, psychotherapy for refugees and other vulnerable populations is scarce due to the high cost and limited skills among trauma specialists to meet the language and cultural needs of these populations (Grasser et al., 2019). This highlights the need for novel, accessible and effective treatment methods for underrepresented, non-Western populations experiencing trauma symptoms and PTSD (Kirmayer et al., 2011; Sharrad et al., 2008).

Art therapies are a form of psychotherapy, that involve a therapeutic relationship between a qualified therapist and an individual who engages in creative activities for diagnostic or remedial purposes (Davies & Clift, 2022). Creative arts therapies (CATs) are treatment interventions that involve art activities within therapy sessions and delivered by a trained creative arts therapist (NCCATA, 2019). Using creative arts therapeutically can either refer to trained therapists using creative arts methods in their sessions or community-based creative arts interventions administered by community-based creative arts instructors with no mental health or therapeutic training. The National Coalition of Creative Arts Therapies Associations (NCCATA) defines Creative Arts Therapists as, "human service professionals who use distinct arts-based methods and creative processes for the purpose of ameliorating disability and illness and optimizing health and wellness"(NCCATA, 2019).

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Creative arts-based interventions may provide novel solutions and alternative options to existing psychotherapies with variable success. Specifically, creative arts are unique therapeutic modalities that have the potential to overcome language barriers by utilizing predominantly nonverbal modalities that allow for the emotional expression of complex feelings in a nonverbal format (Grasser et al., 2019). Creative arts-based interventions can also be viewed as a therapeutic strategy that may mitigate stigma surrounding mental health treatments (Gaiha et al., 2021), as they are not traditional talking therapies, which have been

implicated in lacking engagement specifically with minoritized populations. In traditional talking therapies, these patients have reported feeling unwelcomed in services and stigmatized (Halvorsrud et al., 2018; Synergi Collaborative Centre, 2017). In a scoping review of over 3000 studies on the role of arts in improving health and wellbeing, Fancourt and Finn (2019) found that the arts play a large role in the prevention of ill health and promote good health (Fancourt & Finn, 2019). Arts also have an array of benefits related to building self-esteem, self-acceptance, confidence and self-worth which are all preventative characteristics of mental illness (Fancourt & Finn, 2019).

For Western samples, CATs have been shown to be tentatively promising for reducing symptoms of depression(Heise et al., 2013), anxiety and OCD (Nezgovorova et al., 2022), anorexia nervosa(Applewhite et al., 2020; Krishna Priya et al., 2021) and autism spectrum disorder (Applewhite et al., 2020). They further help with the psychotic symptoms found in schizophrenia (Lee et al., 2015). Evidence for the effectiveness of creative arts-based interventions for non-Western individuals with mental health symptoms has been growing. Among 500 Turkish children, for example, depressive symptoms decreased after a group Turkish traditional folk-dancing intervention(Aydin & Akandere, 2018). Additionally, in a group dance movement therapy and art therapy intervention with 470 participants, PTSD symptoms reduced in Nigerian children who endured a traumatic event (Ezeh et al., 2023). In West African cultures, specifically Nigerian culture, music plays an indispensable role at work, in politics, in socioeconomic engagements, in religious worship and in moral life (Mbaegbu, 2015). In the Yoruba tribes in Nigeria, music is reported to create a diasporic consciousness and becomes an important medium for maintaining contact and identity (Brennan, 2012). Together, these findings suggest that creative arts-based interventions might be an effective treatment in non-Western populations as they incorporate valued cultural elements.

Systematic reviews compiling the existing literature on the usage of creative arts-based interventions as effective treatment methods for children and adolescents with symptoms of trauma and PTSD have been largely inconclusive (Eaton et al., 2007; Van Westrhenen & Fritz, 2014). In these reviews, researchers compiled existing case studies, intervention studies, and qualitative studies to assess the evidence for the use of creative arts-based interventions for PTSD in children; but due to the heterogeneity of methods and outcome measurements utilized, it was difficult to make firm conclusions on these interventions' effectiveness (Eaton et al., 2007; Van Westrhenen & Fritz, 2014). A recently published meta-analysis on the effectiveness of creative arts interventions for treating children and adolescents exposed to traumatic events found that creative arts interventions significantly reduced PTSD symptom scores compared

to baseline scores (Hedge's g= 0.67, $p < .001$) (Morison et al., 2022). However, the meta-analysis had significant limitations due to the limited number of studies (15 pre-post, 7 with a control group), the heterogeneity of traumatic experience and intervention type, and there was no exploration into the effectiveness of CATs in under-represented children and adolescents.

The aims of the present research were twofold. First, we aimed to provide robust empirical evidence for the effectiveness of creative arts-based interventions among children and adolescents. To achieve this, the present meta-analysis includes only quantitative experimental studies, randomized controlled trials and pre-post intervention studies. We also examine which types of creative art intervention reduce PTSD scores, and how well creative arts-based interventions work based on PTSD diagnostic status and the duration of the intervention. Second, we aimed to examine whether creative arts-based interventions are more effective among non-Western than Western youth.

Although this meta-analysis does not include studies conducted specifically with Black British young people in the UK, its focus on non-Western and Global Majority populations is directly relevant to the present thesis. Black British youth are predominantly members of diasporic communities whose cultural frameworks, histories of trauma, and experiences of marginalisation differ substantially from those of White majority populations typically represented in Western clinical trials. Evidence demonstrating the effectiveness of creative arts interventions in African and Middle Eastern contexts therefore provides a critical foundation for examining how such approaches might translate to Black British youth within UK mental health services.

2.2 Methods

This meta-analysis was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021).The protocol was preregistered with PROSPERO (ID: CRD42023389789).

2.2.1 Eligibility Criteria

Studies were included if they met the following criteria: participants had a mean age under 18, exhibited symptoms of PTSD (subclinical or clinically diagnosed based on DSM-5), and interventions involved creative arts-based interventions, such as music, dance, poetry, drama, or art either as standalone treatments or combined with other mediums. Both randomized control trials (RCTs) and non-randomized pre-post intervention studies published

in English were included, with interventions facilitated by licensed or formally trained therapists and lasting at least one day. Comparators included CBT, EMDR, treatment-as-usual (TAU), waitlist controls, or no intervention. The primary outcome measure was PTSD symptom reduction from baseline to post-intervention.

Studies were excluded if they were systematic reviews, meta-analyses, case studies, conference proceedings, abstracts, unpublished theses, or if they were published before 2000. Studies were also excluded if they did not assess PTSD or trauma symptoms at both baseline and post-intervention. Studies were excluded if they were yoga, martial arts, Pilates, Tai Chi, mindfulness-based interventions, relaxation techniques, aromatherapy, reflexology, or acupuncture or talking therapies not as comparators,

2.2.2 Search Strategy & Study Selection

A comprehensive literature search was conducted across PubMed, PsycINFO, Web of Science, ProQuest, CINAHL, and Medline (OVID) for studies published between 2000 and September 17, 2025. Search terms included variations of "PTSD," "post-traumatic stress," "trauma," "child," "adolescent," "youth," and "creative arts therapy", alongside specific terms for music, dance, drama, art, and poetry therapy. Boolean operators were used to refine the search strategy.

Two independent reviewers (B.A. and B.D.) screened titles and abstracts using EndNote 20 and Microsoft Excel. Full texts of eligible studies were retrieved for further assessment. Duplicates were removed, and any discrepancies in inclusion decisions were resolved by consulting a third reviewer (O.S.). Additional studies were identified through hand searching, citation chaining of reference lists, and authors also searched reference lists of previous reviews and meta-analysis (Eaton et al., 2007; Morison et al., 2022; Van Westrhenen & Fritz, 2014) on this topic. The PRISMA flow diagram (Figure 1) presents the study selection process.

2.2.3 Protocol Deviations

This study was preregistered in PROSPERO (ID: CRD42023389789). However, there were two deviations from the original protocol. First, while the preregistration listed Scopus and Embase as databases to be searched, these were ultimately not included due to the overlap of results with other databases. Second, an inconsistency was identified in the preregistration regarding the inclusion of studies from 1990 or 2000 onwards. In this meta-analysis, studies

published from 2000 onwards were included, in alignment with the availability of more standardized PTSD diagnostic criteria. These deviations are documented for full transparency and adherence to PRISMA guidelines.

2.2.4 Quality Assessment

Study quality and risk of bias were evaluated using the Joanna Briggs Institute (JBI) critical appraisal tools(Tufanaru & Joanna Briggs Institute, 2017), applying the checklists specific to randomized controlled trials, quasi-experimental studies, and analytical cross-sectional studies. Studies were required to meet at least 80% of the checklist criteria to be included in the meta-analysis. Two reviewers independently assessed studies, with a cut-off of 80% for inclusion. Given the challenges in blinding participants and facilitators in arts-based interventions, this criterion was not factored into the overall study quality assessment. There were no conflicting judgements of the study quality between the two reviewers. Full quality assessment details are reported in Table 2 (Appendix, Chapter 2).

2.2.5 Data Extraction

Data were extracted into Microsoft Excel 16.79 by B.A. and B.D. then cross-checked by O.S. Extracted data included study characteristics (author, year, location, sample size, age, ethnicity), intervention details (creative arts-based intervention type, session duration, PTSD measure), and comparison group details (pre- and post-intervention PTSD scores, means, standard deviations). The primary outcome measure was change in PTSD symptoms from baseline to post-intervention.

2.2.6 Data Synthesis & Statistical Analysis

The meta-analysis was conducted using STATA 18.5 (StataCorp, 2023). Hedge's g was used to quantify effect sizes, classified as small (0.2–0.5), moderate (0.5–0.8), or large (>0.8) (J. Cohen, 1988). A random-effects model (*restricted maximum likelihood (REML*) was used to account for between-study heterogeneity. Subgroup analyses were conducted based on region of origin, creative arts-based intervention type, and PTSD diagnostic status. Studies were included in subgroup analyses if at least four studies were available per category.

Heterogeneity was assessed using Higgins' I^2, with values ≥75% indicating high heterogeneity. Publication bias was examined through Egger's test (Egger et al., 1997), and

funnel plots were generated using "meta funnelplot" in STATA 18.5. Publication bias was considered low if $p > 0.05$ and Egger's intercept was close to zero.

Sensitivity analysis conducted using the "metanif" command in Stata. Sequentially omitting each study did not meaningfully alter the pooled estimate, which ranged from Hedges' $g = 0.72$ to 0.90 (95% CI [0.71–0.91]). The overall pooled effect remained $g = 0.84$ (95% CI [0.83–0.84]), indicating that no individual study unduly influenced the results. In addition, analyses excluding studies rated below high quality on the JBI appraisal (≥80% threshold) were conducted, and the pooled effect size remained consistent. Finally, the impact of model specification was tested by comparing fixed-effect and random-effects models, with no substantive change in effect direction or magnitude observed.

2.2.7 Quality Assessment Results

All 33 studies included in the meta-analysis met the JBI quality criteria, though blinding of participants and facilitators was generally infeasible. The full quality assessment details are reported in Table 2 (Appendix – Chapter 2).

2.3 Results

2.3.1 Study selection

A total of 3602 records were screened after duplicates were removed. 86 full-text articles were assessed for eligibility, of which 53 were excluded for the following reasons: not a creative arts therapy (n = 18), not PTSD-related (n = 8), qualitative-only study (n = 19), symptoms not assessed (n = 3), systematic reviews (n = 3), and case reports (n = 2). A total of 33 studies were included in the meta-analysis. The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analyses) (Moher et al., 2009) flow chart is presented in Figure 1.

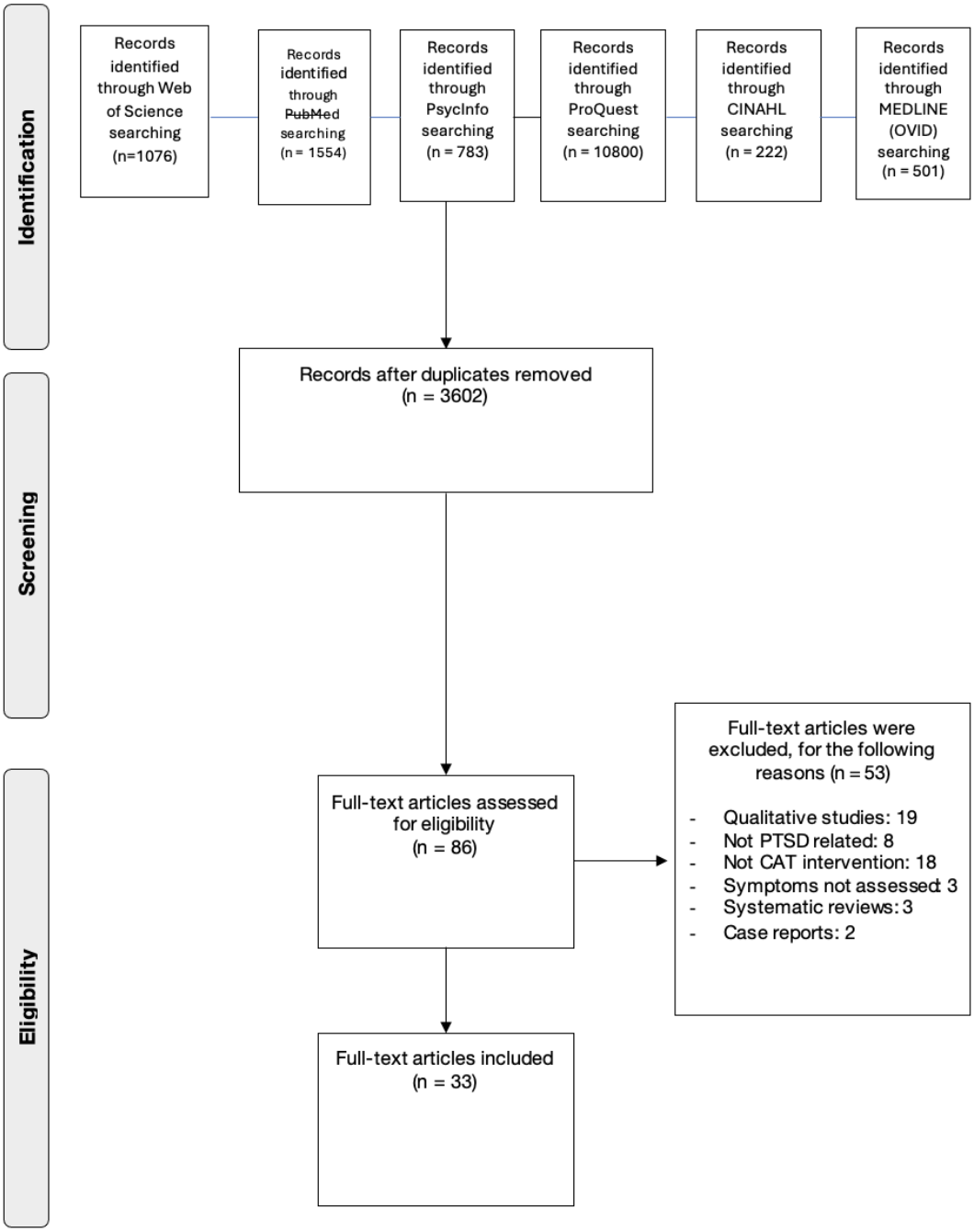


Figure 1. PRISMA Flow-diagram. The PRISMA Flow diagram displays the process for selection of the included full-text articles in the overall analysis.

The duration of the studies ranged from 5 days to 36 weeks (M = 10.06 weeks, SD = 6.88). The age of those allocated to creative arts-based interventions ranged from 3 to 18 years (M = 12.76 years, SD = 2.58). All studies were conducted on children and young people who had symptoms of trauma or a PTSD diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V)(American Psychiatric Association, 2013).

The type of creative arts-based intervention varied greatly. Studies utilized art, poetry, dance or dance movement-based interventions, music or music therapy as standalone treatments or a mixture of multiple creative interventions together. Table 1 provides a summary of the study and sample characteristics for each study.

Author, Year, Country	Sample size (n)	Study Design	Control group	Control condition	Sessions	Duration (weeks)	PTSD measure	Region (Nationality)	Type	Standalone Modality vs Combined	Mode of Delivery	Delivered by	Setting	Diagnostic Status
Anazor et al. 2023, Nigeria	400	Pre-Post	Yes	No intervention	N.R	26	ITQ	Africa (Nigerian)	Art	Standalone	Group, interactive television	Licensed Creative Arts Therapist	School	PTSD symptoms
Anichebe et al. 2024, Nigeria	342	RCT	Yes	TAU (unspecified)	12	6	ITQ	Africa (Nigerian)	Drama or Music	Standalone	Group, in person	Licensed Creative Arts Therapist	N.R.	Trauma symptoms
Bleile et al. 2024, Uganda	511	RCT	Yes	No intervention	11	N.R.	CRIES-8	Africa (Ugandan, South Sudanese)	Dance	Standalone	Group, in person	Trained facilitator	Refugee settlement	Trauma symptoms
Brillantes-Evangelista 2013, Phillipines	29	Pre-Post	No	N/A	8	8	CROPS	Asia (Phillipino)	Art or Poetry	Standalone	Group, in person	Trained facilitator	Hospital	PTSD symptoms
Burruss et al. 2021, USA	28	Pre-Post	No	N/A	4 to 10	N.R.	SDQ	Mixed (Mixed)	Art	Standalone	Group, in person	Licensed Creative Arts Therapist	Community sites	Trauma symptoms
Colegrove et al. 2018, Australia	26	RCT	Yes	TAU (unspecified)	8	8	SDQ	Mixed (Mixed)	Music	Standalone	Individual, in person	Licensed Creative Arts Therapist	Community centre	Trauma symptoms
Culver et al. 2015, Haiti	36	RCT	Yes	Waitlist control	N.R.	8	UCLA PTSD RI	Caribbean (Haitian)	Dance	Standalone	Group, in person	Trained facilitator	School	Trauma symptoms

Dauber et al. 2015, USA	31	Pre-Post	No	N/A	9 to 10	12	TSCC	North-America (American)	Art	Standalone	Individual and group, in person	Licensed Creative Arts Therapist	Outpatient centre	Trauma symptoms
Decosimo et al. 2019, Nigeria	356	Pre-Post	No	N/A	N.R	20	PSS	Africa (Nigerian)	Art, Play, Yoga	Combined	Group, in person	Licensed Creative Arts Therapist	Sites within community	Trauma symptoms
Ewulu et al. 2024, Nigeria	323	Pre-Post	Yes	No intervention	10	10	ITQ	Africa (Nigerian)	Music or Art	Standalone	Group, in person with interactive media	Licensed Creative Arts Therapist	N.R.	PTSD symptoms
Ezeh et al. 2023, Nigeria	470	RCT	Yes	No intervention	20	10	ITQ	Africa (Nigerian)	Dance or Art	Standalone	Group, interactive media	Licensed Creative Arts Therapist	N.R.	Trauma symptoms
Feen-Calligan et al. 2020, USA	24	Pre-Post	Yes	No intervention	12	12	UCLA PTSD RI	Middle East (Syrian)	Art	Standalone	Group, in person	Licensed Creative Arts Therapist	Interventio n site	PTSD symptoms
Gordon et al. 2008, USA	77	RCT	Yes	Waitlist control	12	6	HTQ	Europe (Mixed)	Mix of Creative Expressi on	Combined	Group, in person	Trained facilitator	School	PTSD diagnosis
Grasser et al. 2019, USA	20	Pre-Post	No	N/A	12	12	UCLA PTSD RI	Middle East (Syrian)	Dance	Standalone	Group, in person	Licensed Creative Arts Therapist	Community site	PTSD symptoms

Hylton et al. 2019, USA	34	Pre-Post	No	N/A	N.R.	2	CRTES	North-America (American)	Art, Music, Drama	Combined	Group, in person	Licensed Creative Arts Therapist	School	PTSD diagnosis
Iyendo et al. 2024, Nigeria	429	RCT	Yes	No intervention	6	6	ITQ	Africa (Nigerian)	Art or Music	Standalone	Group, interactive media	Licensed Creative Arts Therapist	School	PTSD symptoms
Kalthom et al. 2024, Iran	20	RCT	Yes	No intervention	12	6	PCL-C	Middle East (Syrian)	Art	Standalone	Group, in person	Trained facilitator	Art Gallery	PTSD diagnosis
Lyshak-Stelzer et al. 2007, USA	29	RCT	Yes	TAU (unspecified)	16	16	UCLA PTSD RI	North-America (Amerian)	Art	Standalone	Group, in person	Licensed Creative Arts Therapist	Inpatient unit	PTSD diagnosis
Momartin et al. 2019, Australia	32	Pre-Post	No	N/A	30	36	SDQ	Mixed (Mixed)	Dance	Standalone	Group, in person	Trained facilitator	School	Trauma symptoms
Moosa et al. 2017, India	30	Pre-Post	No	N/A	5	3	DASS-21	Asia (India)	Art	Standalone	Group, in person	Trained facilitator	Refugee camp	Trauma symptoms
O'Callaghan et al. 2014, Ireland	159	RCT	Yes	Waitlist control	8	8	CRIES-8	Africa (Congolese)	Art	Standalone	Group, in person	Trained facilitator	Resident villages	PTSD symptoms
Pifalo 2002, USA	13	Pre-Post	No	N/A	10	10	TSCC	North-America (American)	Art	Standalone	Group, in person	Trained facilitator	Community centre	PTSD symptoms
Pifalo 2006, USA	41	Pre-Post	No	N/A	8	8	TSCC	North-America (American)	Art	Standalone	Group, in person	Trained facilitator	Community centre	PTSD symptoms

Pretorius & Pfeifer 2010, South Africa	25	Pre-Post	No	N/A	8	8	TSCC	Africa (South African)	Art	Standalone	Group, in person	Trained facilitator	N.R.	Trauma symptoms
Quinlan et al. 2016, Australia	42	Pre-Post	No	N/A	10+	10	HSCL-25	Mixed (Mixed)	Art, Music	Combined	Group, in person	Licensed Creative Arts Therapist	School	Trauma symptoms
Staples et al. 2011, USA	129	Pre-Post	No	N/A	N.R	10	CPSS	Middle East (Palestenian)	Mix of Creative Expression	Combined	Group, in person	Trained facilitator	Non-Profit Organisations where participants were recruited	PTSD diagnosis
Thabet et al. 2005, Palestine	89	Pre-Post	No	N/A	7	7	CPTSD-RI	Middle East (Palestenian)	Storytelling, Play, Art	Combined	Group, in person	Trained facilitator	Summer camp for Refugee children	PTSD diagnosis
Tol et al. 2008, Indonesia	403	RCT	Yes	Waitlist control	15	5	CPSS	Asia (Indonesian)	Play, Creative expression	Combined	Group, in person	Trained facilitator	School	PTSD symptoms
Truppi 2001, USA	28	Pre-Post	No	N/A	N.R.	10	TSCC	North-America (American)	Dance	Standalone	Group, in person	Licensed Creative Arts Therapist	Hospital	Trauma symptoms
Ugurlu et al. 2016, Turkey	35	Pre-Post	No	N/A	15	0.71	UCLA PTSD RI	Middle East (Syrian)	Art, Dance, Music	Combined	Group, in person	Trained facilitator	Refugee houses	PTSD symptoms

van Westrhenen et al. 2019, South Africa	47	Pre-Post	No	N/A	10	10	C-PTSD-C	Africa (South African)	Art, Dance, Music, Drama, Storytelling	Combined	Group, in person	Trained facilitator	Child abuse clinic	Trauma symptoms
Woollett et al. 2020, South Africa & USA	9	Pre-Post	No	N/A	12	12	PTSD-RI	Mixed (Mixed)	Art, Play	Combined	Group, in person	Trained facilitator	Domestic violence shelter	PTSD symptoms
Zhang et al. 2023, Nigeria	470	RCT	Yes	TAU (unspecified)	6	6	ITQ	Africa (Nigerian)	Music, Art, or Poetry	Standalone	Group, in person, interactive media	Licensed Creative Arts Therapist	School	PTSD symptoms

Table 1: Summary of the studies included in the meta-analysis. Studies are listed in alphabetical order. Study characteristics include sample size, study design, control conditions, number of sessions, duration of intervention, type of PTSD measure, region of population, treatment setting, and diagnostic status.

Abbreviatons: CPSS= Child PTSD Symptom Scale for DSM-5, CPTSD-C, CPTSD-RI=Child Post-Traumatic Stress Disorder Reaction Index; CRIES-8= Children's Revised Impact of Event Scale;, CROPS= Child Report of Post-traumatic Symptoms; CRTES= Child's Reaction to Traumatic Events Scale; DASS-21=The Depression, Anxiety and Stress Scale;,HSCL-25= Hopkins Symptom Checklist-25;, HTQ= Harvard Trauma Questionnaire, ITQ = International Trauma Questionnaire; N/A - not applicable; N.R = None reported; RCT = Randomised controlled trial. TAU = Treatment As Usual, SDQ= Strength and Difficulties Questionnaire, PSS=PTSD Symptom Scale, PTSD-RI=UCLA Child/Adolescent PTSD Reaction Index for DSM-5; TSCC=Trauma Symptom Checklist for Children.

2.3.2 Effectiveness of creative arts-based interventions among children and adolescents

The pooled effect size, reported as Hedges' g, of the meta-analysis across all study types for the effect of creative arts-based interventions on PTSD symptoms are reported in Figure 2. Effects are classified as small (0.2-0.5), medium (0.5-0.8) and large (≥.08). All 33 studies included uncontrolled pre-post measurement of trauma or PTSD (Anazor et al., 2023; Anichebe et al., 2024; Bleile et al., 2025; Brillantes-Evangelista, 2013; Burruss et al., 2021; Colegrove et al., 2018; Culver et al., 2015; Dauber et al., 2015; Decosimo et al., 2019; Ewulu et al., 2024; Ezeh et al., 2023; Feen-Calligan et al., 2020; Gordon et al., 2008; Grasser et al., 2019; Hylton et al., 2019; Iyendo et al., 2024; Kalthom et al., 2025; Lyshak-Stelzer et al., 2007; Mom et al., 2019; Moosa et al., 2017; O'Callaghan et al., 2014; Pifalo, 2002, 2006; Pretorius & Pfeifer, 2010; Quinlan et al., 2016; Staples et al., 2011; Thabet et al., 2005; Tol et al., 2008; Truppi, 2001). The results of the pooled standardised effect sizes show a significant decrease in PTSD symptoms when a creative arts-based intervention was utilised with a large effect size (Hedge's $g = 0.85$; $p < 0.001$; 95% CI [0.70, 1.00]).

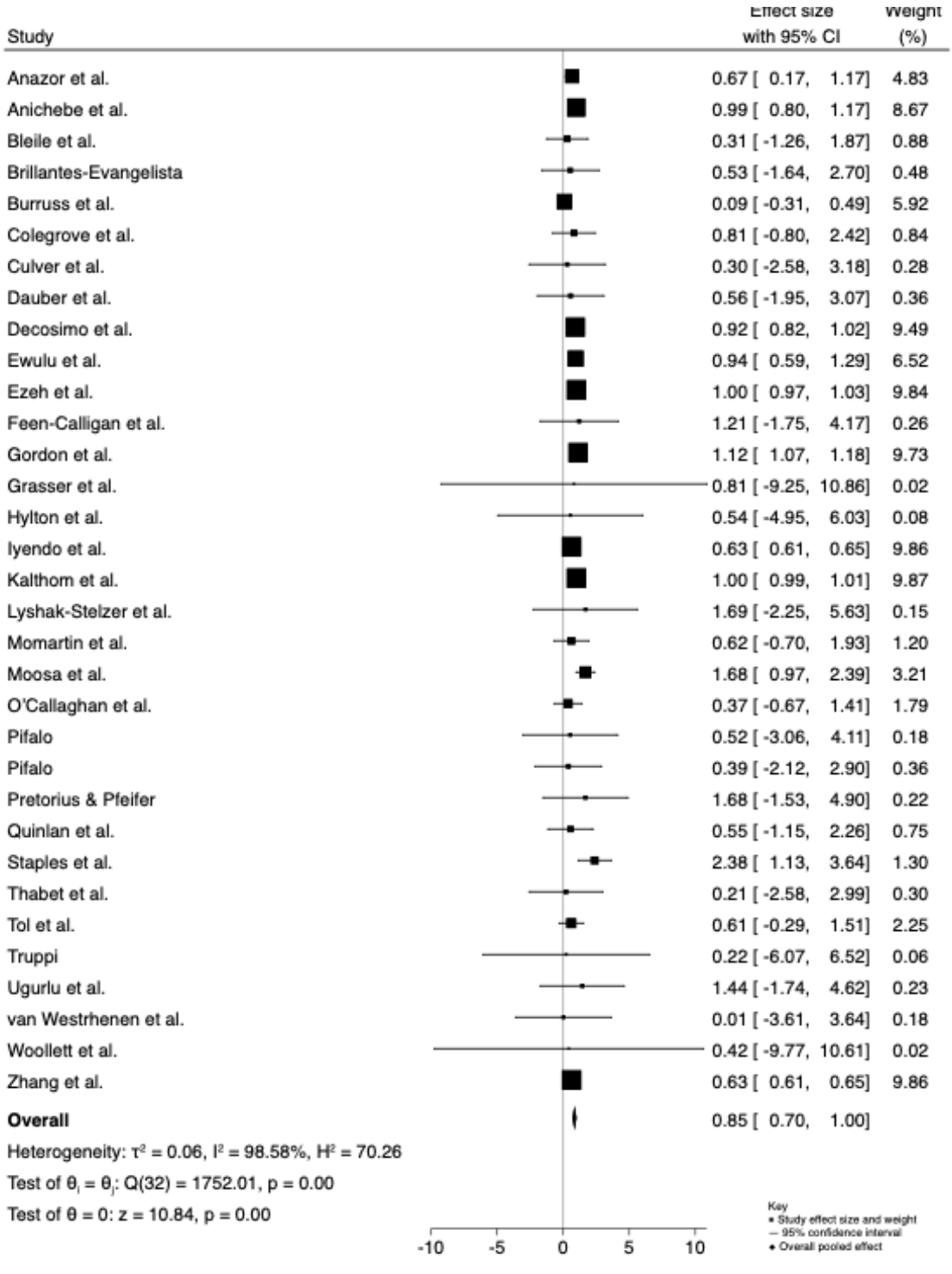


Figure 2: Forest plot of the individual and overall study effect sizes. This plot shows the overall effect size for all 33 studies included in the meta-analysis (g=0.85) [95% CI: 0.70, 1.00]. Effect sizes (Hedges' g) and their 95% confidence intervals (CIs) were calculated for each study. The pooled effect size was estimated using a random-effects model with restricted maximum likelihood (REML). Heterogeneity was assessed using Cochran's Q test ($Q(32) = 1752.01$, $p < 0.001$), the I^2 statistic ($I^2 = 98.58\%$), and $\tau^2 = 0.06$. All tests were two-sided. No adjustments for multiple comparisons were applied, as this analysis addressed a single pooled hypothesis test.

2.3.3 Pre-Post comparisons in non-randomized trials

Data from a total of 20 non-randomized studies (Anazor et al., 2023; Brillantes-Evangelista, 2013; Burruss et al., 2021; Dauber et al., 2015; Decosimo et al., 2019; Feen-Calligan et al., 2020; Grasser et al., 2019; Hylton et al., 2019; Mom et al., 2019; Moosa et al., 2017; Pifalo, 2002, 2006; Pretorius & Pfeifer, 2010; Quinlan et al., 2016; Staples et al., 2011; Thabet et al., 2005; Truppi, 2001; Ugurlu et al., 2016; Van Westrhenen & Fritz, 2014; Woollett et al., 2020) using a sample of 1,442 participants at baseline to follow-up were included in this meta-analysis (see Table 1).

All 20 studies used uncontrolled pre-post designs and took PTSD measurements at baseline and follow-up, and nine studies(Anazor et al., 2023; Bleile et al., 2025; Brillantes-Evangelista, 2013; Ewulu et al., 2024; Pretorius & Pfeifer, 2010; Thabet et al., 2005; Truppi, 2001; Ugurlu et al., 2016; Van Westrhenen & Fritz, 2014) included non-randomized comparison groups. However, in these studies, participants were not randomized to either intervention, which suggests the potential presence of selection bias. Nonetheless, the data suggests a significant reduction in PTSD symptoms from baseline to follow-up with an overall large effect size (Hedge's $g = 0.86$, $p < 0.001$, 95% CI [0.44, 1.28], Figure 3).

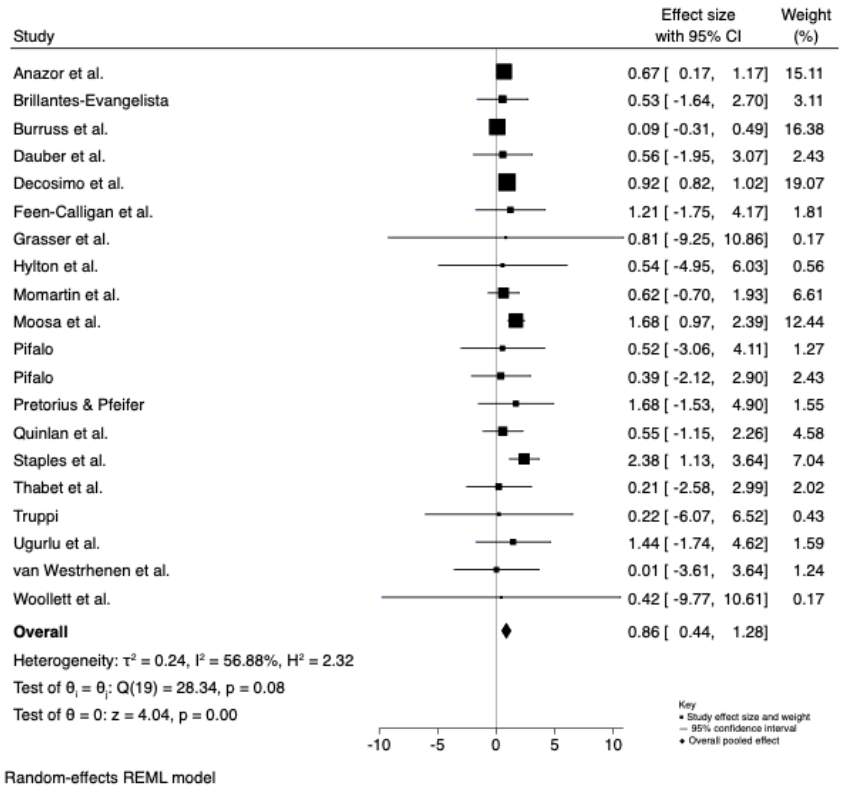


Figure 3: Forest plot of pre-post studies effect sizes and pooled estimate. This forest plot shows the overall effect size for the pre-post studies (n=20) included in the meta-analysis. The overall pooled effect was statistically

significant ($z = 4.04$, $p < 0.001$), with an estimated effect size of 0.86 [95% CI: 0.44, 1.28]. Effect sizes (Hedges' g) and their 95% confidence intervals (CIs) were calculated for each study. The pooled effect size was estimated using a random-effects model with restricted maximum likelihood (REML). Heterogeneity was assessed using Cochran's Q test ($Q(19) = 28.34$, $p = 0.08$), the I^2 statistic ($I^2 = 56.88\%$), and $\tau^2 = 0.24$. All tests were two-sided. No adjustments for multiple comparisons were applied, as this analysis addressed a single pooled hypothesis test.

2.3.4 Controlled comparisons with active vs. passive control groups

We conducted a subgroup analysis on studies using controlled post-treatment comparisons with either an active or passive control condition. Four studies (Anichebe et al., 2024; Colegrove et al., 2018; Lyshak-Stelzer et al., 2007; Zhang et al., 2023) included an active control group (receiving treatment as usual (TAU) in addition to pre-post measurements (Figure 4). Across the included studies, TAU was generally described by authors as routine care but was rarely specified in detail. It is unclear whether TAU involved evidence-based treatments such as CBT or EMDR, group therapy, or non-specific supportive care. Across these studies, 501 participants participated in a creative arts-based intervention and 362 in a control condition. At follow-up, those who participated in one of the creative arts-based interventions showed a lower PTSD score in comparison with those who participated in no intervention, continued treatment as usual or stayed on the waitlist. Results showed a significantly large effect size for the reduction of PTSD symptoms when a creative arts-based intervention was used compared to the active control condition treatment as usual (Hedge's $g = 0.80$, $p < 0.001$; 95% CI [0.48, 1.12]).

Nine studies (Bleile et al., 2025; Culver et al., 2015; Ewulu et al., 2024; Ezeh et al., 2023; Gordon et al., 2008; Iyendo et al., 2024; Kalthom et al., 2025; O'Callaghan et al., 2014; Tol et al., 2008) included a passive control group (no intervention, waitlist controls) in addition to pre-post measurements (Figure 4). Across these studies, 1,142 participants participated in a creative arts-based intervention and 1,126 in a passive control condition. At follow-up, those who participated in one of the creative arts-based interventions showed a lower PTSD score in comparison with those who participated in no intervention or stayed on the waitlist. Results showed a significantly larger reduction of PTSD symptoms when a creative arts-based intervention was utilized compared to passive control conditions (Hedge's $g = 0.91$, $p < 0.001$; 95% CI [0.73, 1.08]).

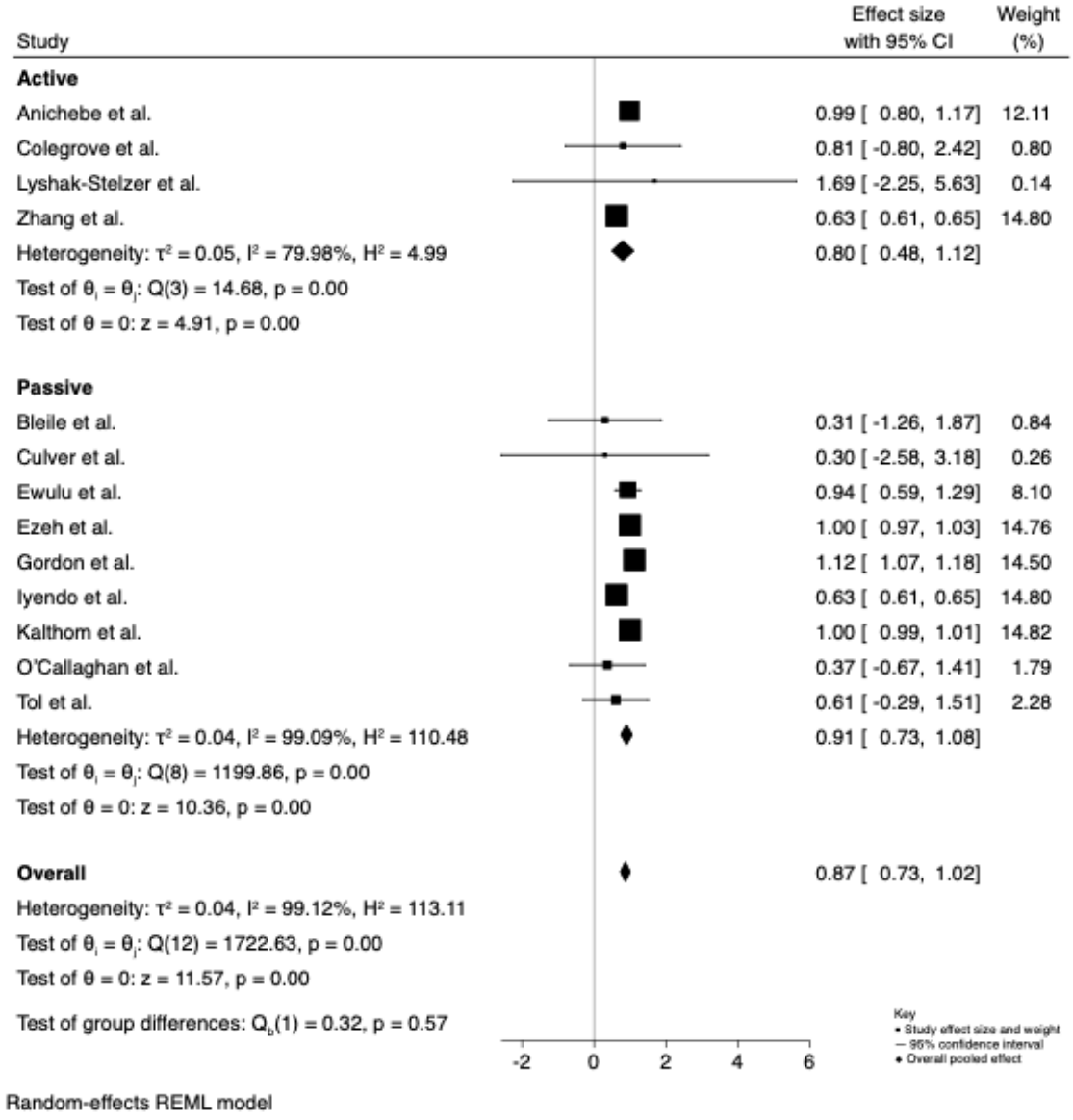


Figure 4: Forest plot of active vs. passive control conditions. This forest plot shows the subgroup analysis on interventions with active vs passive control groups. Active control groups included receiving treatment as usual (TAU) while passive control conditions included waitlist or receiving no treatment. Active interventions showed a significant pooled effect (g = 0.80, 95% CI: 0.48–1.12; Q(3) = 14.68, $p < 0.001$; $I^2 = 79.98\%$), as did passive interventions (g = 0.91, 95% CI: 0.73–1.08; Q(8) = 1199.86, $p < 0.001$; $I^2 = 99.09\%$). Effect sizes (Hedges' g) with 95% confidence intervals (CIs) were estimated using a random-effects REML model. Overall effect was significant (g = 0.87, 95% CI: 0.73–1.02; Q(12) = 1722.63, $p < 0.001$; $I^2 = 99.12\%$). No subgroup difference was observed (Q_b(1) = 0.32, $p = 0.57$). All tests two-sided; no adjustments for multiple comparisons.

2.3.5 Publication bias

All 33 meta-analyses showed high heterogeneity (75-95%) indicating the heterogeneity of the studies. The results of the Egger test indicated no significant evidence of small-study effects in the pre-post analysis including all studies (z = -0.31; p = 0.76), the non-randomized pre-post interventions (z=0.05; p=0.96), and those with active and passive control groups (z = -0.67; p = 0.51) suggesting that publication bias is unlikely to have substantially influenced the meta-analysis results.

2.3.6 Subgroup analysis of different types of creative arts-based intervention

A subgroup analysis was performed on the uncontrolled pre-post comparisons with the type of creative arts-based intervention. This subgroup analysis included both CAT interventions as well as creative arts-based interventions. Intervention types were only considered if they contained five or more studies (see Table 1 for a full breakdown). We thus considered Art, Dance, Music, and a Mix group that included creative arts-based interventions that utilized music, dance, art, drama, poetry, in different sessions in combination. Results indicate a significant and large effect for Mix interventions (Hedge's g = 1.01, $p < 0.001$, 95% CI [0.81, 1.20]) and a significant and large effect for both Art interventions (Hedge's g = 0.79, $p < 0.001$, 95% CI [0.56, 1.03]), and Dance interventions (Hedge's g = 1.00, $p < 0.001$, 95% CI [0.96, 1.04]. In the Music group, there was a significant medium effect for the reduction of PTSD scores (Hedge's g = 0.63, $p < 0.001$, 95% CI [0.61, 0.65], see Figure 5).

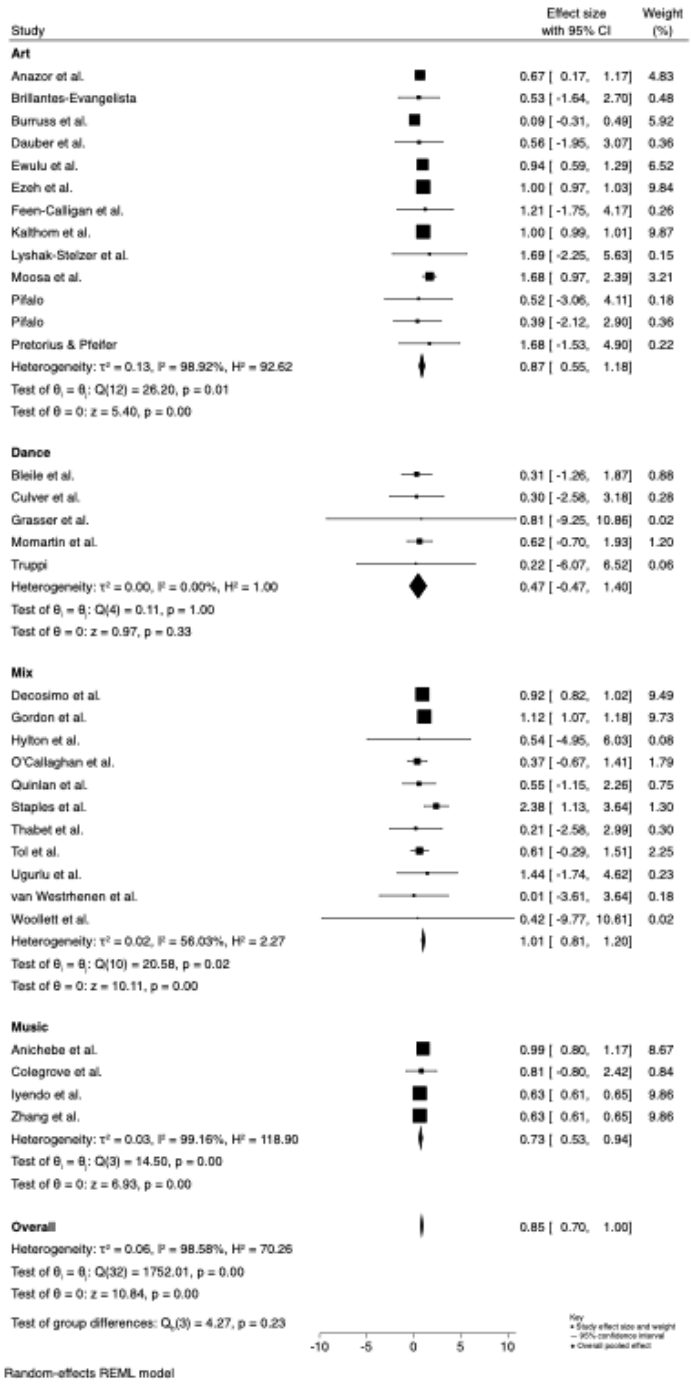


Figure 5: Subgroup meta-analysis by intervention type (Art, Dance, Mix, Music). This forest plot shows the effect sizes by intervention type. Effect sizes (Hedges' g) with 95% confidence intervals (CIs) were estimated using a random-effects REML model. Pooled effects were: Art (g = 0.79, 95% CI: 0.56–1.03; Q(14) = 916.60, p < 0.001; I^2 = 99.14%), Dance (g = 1.00, 95% CI: 0.82–1.20; Q(5) = 13.86, p = 0.02; I^2 = 0.00%), Mix (g = 1.01, 95% CI: 0.81–1.20; Q(10) = 20.58, p = 0.02; I^2 = 56.03%), and Music (g = 0.63, 95% CI: 0.61–0.65; Q(4) = 2.43, p = 0.66; I^2 = 0.04%). The overall pooled effect was significant (g = 0.83, 95% CI: 0.70–0.95; Q(36) = 1734.62, p < 0.001; I^2 = 98.25%). A significant subgroup difference was observed (Q_b(3) = 271.36, p < 0.001). All tests two-sided; no adjustments for multiple comparisons.

2.3.7 Subgroup analysis of PTSD diagnostic status

We next performed an uncontrolled pre-post comparison subgroup analysis on PTSD diagnostic status in all 33 studies in three different categories: "PTSD diagnosis," which represents studies where patients were diagnosed with PTSD based on the DSM-V criteria (American Psychiatric Association, 2013) prior to beginning the creative arts-based intervention; "PTSD symptoms," which represents studies where patients had symptoms of PTSD but not a diagnosis; and "Trauma symptoms," which represents studies where patients have cited symptoms of trauma for a short period of time, but not full presentation of PTSD symptoms or a PTSD diagnosis.

This analysis yielded a significant reduction in PTSD and trauma symptoms with a large effect size in both the "PTSD diagnosis" group (Hedge's g = 1.07, $p < .0001$, 95% CI [0.94, 1.20)] and the "Trauma symptoms" group (Hedge's g = 0.82, $p < .0001$, 95% CI [0.50, 1.14]). Additionally, there was a medium effect size and a significant reduction in the "PTSD symptoms" group (Hedge's g = 0.73, $p < 0.001$, 95% CI [0.54, 0.92], see Figure 6).

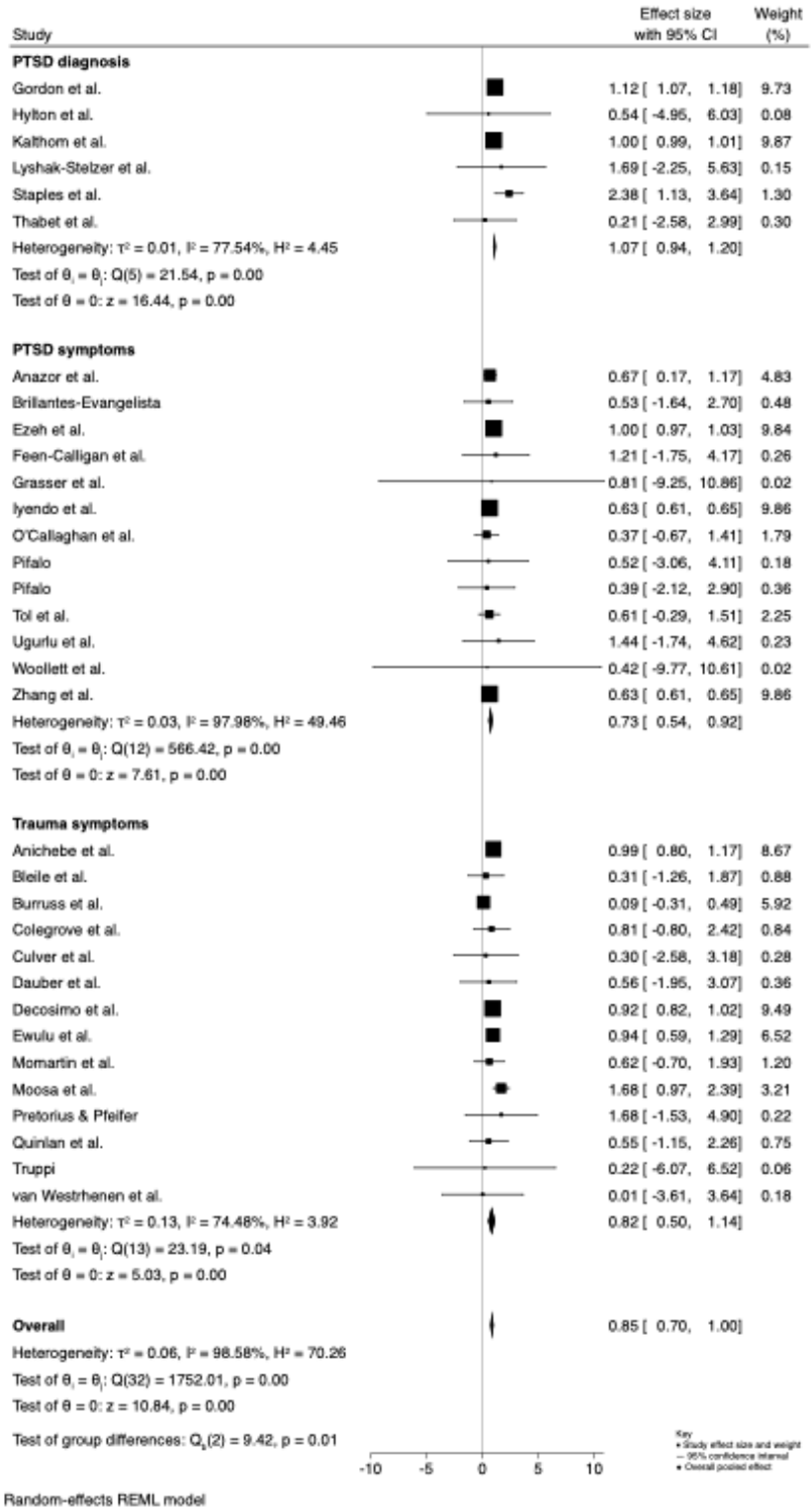


Figure 6: Subgroup meta-analysis by symptom severity. This forest plot shows the overall effect sizes based on the type of symptoms experienced by participants (PTSD diagnosis, PTSD symptoms, trauma symptoms. Pooled effects were: PTSD diagnosis (g = 1.07, 95% CI: 0.94–1.20; Q(5) = 21.54, $p < 0.001$; $I^2 = 77.54\%$), PTSD symptoms (g = 0.73, 95% CI: 0.54–0.92; Q(12) = 566.42, $p < 0.001$; $I^2 = 97.98\%$), and trauma symptoms (g = 0.82, 95% CI: 0.50–1.14; Q(13) = 23.19, p = 0.04; $I^2 = 74.48\%$). Effect sizes (Hedges' g) with 95% confidence intervals (CIs) were estimated using a random-effects REML model. The overall pooled effect was significant (g

= 0.85, 95% CI: 0.70–1.00; Q(32) = 1752.01, p < 0.001; I^2 = 98.58%). A test of subgroup differences was significant (Q_b(2) = 9.42, p = 0.01). All tests two-sided; no adjustments for multiple comparisons.

2.3.8 Meta-regression analysis on duration of intervention

We conducted meta-regression analysis (uncontrolled, pre-post) on the continuous variable time interval in weeks of the creative arts intervention. Thirty-one studies (Anazor et al., 2023; Anichebe et al., 2024; Brillantes-Evangelista, 2013; Colegrove et al., 2018; Culver et al., 2015; Dauber et al., 2015; Decosimo et al., 2019; Ewulu et al., 2024; Ezeh et al., 2023; Feen-Calligan et al., 2020; Gordon et al., 2008; Grasser et al., 2019; Hylton et al., 2019; Iyendo et al., 2024; Kalthom et al., 2025; Lyshak-Stelzer et al., 2007; Mom et al., 2019; Moosa et al., 2017; O'Callaghan et al., 2014; Pifalo, 2002, 2006; Pretorius & Pfeifer, 2010; Quinlan et al., 2016; Staples et al., 2011; Thabet et al., 2005; Tol et al., 2008; Truppi, 2001) (n = 4,048) reported the length of time of creative arts-based intervention. Results show that the effect of time interval was not significantly associated with a reduction in PTSD scores over time (β = -0.006, *SE* = . .011, p = 0.572, 95% CI [-.027, .015]). This means that the amount of time the creative arts-based intervention lasted did not significantly effect the reduction of PTSD scores in the patient population.

2.3.9 Effectiveness of Interventions by Therapist Qualification

To examine whether the effectiveness of creative arts-based interventions differed based on the qualifications of the interventionist, we conducted a subgroup analysis in 32 studies with uncontrolled pre-post data to compare effects between interventions delivered by licensed creative arts therapists and those delivered by trained facilitators (one study was excluded as it contained a mixture of licensed creative therapists and trained facilitators (Dauber et al., 2015)). The pooled effect size was significantly larger for interventions delivered by trained facilitators compared to licensed creative arts therapists, suggesting that trained facilitators may deliver creative arts-based interventions with comparable or even greater efficacy (see Appendix, Chapter 2, Figure 4).

2.3.9.1 Meta-Regression Analysis of Within-Study Differences by Intervention Type

To further explore whether effect sizes differed by intervention type within studies, a series of random-effects meta-regressions were conducted on the six studies (Anichebe et al., 2024; Brillantes-Evangelista, 2013; Ewulu et al., 2024; Ezeh et al., 2023; Iyendo et al., 2024; Zhang et al., 2023) (uncontrolled, pre-post comparison) that included multiple creative arts therapies.

Intervention type was included as a categorical moderator, and each model rotated the reference category (Art, Music, Dance, Drama, and Poetry) to enable all pairwise comparisons between modalities. Across all models, the meta-regression revealed no significant differences in effect sizes between intervention types (Wald χ^2 (4) = 2.24, p = 0.692), and the moderator explained none of the between-study heterogeneity (R^2 = 0.00).

These findings suggest that, within studies directly comparing multiple creative arts-based interventions, no single modality (e.g., Art, Music, Dance, Drama, or Poetry) showed a consistent advantage over another. The therapeutic benefit observed may therefore reflect a shared underlying mechanism common to creative arts therapies rather than being driven by one specific modality (Appendix Chapter 2, Table 3).

2.3.9.2 Effectiveness of creative arts-based interventions among non-Western children and adolescents

To address our second research aims, we next compared the effectiveness of creative arts-based interventions in Western and non-Western populations by grouping the studies according to participants' region of origin (e.g., the Middle East). This subgroup analysis used uncontrolled pre–post comparisons within each region. Populations were only considered if they contained five or more studies. Thus, only samples from Africa, the Middle East and North America were analyzed for subgroup effects. Africa comprised mostly samples from Nigeria, the Middle East samples from Syria and Palestine, and North America samples from only the United States. While there were five studies in the Mixed group, this group contained too many different ethnicities to draw meaningful conclusions.

We found significant reductions in PTSD symptoms from pre- to post-creative arts-based intervention in Africa (Anazor et al., 2023; Anichebe et al., 2024; Bleile et al., 2025; Decosimo et al., 2019; Ewulu et al., 2024; Ezeh et al., 2023; Feen-Calligan et al., 2020; Iyendo et al., 2024; Pretorius & Pfeifer, 2010; Van Westrhenen et al., 2019; Zhang et al., 2023) (n = 3,353, Hedge's g = 0.81, $p < 0.001$, 95% CI [0.68, 0.95]) and the Middle East (Feen-Calligan et al., 2020; Grasser et al., 2019; Kalthom et al., 2025; Staples et al., 2011; Thabet et al., 2005; Ugurlu et al., 2016) (n = 317, Hedge's g = 1.30, $p < 0.001$, 95% CI [0.51, 2.10]) but not in North America (Dauber et al., 2015; Hylton et al., 2019; Lyshak-Stelzer et al., 2007; Pifalo, 2002, 2006; Truppi, 2001) (n = 176, Hedge's g = 0.62, $p >.05$, 95% CI [-0.76, 2.01]) (see Figure 7). In terms of effect sizes, the findings suggest a greater reduction in PTSD scores when a creative

arts-based intervention was utilized within African and Middle Eastern samples; however, the differences between the three regions was not statistically significant.

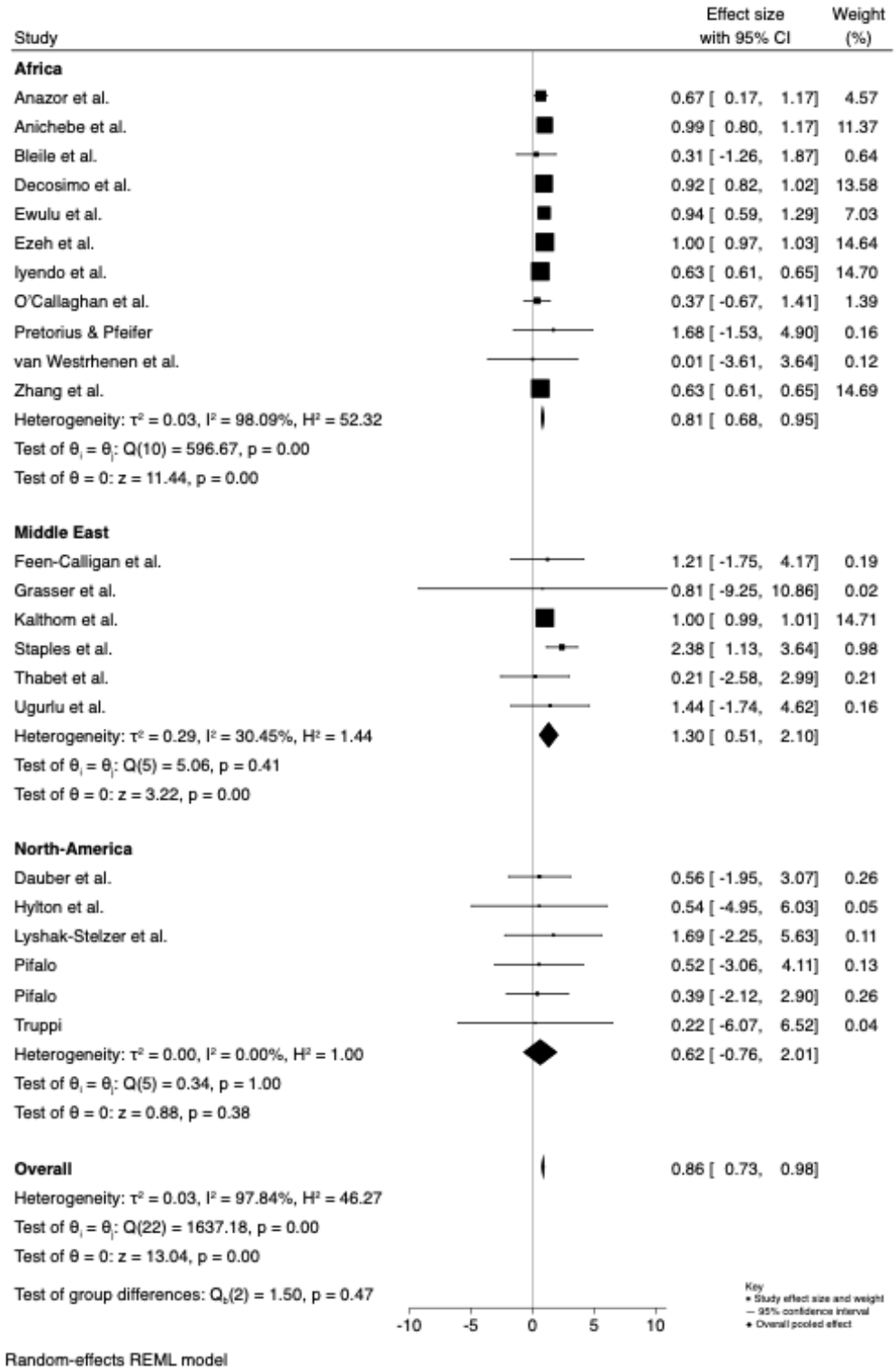


Figure 7: Subgroup meta-analysis by region. This forest plot shows the overall effect sizes by region. Africa, the Middle East and North America are included in this subgroup analysis. The pooled effects by Region were: Africa (g = 0.81, 95% CI: 0.68–0.95; Q(10) = 596.67, p < 0.001; I^2 = 98.09%), Middle East (g = 1.30, 95% CI: 0.51–2.10; Q(5) = 5.06, p = 0.41; I^2 = 30.45%), and North America (g = 0.62, 95% CI: –0.76–2.01; Q(5) = 0.34, p = 1.00; I^2 = 0.00%). Effect sizes (Hedges' g) with 95% confidence intervals (CIs) were estimated using a random-effects REML model. The overall pooled effect was significant (g = 0.86, 95% CI: 0.73–0.98; Q(22) = 1637.18, p < 0.001; I^2 = 97.84%). No significant subgroup differences were observed (Q_b(2) = 1.50, p = 0.47). All tests two-sided; no adjustments for multiple comparisons.

2.4 Discussion

This meta-analysis found that creative arts-based interventions significantly reduce PTSD symptoms in children and adolescents, with an overall large effect size (Hedge's g = 0.85). Subgroup analysis suggested that children with a PTSD diagnosis or trauma symptoms may benefit more from creative interventions. We also found that the duration of creative arts-based intervention was not associated with a reduction in PTSD scores over time suggesting that the length of time an individual participates in a creative arts intervention does not impact the overall effect of their PTSD symptoms. As previous meta-analyses have not explored the effect of study duration on symptom reduction, follow-up analyses should be conducted to assess if the length of participation impacts symptom reduction as well as the duration of effects post-intervention.

A meta-regression of the six studies (Anichebe et al., 2024; Brillantes-Evangelista, 2013; Ewulu et al., 2024; Ezeh et al., 2023; Iyendo et al., 2024; Zhang et al., 2023) with multiple creative arts-based intervention types revealed no significant differences in effect sizes between creative arts therapies, suggesting that therapeutic benefits may be shared across modalities rather than specific to any one intervention type.

In terms of the creative arts intervention that produced the largest significant effect in the reduction of PTSD scores, mixed modalities (e.g., music, art, dance) showed the strongest effects (Hedge's g = 1.01), followed by dance (Hedge's g = 1.00) and art (Hedge's g = 0.79). We also observed that interventions delivered by trained facilitators, not necessarily licensed creative arts therapists, were associated with slightly greater symptom reductions. While this finding should be interpreted cautiously, it highlights the potential for community-led, cost-effective models that increase accessibility without compromising impact.

Subgroup analyses revealed particularly large effects in non-Western samples, including West African and Middle Eastern youth. This may reflect both the cultural salience of creative

expression and non-verbal accessibility in these populations. Creative arts interventions appeared to be more effective when participants were displaced from their country of origin (e.g., Palestinian youth in the U.S.) perhaps due to the added therapeutic value of cultural grounding in diasporic contexts. This supports the role of creative arts in enabling social engagement across cultures and emphasizes the need for cultural competence in delivery (Delattre et al., 2024).

By contrast, Western-based interventions in North America showed smaller and statistically nonsignificant effects. However, due to mixed ethnicity in North American samples, it is difficult to tell whether creative arts-based interventions are generally less effective in North American children or less effective specifically in racial majority compared to minoritized children. Due to the lack of statistical significance between groups, we cannot confidently attribute differences in effect to region alone. More research is needed to explore how cultural, structural, and contextual factors might shape the effectiveness of creative interventions across diverse settings.

Our findings build on previous reviews (Morison et al., 2022) which reported only modest effects for creative therapies in youth. We observed larger effects, likely due to stricter inclusion criteria and a more diverse sample base, including high-quality RCTs and non-Western contexts. Moreover, this is the first meta-analysis, to our knowledge, to explicitly examine cultural and regional variation in treatment outcomes.

2.4.1 Clinical & Cultural Implications

In Western regions of the world, children and adolescents from minoritized groups are less likely to access or benefit from conventional psychiatric care, and more likely to report negative experiences with it (Crawford et al., 2016; Mercer et al., 2019; Terlizzi & Zablotsky, 2019). Despite growing calls for culturally responsive care, such as those outlined in the UK's IAPT framework(National Collaborating Centre for Mental Health, 2023), current adaptations largely focus on modifying talking therapies, which may not fully address the needs of these populations.

Our findings suggest that creative arts-based interventions offer a promising alternative, particularly for culturally diverse and underserved youth. These interventions harness non-verbal modes of expression, allowing participants to process trauma in ways that may feel more accessible and less stigmatizing. The effectiveness of these approaches is especially notable in

African and Middle Eastern samples, where creative practices are deeply embedded in cultural life. A recent survey, for example, found that 72% of West African participants reported frequent engagement in creative activities tied to community, adaptation, and expression, suggesting that arts-based therapies may naturally align with cultural coping strategies (Mpofu et al., 2006). Additionally, recent literature has cited the common use of arts-based therapies for working with Middle Eastern populations and the positive effects that they have on reducing trauma symptoms (Grasser et al., 2019).

Clinically, these interventions may also target key trauma-related mechanisms. By engaging both sensory (non-verbal) and narrative (verbal) systems, creative arts therapies help reprocess traumatic memories in a more integrated and less distressing way (Wang et al., 2025). This is supported by neuroimaging studies, which show enhanced connectivity between brain regions responsible for memory and emotion regulation during arts-based interventions (Bolwerk et al., 2014).

While previous reviews have also focused on children and adolescents (Eaton et al., 2007; Morison et al., 2022; Van Westrhenen & Fritz, 2014), few have explicitly addressed how developmental stage may influence the effectiveness of creative arts therapies. Young people are still developing emotional regulation, verbal processing skills, and identity formation, which may make them more responsive to non-verbal, expressive, and relational interventions (Wang et al., 2025). For example, arts-based therapies provide embodied, sensory experiences that may be more developmentally appropriate than cognitively demanding approaches like CBT. Our findings may reflect this developmental sensitivity, particularly given the large effects seen across diverse settings. Future research should investigate which modalities are most effective at different ages, for instance, whether younger children benefit more from visual arts or play-based methods, while adolescents may engage more with music, drama, or dance.

Given their accessibility, cultural relevance, and psychological impact, creative arts therapies should be considered not only as adjuncts, but as potentially central interventions in trauma-informed care for young people, particularly those from underrepresented backgrounds.

2.4.2 Limitations

Despite the strengths of the study, there are several limitations. A main limitation of this meta-analysis was the heterogeneity of the studies with respect to the type of creative arts intervention. The methods used across studies (e.g., RCT, cross-sectional, pre-post) also varied greatly, as well as the duration of the interventions. Additionally, due to the limited number of studies in this meta-analysis, the subgroup analysis compared the effectiveness of creative arts-based interventions in Western, African and Middle Eastern samples but could not investigate its effectiveness in other regions of the world. Therefore, in further research, it would be beneficial to examine the effectiveness of creative arts therapies in other cultures to make firmer conclusions on their effectiveness in non-Western populations.

It is also important to note that only ten out of 33 studies were statistically significant (Anazor et al., 2023; Anichebe et al., 2024; Decosimo et al., 2019; Ewulu et al., 2024; Ezeh et al., 2023; Gordon et al., 2008; Iyendo et al., 2024; Kalthom et al., 2025; Moosa et al., 2017; Zhang et al., 2023). Most of these studies were RCTs with sample sizes ranging from 30 to 470 participants and at least 5 sessions of a creative arts-based intervention. These studies included art, drama, music, poetry, and a mixture of creative interventions. Seven of these studies (Anazor et al., 2023; Anichebe et al., 2024; Decosimo et al., 2019; Ewulu et al., 2024; Ezeh et al., 2023; Iyendo et al., 2024; Zhang et al., 2023) were studies with homogenous samples of Nigerian participants which again emphasizes creative arts-based interventions effective uses with West-African populations. Future studies related to creative arts-based interventions for PTSD should therefore focus on RCT study designs with large sample sizes for reliable, statistically significant results.

We were also unable to comment on creative arts-based interventions effectiveness in comparison to current standardized treatments. Our findings point towards a large effect of creative arts-based interventions for the treatment of PTSD symptoms on children. This suggests that creative arts-based interventions are as effective as TF-CBT (Thielemann et al., 2022) which also yields a large effect (Hedge's g = 1.14) and even more effective than group CBT82 (Hedge's g = 0.70), EDMR (Wright et al., 2024) (no significant difference) or pharmacological treatments (Merz et al., 2019) (SMD=-0.63) which yield medium sized effects. A key limitation is the lack of clarity surrounding Treatment as Usual (TAU) conditions across included studies. While several studies used TAU as a control, they often failed to specify whether it involved evidence-based psychotherapy, general counselling, or minimal support. This variability in comparator conditions may influence effect sizes and limits the

precision of cross-study comparisons. Ideally, future research should not only compare creative arts-based interventions with established treatments in RCTs but also provide detailed descriptions of TAU to enhance interpretability. Future studies should also prioritize the use of well-defined control groups, randomization, and large sample sizes to minimize selection bias and establish more robust evidence for comparative effectiveness.

2.5 Conclusions

The results of this chapter provide robust global evidence in a quantitative meta-analysis that creative arts-based interventions may contribute to a reduction in symptoms of trauma and PTSD in children and adolescents from Middle Eastern and West African groups preliminarily indicating the potential uses of creative arts-based interventions as culturally competent therapeutic interventions. These effects were observed through different creative arts modalities, with a mixture of many creative arts modalities producing the largest effects, suggesting the mechanism of change of creative arts interventions may be related to the non-verbal expression of emotions and relational engagement rather than the specific creative modality itself. Given the high global rates of PTSD and the long-lasting effects of the disorder, these findings of reduced PTSD scores in children and adolescents may be particularly noteworthy for those suffering from the disorder.

A key finding of this chapter lies in the variation in effects across different cultural and regional contexts. The strongest effects were observed in non-Western samples, particularly among West-African and Middle Eastern populations where creative practices are deeply embedded within cultural, social and community life. While these differences should be interpreted cautiously given study heterogeneity and study sample composition, they nevertheless suggest that cultural context may play an important role in shaping how creative arts interventions function therapeutically. These findings also challenge the assumption that psychological interventions operate equivalently across contexts and instead point toward the importance of cultural congruence as a potential mechanism of effectiveness.

Further research is necessary, particularly RCTs that have well-defined interventions, control groups utilizing CBT, EDMR, or pharmacological interventions, and long-term follow-ups, in order to recommend creative arts-based interventions to relieve symptoms in children and adolescents as well as studies that examine creative arts-based interventions among African and Middle-Eastern youth in Western contexts; however, this review provides promising evidence of their potential uses in clinical settings.

At the same time, this chapter highlights important limitations in the current evidence base. Despite the strength of the pooled findings, the lack of studies conducted within UK contexts, and specifically with Black British young people, limits the extent to which these results can be directly generalised. Rather than representing a weakness, this gap is central to the broader thesis, as it underscores the need to examine how globally supported interventions are understood, experienced, and enacted within specific service systems.

The findings of this meta-analysis indicate that creative arts-based interventions are not just theoretically effective methods but supported by robust empirical evidence, particularly for populations that are underrepresented in clinical studies. Black Britons experience the highest rates of PTSD more than any other ethnic group, so these results are quite promising in aiding the rehabilitation of these individuals with intense traumas.

Although this meta-analysis does not include studies conducted specifically with Black British young people in the UK, its focus on non-Western and Global Majority populations is directly relevant to the present thesis. Black British youth are predominantly members of diasporic communities whose cultural frameworks, histories of trauma, and experiences of marginalisation are often poorly represented in Western clinical trials. Evidence demonstrating the effectiveness of creative arts interventions in African and Middle Eastern contexts therefore provides a critical theoretical and empirical foundation for examining how such approaches might translate to Black British youth within UK mental health services.

Importantly, these findings should not be interpreted as direct evidence of effectiveness for Black British youth within UK mental health services. Rather, they demonstrate that creative arts–based interventions are effective for trauma-exposed Global Majority youth in contexts where cultural grounding and non-verbal modalities are central, thereby justifying closer examination of how such approaches are understood and implemented within UK services.

In the UK, where Black young people disproportionately encounter barriers to care and often enter services through crisis-driven pathways, it is essential to examine the available evidence of how Black young people engage with mental health services and how helpful they find them.

The next chapter therefore examines UK population evidence of how Black British young people navigate mental health support, how helpful they perceive available services to be, and what barriers shape their help-seeking decisions.

Chapter 3

How Black and Mixed Black adolescents navigate mental health support: Findings from the OxWell 2023 Survey

Chapter Summary

This thesis has discussed how Black and Black Mixed Ethnic adolescents experience persistent mental health inequities in the UK. However, less is known about how these young people navigate different sources of mental health support, how helpful they perceive available services to be, what types of additional support they would like to access, and what barriers shape their help-seeking decisions. Data was drawn from the 2023 OxWell Student Survey, a large school-based survey of secondary school and further education students in England. Focusing on Black and Black Mixed ethnic adolescents, this chapter examines experiences of mental health support sought in the past 12 months, perceived helpfulness of support, preferences for future support, and perceived barriers to accessing care as well as differences in each of these outcomes relative to White British peers.

The final sample included 1080 Black, 590 Black Mixed ethnic, and 10,768 White British adolescents. Across ethnic groups, informal supports were most frequently accessed and rated as most helpful followed by school & community-based supports. Compared with White British adolescents, Black and Black Mixed Ethnic adolescents were less likely to have sought formal mental health services, including CAMHS and general practitioners.

Given lower rates of help-seeking amongst Black and Black Mixed Ethnic adolescents, it is essential to create care pathways that encourage them to seek mental health support when needed. These findings underscore the importance of centering adolescent perspectives and addressing structural and relational factors within mental health systems to reduce ethnic inequities in access and experience of care.

3.1 Background

Building on the evidence outlined in Chapter 3 regarding the global findings of utilizing creative arts interventions for the alleviation of PTSD symptoms in non-Western populations, this chapter zoom in on the population-level data with the 2023 OxWell Student Survey of Black and Mixed Black adolescents in secondary school to examine how mental health

inequalities manifest in adolescents' real-world help-seeking behaviours. Specifically, it focuses on differences in access to mental health support, perceived helpfulness of services, and barriers to care among Black and Mixed Black adolescents compared with their White British peers.

Currently in the UK, there is a lack of understanding surrounding how best to support Black and Black Mixed young people with mental health needs and the perceived helpfulness of current services (Devonport et al., 2023). There are large gaps in the literature concerning the treatment outcomes of Black and Black Mixed ethnic adolescents living with mental health problems due to poor representation of these young people both in services and in research studies and often research studies collapsing ethnicity into larger groups encompassing several ethnic identities (Dogra et al., 2012). Furthermore, there is little evidence about the mental health of Black Mixed ethnic individuals in Britain, who have reported experiencing racism because of their mixed ethnicity leading to introspection about their place and society and belonging identity within British society (Tizard & Phoenix, 2002). This chapter seeks to address the gaps in evidence of the mental health of Black Mixed ethnic young people.

A more nuanced understanding of how Black and Black Mixed adolescents seek and experience mental health support is central to addressing inequities in access and improving the quality of care (Howarth et al., 2019; MacDonald et al., 2018; Persson et al., 2017). Evidence consistently indicates that Black and Black Mixed Ethnic adolescents experience greater unmet mental health need alongside lower engagement with formal mental health services, yet little is known about how these young people navigate mental health services or which forms of support they perceive as helpful. Incorporating perspectives from Black and Mixed Black ethnic groups, is critical to address these gaps (Mansfield et al., 2021a). The present chapter analysed data from a large, school-based survey to examine ethnic differences in adolescents' mental health help-seeking. Specifically, we investigated patterns of support accessed in the past year, perceived helpfulness of different support types, preferences for future support, and perceived barriers to accessing care among Black and Black Mixed Ethnic adolescents compared with their White British peers.

Within the broader thesis, this chapter provides the population-level context that informs subsequent qualitative and intervention-based analyses. By identifying where Black and Mixed Black adolescents seek support, which forms of support they find helpful, and which barriers they encounter, these findings help to explain why alternative, community-based and culturally grounded approaches may be necessary.

The present chapter analysed data from the OxWell 2023 Student Survey for ethnic differences in adolescents' mental health help-seeking. Specifically, we investigated the following research questions (RQs):

RQ 1. *What types of mental health support did Black and Black Mixed ethnic youth seek in the past year, and are there differences compared to White British youth?*

RQ 2. *How helpful do Black and Black Mixed ethnic youth find mental health support, and are there differences compared to White British youth?*

RQ 3. *What type of support would Black and Black Mixed ethnic youth have liked to access, and are there differences compared to White British youth?*

RQ 4. *What barriers did Black and Black Mixed ethnic youth perceive when accessing mental health support, and are there differences compared to White British youth?*

Where sample sizes permit, this chapter distinguishes between Black and Mixed Black adolescents to capture population-level differences in service access. Subsequent chapters adopt broader identity categories appropriate to qualitative, global, and applied research contexts.

3.2 Methods

3.2.1 Data source

This study used the 2023 OxWell Student Survey(Mansfield et al., 2021b), specifically the secondary school data primarily covering ages 11 to 18 years. The OxWell Survey is a repeated cross-sectional survey of schools and further education colleges (FECs) in England, examining the health and wellbeing, life experiences and behavior of young people(Mansfield et al., 2021b). Full details are available in the protocol, but in brief, local authority partners recruited schools in their area, who then enrolled their students using either a parental opt out model with student assent for students <16 years or informed consent for students age ⩾16 years. The survey was completed during the school day and collected no identifiable data about students to increase participation and promote more honest responses (Mansfield et al., 2021b; Soneson et al., 2025). The 2023 survey responses were collected from February-March 2023.

3.2.2 Ethical Approval

The 2023 OxWell Student Survey was approved by the University of Oxford Research Ethics Committee (reference:R62366/RE014).

3.2.3 Participants

We restricted our analyses to Black African, Black Caribbean, Black Other, Mixed White-Black African, Mixed White-Black Caribbean and White British (as a comparator) secondary school and FEC students (i.e. Year 7-13). We further excluded students who, based completion patterns, likely did not reach the mental health help-seeking questions within the survey (which were located toward the end of the survey).

3.2.4 Measures

Appendix 1 overviews exact question wording and response options and the full variable guide is available on the Open Science Framework (osf.io/bwech).

3.2.5 Variables

3.2.5.1 Ethnicity

Ethnicity was self-reported in the OxWell 2023 Survey using the UK 2021 Census classifications (Office for National Statistics, 2018) and was analysed in two ways. First, to provide a more granular and nuanced picture, a six-category variable was used, comprising: *Black African*, *Black Caribbean*, *Black Other*, *Mixed White–Black African*, *Mixed White–Black Caribbean*, and *White British*. Second, to aid interpretation where cell sizes were small, a collapsed three-category variable was created (*White British*, *Black* [Black African, Black Caribbean, Black Other], and *Mixed* [Mixed White–Black African, Mixed White–Black Caribbean]).

3.2.5.2 Outcomes (RQ1) - What *types of mental health support did Black and Black Mixed ethnic youth seek in the past year, and are there differences compared to White British youth?*

The OxWell 2023 Survey has questions related to the type of mental health support students have sought in the last 12 months in a "tick all that apply" format. These cover 19 different types of support (see Appendix, Chapter 3 Table A2 for full breakdown). For our analysis, we grouped these types of support into four categories: 1) Informal support (e.g. from friends and family), 2) School & community-based support (e.g. from school mental health teams or

charities), 3) Formal support (e.g. from CAMHS or GPs), and 4) Phone & online support (e.g. websites and helplines).

3.2.5.3 Outcomes (RQ2) - How helpful do Black and Black Mixed ethnic youth find mental health support, and are there differences compared to White British youth?

For each type of support that was sought, students were subsequently asked about how helpful they perceived that support. For this analysis, responses were collapsed into 2 different categories, following the approach taken in previous OxWell studies(White et al., 2024) 1) Helpful (*Quite helpful; Very helpful; Just about helpful enough*) and 2) Not helpful (*Not helpful at all; Not helpful enough*).

3.2.5.4 Outcomes (RQ3) - What type of support would Black and Black Mixed ethnic youth have like to access, and are there differences compared to White British youth?

Students were asked what type of support they would have liked to access in the last 12 months in a "tick all that apply" format. This question was asked of all students whether or not they had indicated prior help-seeking. These cover 17 different types of support grouped into four categories mirroring RQ1: 1) Informal support (e.g. from friends and family), 2) School & community-based support (e.g. from school mental health teams or charities), 3) Formal support (e.g. from CAMHS or GPs), and 4) Phone & online support (e.g. websites and helplines). See Appendix Table A3 for full breakdown.

3.2.5.5 Outcomes (RQ4) - What barriers did Black and Black Mixed ethnic youth perceive when accessing mental health support, and are there differences compared to White British youth?

All students were also asked about whether they had experienced any of the 14 barriers listed in accessing mental health support (Appendix, Chapter 3 Table A4). For this analysis, we categorised the barrier response questions into four different categories, following the approach taken in previous studies(Fazel et al., 2025): 1) Privacy & confidentiality – Wider networks (*not wanting their parents, other young people or other teachers/school staff to know about seeking support*) , 2) Privacy & confidentiality – Response to disclosures (*not feeling safe to share, not wanting the stigma, and scared/worried about what people might say*), 3) Perceptions of care provisions (*not liking the person providing support, being worried they would not be taken seriously, not liking to talk to strangers, and not wanting to burden anyone*),

and 4) Practical & Logistical Concerns (*not knowing who to ask, not being seen as a priority for the service, long waiting times, too much hassle getting help*).

3.2.6 Covariates

All adjusted regression models included year group, gender, and mental health symptom severity as covariates. School year group was recorded as Years 7–13. Gender was categorised as boy, girl, or gender diverse/gender non-disclosing; due to small cell sizes, gender diverse and gender non-disclosing (i.e. those who chose 'Prefer not to say') participants were combined for analysis. We additionally adjusted for current mental health difficulties using the 11-item Revised Children's Anxiety and Depression Scale (RCADS-11)(Radez et al., 2021), which contains two subscales assessing anxiety (6 items) and depression (5 items) plus two additional impact items. Scores sum to a total score of 0-39, with higher scores indicating greater difficulties and/or impact. As there is no official guidance on how to handle missing data, we used mean imputation by subscale, allowing for up to one missing item per subscale, with no imputation used for the impact items.

3.2.7 Statistical analysis

Descriptive statistics were used to summarize demographic characteristics in the data and general patterns in our four outcomes. To understand differences related to what mental health support adolescents sought over the last year (RQ1), what additional support they would have liked to access (RQ 3), and the perceived barriers in accessing support (RQ 4), we examined differences by ethnicity using binary logistic regression controlling for year group, gender, and mental health symptom severity. Given relatively low levels of missingness (0%-6.4% across relevant variables), we used a complete case approach. Adjusted odds ratios (aORs) and 95% confidence intervals (CIs) are reported. For each RQ, we ran separate regression analyses for the 3- and 6-category ethnicity variable. For how helpful young people found the mental health support (RQ 2), we summarized findings using descriptive statistics and visualizations (*ggplot2*;(Wickham, 2016)) utilizing the collapsed three-category ethnicity variable due to small cell counts. All analyses were conducted in R (version 4.5.0)(R Core Team, 2025) and the code is openly available in the Open Science Framework (OSF) repository at DOI: https://doi.org/10.17605/OSF.IO/HRX7J (Applewhite, 2026).

3.3 Results

3.3.1 Participants & Descriptive Data

The 2023 OxWell Survey encompassed 32,965 participants in Years 7-13. Overall, 12,438 participants were included in our final analysis based on our inclusion criteria: 16,047 were excluded due to their ethnicity and then, of the 16,918 who remained, 4480 were excluded due to not reaching the question. In the final sample, 52.2% were girls, 42.4% were boys, and 2.3% GD/GND individuals. In terms of ethnicity, 86.6% were White British, 8.7% were Black/Black British/African/Caribbean (6.7% Black African, 1.1% Black Caribbean, 0.1% Black Other), and 4.7% were Mixed Black (2.1% Mixed White–Black African, 2.7% Mixed White–Black Caribbean). In total, 28.3% reported within the past year having a mental-health problem that has affected their daily life and the mean RCADS-11 total symptom + impact score for the full sample was 13.40 (SD = 9.79).

Table 1. Sample Characteristics. This table shows the sample characteristics of secondary and further education adolescents included in the analysis (N = 12,438)

Responder Descriptive	Category	n	%
	All participants	12,438	100.0
Gender *n (%)*	Girls	6,487	52.2
	Boys	5,283	42.4
	GD/GND	568	4.6
	No response	100	0.8
Year group *n (%)*	Year 7	2,493	20.0
	Year 8	2,363	19.0
	Year 9	2,435	19.6
	Year 10	1,677	13.5
	Year 11	1,677	13.5
	Year 12	1,097	8.8
	Year 13	696	5.6
Ethnicity Overall *n (%)*	White-English/Welsh/Scottish/Northern Irish/British	10,768	86.6
	Black/Black British/African/Caribbean	1,080	8.7
	Black/African/Caribbean/Black British - African	832	6.7
Ethnicity *n (%)*	Black/African/Caribbean/Black British - Caribbean	134	1.1
	Black/African/Caribbean/Black British - Other	114	0.9

	Mixed/Multiple ethnic groups - White and Black African/Caribbean	590	4.7
	Mixed/Multiple ethnic groups - White and Black African	257	2.1
	Mixed/Multiple ethnic groups - White and Black - Caribbean	333	2.6
Mental health *n (%)*	Problem affecting daily life (past year)	3,520	28.3
RCADS-11 total symptom + impact score *mean (SD)*	Elevated depression/anxiety	13.4	9.79

3.3.2 Main findings

RQ1 - What types of mental health support did Black and Black Mixed ethnic youth seek in the past year, and are there differences compared to White British youth?

Overall, 36.5% of adolescents reported having sought at least one source of support (Table 2). 27.7% of Black adolescents reported having sought support in the past year, while 37.6% of Black Mixed adolescents sought support. Support use varied by ethnicity, with White British adolescents reporting the highest levels of help-seeking across all types of support categories, and Black and Black Mixed ethnic groups reporting lower levels. Informal support was the most sought across all Black and Black Mixed ethnic groups (22.1-33.0%), followed by school & community-based support (7.8-17.1%), with formal (4.8-13.8%) and phone & online support (2.7-6.7%) accessed less frequently. Notably, there was substantial variation within Black and Black Mixed ethic groups in terms of the types of support sought.

Compared with White British adolescents, Black African adolescents had significantly lower odds of having sought informal support (22.1%) (aOR = 0.63, 95% CI [0.52-0.76]), school and community support (7.8%) (aOR = 0.53, 95% CI [0.40–0.69], and formal mental health support (4.8%) (aOR = 0.45, 95% CI [0.32–0.63]), even after adjustment for year group, gender, and mental health symptom severity. A notable exception to the general trend of help seeking was that Black Caribbean young people were *more* likely to report having sought phone and online support (6.7%) (aOR = 2.54, 95% CI [1.19–5.43]). Differences were less pronounced for adolescents from Black Mixed ethnic backgrounds, whose help-seeking rates were generally comparable to those observed among White British adolescents, with the exception that Mixed White–Black African adolescents were less likely to have sought formal support compared with White adolescents (5.8%) (aOR = 0.57, 95% CI [0.33–0.98]).

In the analyses using amalgamated categories (i.e. White British, Black, and Black Mixed ethnic), Black adolescents were less likely to have sought informal support (aOR = 0.66, 95% CI [0.59–0.78]), school and community support (aOR = 0.58, 95% CI [0.46–0.74]), and formal support (aOR = 0.49, 95% CI [0.36–0.66]) in the last year relative to White adolescents. There were no significant differences between Black Mixed ethnic and White adolescents.

Ethnicity	**Informal support, N (%)**	**aOR (95%CI, p)**	**School& community support N (%)**	**aOR (95%CI, p)**	**Formal support N (%)**	**aOR (95%CI, p)**	**Phone& online support N (%)**	**aOR (95%CI, p)**
White British	3500 (32.5)	Ref	1560 (14.5)	Ref	1171 (10.9)	Ref	354 (3.3)	Ref
			6-category ethnicity					
Black African	184 (22.1)	0.63 (0.52–0.76), p < 0.001	65 (7.8)	0.53 (0.40–0.69), p < 0.001	40 (4.8)	0.45 (0.32–0.63), p<0.001	24 (2.9)	1.09 (0.70–1.71), p = 0.695
Black Caribbean	33 (24.6)	0.75 (0.48–1.17), p = 0.204	18 (13.4)	0.96 (0.55–1.67), p= 0.880	14 (10.4)	0.85 (0.44–1.66), p=0.838	9 (6.7)	2.54 (1.19–5.43), p = 0.016
Black Other	28 (24.6)	0.82 (0.51–1.32), p = 0.414	9 (7.9)	0.63 (0.31–1.29), p = 0.206	N.R.	0.39 (0.14–1.08), p = 0.063	N.R.	N.R.
Mixed White–Black African	73 (28.4)	0.84 (0.62–1.13), p = 0.243	31 (12.1)	0.89 (0.60–1.32), p = 0.551	15 (5.8)	0.57 (0.33–0.98), p = 0.032	7 (2.7)	0.83 (0.36–1.90), p = 0.652
Mixed White–Black Caribbean	110 (33.0)	0.94 (0.72–1.22), p = 0.628	57 (17.1)	1.12 (0.82–1.54), p = 0.479	46 (13.8)	1.21 (0.85–1.73), p = 0.377	21 (6.3)	1.61 (0.95–2.70), p = 0.074
			3-category ethnicity					
Black	245 (22.7)	0.66 (0.59–0.78), p < 0.001	92 (8.5)	0.58 (0.46–0.74), p < 0.001	58 (5.4)	0.49 (0.36–0.66), p < 0.001	37 (3.4)	1.32 (0.91–1.91), p = 0.145

Ethnicity		Informal support, N (%)	aOR (95%CI, p)	School& community support N (%)	aOR (95%CI, p)	Formal support N (%)	aOR (95%CI, p)	Phone& online support N (%)	aOR (95%CI, p)
Black ethnic	Mixed	183 (31.0)	0.89 (0.73–1.09), p = 0.262	88 (14.9)	1.02 (0.79–1.31), p = 0.879	61 (10.3)	0.93 (0.69–1.26), p = 0.644	28 (4.7)	1.29 (0.82–2.01), p = 0.267

Table 2. Mental health support sought in the past 12 months by ethnicity. This table shows the type of support adolescents accessed in the past 12 months with the 6 and 3-category ethnicity groupings. Percentages represent the proportion of adolescents within each ethnic group who reported seeking at least one support type within each category. Adjusted odds ratios (aORs) and 95% confidence intervals [,] are from logistic regression models controlling for year group, gender, and mental health symptom severity, with White British adolescents as the reference group. N.R. indicates estimates based on fewer than five respondents and therefore not reported.

RQ2 - How helpful do Black and Black Mixed ethnic youth find mental health support, and are there differences compared to White British youth?

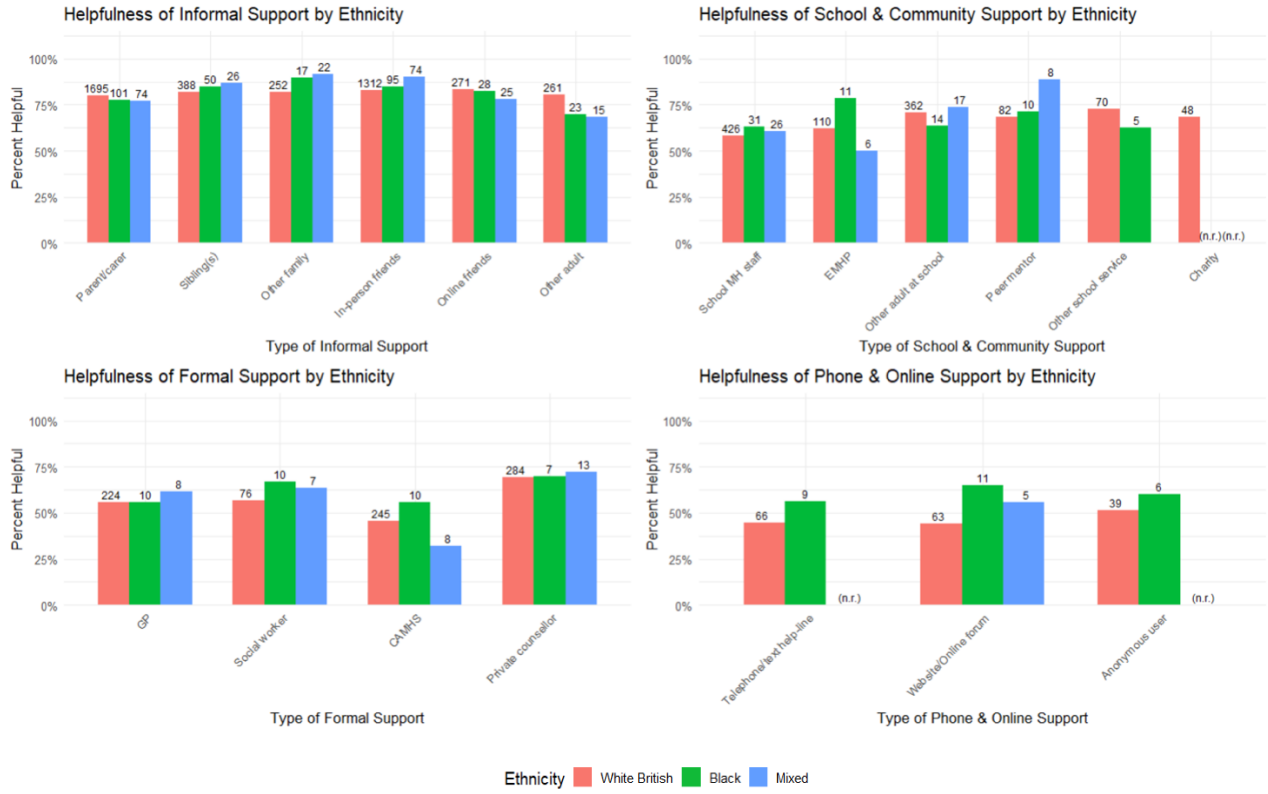


Figure 1. Perceived helpfulness of support by ethnicity. This figure shows how helpful Black, Black Mixed and White adolescents found the support they accessed. The types of support are grouped into (A) informal support, (B) school & community support, (C) formal support, and (D) phone & online support. Ethnicity is presented using collapsed categories (White British, Black, and Mixed) to improve interpretability due to small cell sizes for individual ethnic subgroups. Bars represent the percentage of respondents rating each support type as 'helpful'. Cells with insufficient numbers for reliable reporting are indicated as *n.r.* (not reported). *Abbreviations: CAMHS = Child and Adolescent Mental Health Services, EMHP = Education Mental Health Practitioner, GP = General Practitioner; a full list of support types can be found in Appendix Table A2.*

Overall, perceived helpfulness of mental health support followed a consistent gradient across ethnic groups, with informal supports rated most helpful, followed by school & community-based supports, and then formal and phone & online services. While some variation was observed between ethnic groups for specific support types, differences were modest, and interpretation is limited by small sample sizes for certain types of support.

Informal support from parents/carers, siblings, and in-person friends was perceived as helpful by most adolescents, with broadly similar patterns observed across White British, Black, and Black Mixed ethnic youth. The types of support within this category that were perceived as

most helpful by Black adolescents were other family (89.5%) and the same for Black Mixed ethnic adolescents (91.2%). Across both groups, adults outside of the family were the least helpful within this category but even still 68.2-69.7% rated these as helpful.

The other categories of support (i.e. school and community, formal, and phone and online) had much smaller sample sizes for Black and Black Mixed ethnic groups, making it difficult to draw confident conclusions regarding helpfulness or differences in helpfulness. For Black adolescents, the perceived helpfulness of different types of school and community support ranged from 62.5% (other school services) -78.6% (EMHPs), formal support from 55.6% (CAMHS and GP) – to 70.0% (private counsellors), and phone and online support 56.3% (telephone/text helpline)-64.7% (website/online forum). The equivalent ranges for Black Mixed ethnic adolescents were 50% (EMHPs), 88.9% (peer mentors), 32.7% (CAMHS) – 72.2% (private counsellors), and 55.6% (website/online forum).

RQ3 - What type of support would Black and Black Mixed ethnic youth have liked to access, and are there differences compared to White British youth?

In terms of preferences for additional support in different ethnic groups, results closely mirrored observed patterns of past-year support use. The categories of support that students would most like to have accessed were informal support (22.0% - 28.1%) and least were phone and online support (3.6% - 5.7%).

Overall, 27.8% of adolescents reported wanting at least one type of additional support. 28.5% of Black and 31.2% of Black Mixed ethnic adolescents reported wanting additional support. Relative to other outcomes, there was less variation in terms of preferences for additional support. Informal support was the most common type of additional support wanted (22.0-28.1%), followed by formal support (7.9-13.5%), school and community support (6.0-9.7%), and phone and online support (3.6-5.7%).

Compared with White British adolescents, Black African adolescents had significantly higher odds of wanting additional phone and online support (4.2%) (aOR = 1.54, 95% CI [1.06–2.22]) whilst Black – Other adolescents were more likely to report wanting additional informal support (28.1%) (aOR = 1.68, 95% CI [1.06–2.66]). There were no other statistically significant differences, either for the 6- or 3-category ethnicity groupings, but it should be noted that for the more granular categorisations there were several small cell counts.

Ethnicity	Informal support N (%)	aOR (95%CI, p)	School &community support N (%)	aOR (95% CI, p)	Formal support N (%)	aOR (95%CI, p)	Phone &online support N (%)	aOR (95%CI, p)
White British	2470 (22.9)	Ref	847 (7.9)	Ref	1118 (10.4)	Ref	386 (3.6)	Ref
6-category ethnicity								
Black African	183 (22.0)	1.09 (0.91–1.31), p = 0.363	50 (6.0)	0.89 (0.65–1.22), p = 0.476	74 (8.9)	1.06 (0.81–1.38), p = 0.685	35 (4.2)	1.54 (1.06–2.22), p = 0.011
Black Caribbean	32 (23.9)	1.31 (0.84–2.05), p = 0.230	13 (9.7)	1.39 (0.72–2.67), p = 0.326	18 (13.4)	1.59 (0.89–2.82), p = 0.116	N.R.	N.R.
Black Other	32 (28.1)	1.68 (1.06–2.66), p = 0.028	9 (7.9)	1.37 (0.67–2.82), p = 0.385	9 (7.9)	0.92 (0.43–1.97), p = 0.835	N.R.	N.R.
Mixed White–Black African	64 (24.9)	1.21 (0.89–1.64), p = 0.228	21 (8.2)	1.19 (0.74–1.91), p = 0.464	30 (11.7)	1.38 (0.91–2.09), p = 0.128	10 (3.9)	1.28 (0.66–2.46), p = 0.466
Mixed White–Black Caribbean	80 (24.0)	0.95 (0.72–1.27), p = 0.739	24 (7.2)	0.86 (0.55–1.34), p = 0.508	45 (13.5)	1.23 (0.86–1.77), p = 0.255	19 (5.7)	1.36 (0.80–2.30), p = 0.258
3-category ethnicity								
Black	247 (22.9)	1.17 (0.99–1.37), p = 0.063	72 (6.7)	1.00 (0.76–1.30), p = 0.978	101 (9.4)	1.10 (0.87–1.40), p = 0.408	42 (3.9)	1.40 (0.99–1.97), p = 0.054
Black-Mixed ethnic	144 (24.4)	1.06 (0.86–1.31), p = 0.591	45 (7.6)	0.99 (0.72–1.38), p = 0.968	75 (12.7)	1.29 (0.98–1.70), p = 0.069	27 (4.6)	1.32 (0.87–2.01), p = 0.188

Table 3. Mental health support adolescents would have liked to access in the future by ethnicity. This table shows what adolescents would have preferred to access in the past 12 months. Percentages represent the proportion of adolescents within each ethnic group who reported wanting to access at least one support type over the past year. Adjusted odds ratios (aORs) and 95% confidence intervals are from logistic regression models controlling for year group, gender, and mental health symptom severity, with White

British adolescents as the reference group. N.R. indicates estimates based on fewer than five respondents and therefore not reported.

RQ4 - What barriers did Black and Black Mixed Ethnic experience when accessing mental health support, and are there differences compared to White British youth?

Barriers to accessing mental health support were commonly reported across all ethnic groups (Table 4). Overall, 36.1% of adolescents reported experiencing at least one type of barrier to accessing support. 33.1% of Black and 38.6% of Black Mixed ethnic adolescents reported wanting additional support.

Barriers related to perceptions of care provision (21.1%–27.2%) and practical and logistical concerns (19.4%–28.2%) were among the most frequently endorsed across groups, followed by responses to disclosures (21.5%–24.9%) and wider network concerns (17.5%–26.1%). Overall, barriers to accessing mental health support were commonly reported across all ethnic groups. Levels of endorsement were broadly similar across ethnic categories, with some variation observed, particularly for wider network barriers among Mixed White–Black African adolescents (26.1%).

Compared with White British adolescents, Mixed White–Black African adolescents had significantly higher odds of reporting wider network–related barriers (aOR = 1.59, 95% CI [1.15–2.21]). No statistically significant differences were observed between other ethnic categories. There were no other statistically significant differences, either for the 6- or 3-category ethnicity groupings across any of the four barrier domains.

Ethnicity	Privacy& confidentiality: Wider networks N (%)	aOR (95% CI, p)	Privacy& confidentiality: Response to disclosures N (%)	aOR (95% CI, p)	Perceptions of care provisions N (%)	aOR (95%CI,p)	Practical& logistical concerns N (%)	aOR (95%CI,p)
White British	2295 (21.3)	Ref	2590 (24.1)	Ref	2888 (26.8)	Ref	2658 (24.7)	Ref
			6-category ethnicity					
Black African	155 (18.6)	1.03 (0.83–1.26) p=0.776	179 (21.5)	1.07 (0.87–1.30) p = 0.521	196 (23.6)	1.00 (0.82–1.22) p= 0.958	165 (19.8)	0.89 (0.72–1.08) p= 0.254
Black Caribbean	29 (21.6)	1.26 (0.77–2.07) p=0.308	29 (21.6)	1.12 (0.69–1.81) p= 0.532	35 (26.1)	1.12 (0.69–1.81) p= 0.532	26 (19.4)	0.79 (0.48–1.32) p= 0.449
Black Other	20 (17.5)	1.04 (0.59–1.83) p=0.982	28 (24.6)	0.93 (0.54–1.60) p= 0.716	24 (21.1)	0.93 (0.54–1.60) p= 0.716	24 (21.1)	1.13 (0.67–1.90) p= 0.615
Mixed White–Black African	67 (26.1)	1.59 (1.15–2.21) p=0.008	64 (24.9)	1.15 (0.83–1.59) p= 0.511	70 (27.2)	1.15 (0.83–1.59) p= 0.511	71 (27.6)	1.36 (0.99–1.88) p= 0.067
Mixed White–Black Caribbean	69 (20.7)	0.84 (0.61–1.15) p=0.271	75 (22.5)	0.78 (0.58–1.05) p= 0.109	86 (25.8)	0.78 (0.58–1.05) p= 0.109	94 (28.2)	1.17 (0.88–1.55) p= 0.286
			3-category ethnicity					
Black	204 (18.9)	1.05 (0.87–1.27) p=0.590	236 (21.9)	1.01 (0.85–1.20) p = 0.925	255 (23.6)	1.01 (0.85–1.20) p = 0.925	215 (19.9)	0.90 (0.75–1.07) p = 0.235
Black Mixed ethnic	136 (23.1)	1.12 (0.89–1.41) p=0.338	139 (23.6)	0.93 (0.74–1.16), p = 0.506	156 (26.4)	0.93 (0.74–1.16) p = 0.506	165 (28.0)	1.25 (1.01–1.55) p = 0.044

Table 4. Perceived barriers to accessing mental health support by ethnicity). This table displays the types of barriers Black, Black Mixed, and White British adolescents experienced when accessing mental health support. The types of barriers include concerns related to privacy and confidentiality within wider networks, anticipated responses to disclosure, perceptions of care provision, and practical or logistical constraints. Percentages represent the proportion of adolescents within each ethnic group endorsing each barrier domain. Adjusted odds ratios (aORs) and 95% confidence intervals are from logistic regression models controlling for year group, gender, and mental health symptom severity, with White British adolescents as the reference group.

3.4 Discussion

Overall, this study provides needed evidence regarding Black and Black Mixed ethnic adolescents' experiences of mental health support, including what types of support they seek, how they perceive that support, barriers to accessing care, and unmet needs. Across all ethnic groups, informal support, which includes seeking support from a parent, carer, sibling or friend, was the most frequently sought and consistently rated as most helpful, particularly amongst Black and Black Mixed ethnic adolescents. In contrast, formal support services such as health and social care were accessed less frequently by Black and Black Mixed ethnic adolescents and were perceived as less helpful than informal support. School & community support seemed to serve as an important intermediate pathway for young people seeking mental health services, however, they were perceived as less consistently helpful in Black and Black Mixed ethnic adolescents compared to informal support. Phone & online support, including telephone and text helplines, were the least accessed and least helpful out of all the support types across all ethnic groups.

Together, these findings indicate a clear trend in adolescents' mental health support experiences, with informal supports most valued, followed by school & community-based supports, and then formal and digital services. Whilst Black and Black Mixed ethnic adolescents' experiences were often similar to those of their White British peers, there were some of notable differences; specifically, Black African adolescents were less likely than White British peers to have sought informal, school and community, and formal support and Mixed White–Black African adolescents were less likely to have sought formal support. Conversely, Black Caribbean adolescents were more likely than White British peers to have sought phone and online support, perhaps indicating greater accessibility for a group where more formal services are not readily available, accessible, or acceptable.

Perceived barriers to accessing mental health support were common across all ethnic groups, with between approximately one-in-six and one-in-four Black and Back Mixed ethnic adolescents reporting barriers pertaining to privacy and confidentiality within their wider

networks, responses to disclosures, perceptions of care provision, and practical and logistical concerns. There were relatively few differences observed between Black and Black Mixed ethnic adolescents and their White British peers after adjustment for year, gender, and mental health symptom severity. In particular, barriers related to responses to disclosure and perceptions of care provision were reported at similar levels across White British, Black, and Black Mixed ethnic groups, suggesting that concerns about disclosure and service quality are widely shared rather than specific to ethnic groups. However, adolescents from Mixed White–Black African backgrounds were more likely than White British adolescents to report barriers related to privacy and confidentiality within their wider networks, indicating greater concern about involving others or navigating social contexts when seeking help.

Furthermore, relative to White British adolescents, the combined Mixed Black ethnic group was more likely to report barriers pertaining to practical and logistical concerns – a category that includes perceptions of not being seen as a 'priority' for services, not knowing where to seek support, and wait lists. This pattern aligns with wider UK evidence documenting coercive or adverse pathways into care, lower satisfaction with services, and higher dropout rates among Black young people once support is accessed (Bhui et al., 2003; Kapadia et al., 2018; Keating & Robertson, 2004; McLean et al., 2003; NHS Race and Health Observatory, 2023). Together, these findings suggest that structural features of mental health systems, including culturally insensitive care and limited trust, may shape both access to support and young people's engagement with services, and that while many barriers to mental health support are broadly experienced, certain social and relational as well as logistical barriers may be more salient for some Black and Black Mixed ethnic groups.

Findings indicate that lower engagement with mental health support among Black and Black Mixed adolescents reflects a broader access gap across multiple pathways, rather than a simple preference for informal sources of care relative to White British peers.

However, informal support remained the most sought type amongst Black and Black Mixed ethnic adolescents than other support, hinting at a clear importance of informal support for Black and Black Mixed ethnic adolescents and often represents the first and most accessible avenue for help-seeking in these young people. These finding align with existing literature on the networks of care young people associate with their mental health support, which consistently highlighted the central role informal support, namely from family members and friends, in accessing mental health support (Brown et al., 2014; Lynch et al., 2023; Sadler et al., 2018; White et al., 2024).Within Black communities, care responsibilities are embedded within family and community structures, and often fears of confidentiality issues, language

barriers, and a lack of cultural competence in formalized mental health services deter Black populations from engaging in formal settings and further encourage young people to keep their mental health needs central in informal, often family-based, settings (Adams et al., 2015; Lawrence et al., 2021; Rabiee & Smith, 2013). Prior research has shown Black and Black Mixed ethnic populations to seek care within their communities, namely from faith leaders and other community leaders, who often play a vital role in early intervention and signposting to mental health services (Brown et al., 2014; Kapadia et al., 2018; Lynch et al., 2023). Previous qualitative research has shown Black service users bypassing traditional GP services and accessing psychiatric services from accident and emergency departments, either due to limited awareness of available options, or a lack of early detection from GP practices (Adams et al., 2015; Brown et al., 2014; Fernández De La Cruz et al., 2016; Karadzhov & White, 2020; Lawrence et al., 2021; Rabiee & Smith, 2013).Together, these findings show that while informal and community-based supports are valued and frequently perceived as helpful, they may also represent a compensatory pathway in contexts where formal mental health services are perceived as less helpful, less accessible, or insufficiently culturally responsive.

Importantly, this study also examined adolescents' preferences for mental health support, offering insight into what young people themselves would have liked to access. The inclusion of preference data provides a novel contribution to the literature, which has largely focused on disparities in access and service pathways, but less frequently asked young people directly what forms of support they would value. Black African adolescents were more likely than White British adolescents to express a preference for phone and online support, and Black Other adolescents were more likely to prefer informal support. These findings highlight that Black young people's voices do not indicate rejection of formal services but rather reflect nuanced preferences across multiple support pathways.

3.5 Strengths and limitations

There are several strengths of the current study. The study comprehensively assessed mental health help-seeking across all five ONS census categories for Black and Black Mixed ethnic groups accounting for nuanced differences between ethnic categories, a unique approach in comparison to previous studies where ethnic categories were often broad and collapsed in broad ethnic minority categories (Dogra et al., 2012). We also assessed help-seeking outcomes across multiple domains of support, including informal, school & community-based, formal, and phone & online services.

Importantly, this study includes what support adolescents would have liked to access, foregrounding youth perspectives at the core of this research and integrating young people's voices in future mental health designs that they deem accessible and helpful. Finally, the use of a large school-based survey spanning 78 secondary and FECs across England, further enabled inclusion of adolescents who may not otherwise be captured in clinical or service-based research.

Despite the study's strengths, there were several limitations. The recruitment strategy used to collect data with the OxWell survey prevented calculation of a participation rate, limiting our understanding of potential selection bias (Mansfield et al., 2021b). Also, the type of support sought was collected through self-report measures and limits context as to what types of support were available in each student's school and region. A further limitation relates to missing data and attrition. A substantial proportion of respondents did not provide their ethnicity or did not reach the later sections of the survey where mental health support questions were asked, resulting in the exclusion of these participants from the analytic sample. Sample sizes for the more granular categories of Black and Black Mixed ethnicities, ranging 590 to 2160, were substantially smaller than those for White British adolescents. As a result, estimates for some ethnicity–support combinations were based on small cell counts and should be interpreted with caution.

Finally, although the study examined perceived barriers to accessing mental health support, the survey did not include items directly assessing experiences of cultural competence, cultural safety, or perceived discrimination within mental health services. As a result, interpretations regarding the role of trust, cultural responsiveness, and service acceptability are necessarily indirect. Future research is needed to examine within-group differences in greater detail. It may be informative to incorporate validated measures of cultural competence and service experiences while also exploring other intersecting factors such as socioeconomic status, migration history, and experiences of discrimination.

3.6 Implications and future directions

Our findings have important implications for mental health service design and delivery for adolescents from Black and Black Mixed ethnic backgrounds in the UK. Informal and school- and community-based mental health support were commonly sought and perceived as helpful when accessed, highlighting the importance of strengthening these settings as viable and

legitimate entry points to care, rather than viewing them solely as precursors to formal services. Interventions that support families, school & community organizations to provide early, culturally informed support may help reduce delays in help-seeking and prevent escalation to crisis-driven pathways.

Policymakers should focus on cultural competence and training staff on working with diverse populations, while also providing, safe, trusted care, particularly around areas of confidentiality and anticipated responses to disclosures, which were barriers endorsed by 31% of our sample. Future research should explore longitudinal study designs with larger sample sizes that examine the early experiences of support in Black and Black Mixed ethnic adolescents and the perceived helpfulness of this support that shape trajectories of engagement over time. Qualitative work is also needed to deepen understanding of adolescents' lived experiences of navigating mental health systems.

3.7 Conclusions

This chapter provides a comprehensive examination of Black and Black Mixed ethnic adolescents' mental health help-seeking, perceived helpfulness of support, preferences for future care, and perceived barriers to access, as well as whether these outcomes varied compared with White British adolescents. Across analyses, a clear pattern emerged: formal mental health services were found to be less frequently accessed and rated as helpful for both Black and Black Mixed ethnic adolescents while informal and school & community-based supports were highly valued and most consistently sought out by these adolescents. This suggests that Black and Mixed Black young people are actively seeking support, albeit less frequently than White British adolescents, but may be doing so through pathways that feel more accessible or culturally familiar pathways. In this sense, informal and community-based supports may function not only as preferred options, but also as compensatory pathways in response to limitations within formal mental health services.

Perceptions of helpfulness of these support options along with barriers related to trust, confidentiality, and logistical constraints were rated similarly across ethnic groups pointing to systemic challenges more so than differences that are group specific. However, the lower likelihood of accessing support among Black adolescents, particularly in formal settings, points to structural inequalities that shape how and when young people are able to engage with care. These patterns are consistent with wider UK literature documenting mistrust of services, culturally insensitive care, and inequitable pathways into treatment among Black populations.

Barriers related to trust, confidentiality, and perceptions of care emerged and may contribute to patterns of delayed access and disengagement from formal services. These findings underscore the importance of centering adolescent perspectives and addressing structural and relational factors within mental health systems to reduce ethnic inequities in access and experience of care.

These findings established informal modes of support along with school and community support as integral intermediary support options that Black youth would like to access when seeking future support, however they do not address whether alternative therapeutic approaches might be effective in reducing mental health symptoms for young people who are underserved by conventional models of care. In particular, they raise the question of whether non-traditional, creative, community, and culturally grounded interventions may offer viable avenues for improving mental health outcomes where standard talking therapies have shown limited reach or acceptability.

In the previous chapter, we've examined the global quantitative evidence for the use of creative arts-based interventions in African populations asking whether such approaches are associated with improvements in mental health outcomes for children and adolescents, and whether their effectiveness differs across cultural and regional contexts. The next chapter therefore examines how Black British young people with psychiatric disorders and NHS clinicians understand and experience creative arts therapies in practice, exploring the cultural relevance of creative arts in mental health practice as well as the structural constraints that shape their use within UK mental health services.

Chapter 4

BLACK-ARTS: A qualitative study exploring the insights of Black young people with psychiatric disorders and the uses of creative arts therapies to improve mental well-being

Chapter Summary

This chapter explores if Creative Arts Therapies (CATs), including music, art, dance, and drama therapy, may offer culturally relevant, non-verbal approaches to mental health support for this population. The aims of this chapter are to explore how Black young people with mental health challenges and NHS clinicians perceive the usefulness and cultural relevance of CATs, and to examine their potential as culturally competent interventions for improving mental well-being.

A qualitative, multicentre study was conducted across five NHS Trusts in England. Twenty Black service users (aged 16–24) and 15 clinicians participated in ten online focus groups (45–60 minutes each). Transcripts were analysed thematically using using Braun and Clarke (2006)'s six- step thematic analysis method constructed with NVivo 12 software. Coding was led by B.A., with regular discussions with a second researcher to refine interpretations and develop themes.

Five overarching themes were identified: (1) Creative arts as vehicles for emotional healing, identity, and agency, (2) Challenges and barriers to CAT implementation, (3) Disconnection and mistrust within clinical encounters, (4) Discovering therapeutic potential through creative experience, and (5) Creative expression as a bridge between culture and care. Participants viewed CATs as emotionally regulating, accessible, and aligned with Black cultural identity, though limited by under-funding, stigma, and insufficient cultural competence within the NHS.

CATs may provide a culturally congruent and emotionally accessible approach to mental health care for Black youth. Embedding culturally competent, creative modalities within NHS pathways could enhance engagement, trust, and equity in service outcomes.

Building on the population-level findings of Chapter 2 and the global evidence base established in Chapter 3, the present chapter explores the lived experiences and perspectives of Black young people with psychiatric disorders and clinicians working within NHS mental health services. Through qualitative inquiry, this chapter seeks to illuminate why conventional

talking therapies are often experienced as alienating or insufficient, and how CATs are understood as emotionally accessible, culturally resonant, and potentially transformative forms of care. In doing so, the chapter shifts the analytic focus from whether creative arts interventions *can* work to how they are interpreted, negotiated, and constrained within everyday clinical practice and specifically how to integrate them with Black service users in NHS mental health services.

4.1 Objective

Despite their promise, the cultural relevance and perceived usefulness of CATs for Black young people within NHS mental health services remain underexplored. There is limited qualitative research capturing the perspectives of Black service users alongside those of clinicians working within NHS systems. Understanding these perspectives is essential for informing the development of more culturally competent, equitable, and engaging mental health services.

The present study addresses this gap by exploring how Black young people with mental health challenges and NHS clinicians perceive the use of creative arts therapies as culturally competent interventions. By foregrounding lived experience and clinical insight, this study aims to inform service design and contribute to ongoing efforts to reduce mental health inequalities among Black youth in the UK.

4.2 Methods

4.2.1 Study design and setting

This study employed a qualitative, multicentre design using semi-structured focus groups to explore perceptions of CATs among Black young people with mental health challenges and NHS clinicians. Data were collected between December 2023 and September 2024 across five NHS Trusts in England: South London and Maudsley NHS Foundation Trust (SLaM), Berkshire Healthcare NHS Foundation Trust (BH), Central and North West London NHS Foundation Trust (CNWL), Oxford Health NHS Foundation Trust (OH), and the North Central and East London IAPT Service Research Network (NCEL IAPT). The inclusion of five NHS Trusts was intentional to capture variation in service structure, geography, and demographic context across different settings. While the sample size within each Trust was modest, the

multi-site design enabled exploration of patterns that transcended local organisational differences and strengthened the transferability of findings across NHS contexts.

Ethical approval was obtained from the West Midlands – Coventry & Warwickshire Research Ethics Committee (Ref: 23/WM/0208).

4.2.2 Inclusion Criteria

Two participant groups were recruited:

1. **Service users' inclusion criteria:** (1) Black young people aged 16–24 who (2) were either receiving or awaiting NHS mental health care at participating sites (SLaM, BH, CNWL, OH, or NCEL IAPT) (3) The participants can read, write, and speak in English and (4) willing and able to provide written informed consent to participate
2. **Clinicians' inclusion criteria:** (1) Mental health professionals working within SLaM, BH, CNWL, OH, or NCEL IAPT, including creative arts therapists, psychologists, psychiatrists, and allied practitioners.

Exclusion Criteria

1. **Service users' exclusion criteria:** (1) individuals not identifying as Black or Mixed (2) those not receiving treatment or on the waitlist at participating sites, (3) patients lacking mental capacity to provide informed consent
2. **Clinicians' exclusion criteria:** (1) Those not working at participating research sites as mental health professionals

4.2.3 Recruitment

Participants were recruited via clinician referral and professional networks using purposive sampling to ensure representation across service types, age ranges, and Black ethnic backgrounds. This minimized the risk of ineligible participants joining sessions. All participants were able to communicate in English and provided written informed consent prior to participation. Black service users received a £20 voucher in appreciation of their time.

Demographic information (including age, gender, ethnicity, treatment setting, and diagnosis where provided) was collected via a brief structured questionnaire completed prior to the focus group sessions.

4.2.4 Data collection

Ten virtual focus groups were conducted using Microsoft Teams, each lasting approximately 45–60 minutes to balance depth of discussion with participant comfort, particularly given the sensitive nature of topics including race, stigma, and mental health experiences.

Focus groups were selected as the primary method of data collection because the study aimed to explore shared experiences around creative arts therapies and cultural competence. Given the cultural nature of the topic, group discussion was considered appropriate to elicit dialogue among participants. Virtual focus groups were chosen based on findings from previous qualitative research with minority patients as they were cited to be flexible for both participants and the research team, and could be conducted in relaxed environments like one's home, leading to more involvement in the group discussion (Dos Santos Marques et al., 2021). Participants were encouraged, but not required, to keep cameras on.

Black service users and clinicians participated in separate groups to minimise power imbalances and facilitate open discussion. Ground rules were established at the start of each session to promote respectful and open discussion. Each focus group included four to five participants and was moderated by the lead researcher (B.A.). The moderator actively invited contributions from quieter participants and used structured prompts to ensure balanced participation across the group.

Prior to each session, participants received an overview of the study aims and a brief explanation of creative arts therapies and culturally competent care. This included examples of music therapy, art therapy, dance movement therapy, and drama therapy, and clarified that CATs may be delivered in group or individual formats, typically combining creative activity with facilitated reflection or discussion led by a trained therapist. Two semi-structured topic guides, one for service users and one for clinicians, were developed based on existing literature on cultural competence, creative arts therapies, and mental health service engagement.

Discussion topics included experiences of current mental health care, perceptions of CATs, cultural relevance, perceived benefits and challenges, and views on how creative approaches might better meet service users' needs.

Audio recordings were transcribed verbatim and checked against recordings by the lead researcher for accuracy prior to analysis. Identifying information was removed during transcription to ensure confidentiality.

4.2.5 Data analysis

Data were analysed using reflexive thematic analysis following Braun and Clarke's six-phase framework(Braun & Clarke, 2006). Reflexive thematic analysis was selected due to its flexibility in exploring shared meanings across participant groups while allowing reflexive engagement with issues of race, identity, and power. The analytic team consisted of two researchers (B.A. and S.B.), with B.A. leading the coding process. Transcripts were read

repeatedly to support familiarisation, and initial codes were generated inductively across the dataset. In line with reflexive thematic analysis, coding was treated as an active, interpretive process, with themes understood as constructed through researcher engagement with the data rather than discovered as objective categories. The second researcher (S.B.) reviewed transcripts and engaged in collaborative discussions to explore alternative interpretations and refine the developing thematic structure, with the aim of deepening reflexive engagement rather than achieving coding consensus or reliability.

Codes were iteratively reviewed, refined, and organised into broader patterns of meaning, involving recursive movement between data, codes, and emerging themes, leading to the generation of five overarching themes. A summary of coding development is provided in Appendix, Chapter 4 Table 1. NVivo 12 software was used to support data management and organisation (QSR International, 2017). Ongoing reflexive dialogue within the research team enhanced analytic depth and transparency. This study was conducted within a constructivist-interpretivist paradigm, recognising knowledge as co-constructed between researchers and participants.

We used the Standards for Reporting Qualitative Research (SRQR) reporting guideline (O'Brien et al., 2014) to guide manuscript preparation and enhance transparency in reporting qualitative methods and analysis.

4.2.6 Reflexivity and researcher positionality

Given the study's focus on race, culture, and identity, reflexivity was integral to the research process. The lead researcher (B.A.) identifies as part of the Black community and has professional experience within mental health services. This positionality facilitated rapport and sensitivity to cultural nuance but required ongoing reflexive awareness to minimise bias.

The second analyst (S.B.) is a White European doctoral researcher with training as an arts therapist and with culturally competent and trauma-informed approaches. Differences in cultural backgrounds within the analytic team were treated as an analytic resource rather than a source of bias to be eliminated. Regular discussions were held to interrogate assumptions, and question emerging interpretations

Analytic decisions were made through iterative dialogue rather than consensus seeking. Reflexive diaries were maintained throughout data collection and analysis to document positional reflections, analytic shifts, and decisions regarding theme development. Peer debriefing sessions were conducted between the two analysts (B.A. and S.B.) who are doctoral researchers with shared experience in creative arts and mental health research.

We were particularly attentive to issues of power in representing participants' voices and reflexive engagement supported efforts to centre Black young people's perspectives while situating clinician accounts within their institutional context.

4.2.7 Patient and public involvement

We consulted a Young People's Advisory Group (YPAG) at the University of Oxford composed of young people aged 14 and 25 in the Oxford community. The YPAG contributed to the overall study design as well as assisting in the development of the focus group schedule and topic guide for both service users and clinicians.

4.3 Results

4.3.1 Overview of findings

Thirty-five participants took part in the study, including 20 Black service users aged 16–24 and 15 clinicians working across NHS mental health services. Clinician participants included creative arts therapists, psychologists, and multidisciplinary practitioners working across CAMHS, IAPT, and Early Intervention Services (EIS). Those trained in creative arts therapies tended to describe CATs in terms of therapeutic mechanism and clinical legitimacy, whereas other clinicians more frequently positioned CATs within broader discussions of service hierarchy and resource allocation.

Participants quotes are labeled using pseudonymous codes (SU01–SU20 for service users; CL01–CL15 for clinicians with their broader professional roles) to preserve confidentiality.

Reflexive thematic analysis identified five overarching themes reflecting participants' experiences of CATs and NHS mental health care:

1. Creative arts as vehicles for emotional healing, identity, and agency
2. Challenges and barriers to CAT implementation
3. Disconnection and mistrust within clinical encounters
4. Discovering therapeutic potential through creative experience
5. Creative expression as a bridge between culture and care

These themes capture both the perceived benefits of CATs and the structural and relational barriers shaping engagement with mental health services. Participants' reflections were informed by the description of CATs provided during the session, which framed CATs as therapist-led creative interventions incorporating both expressive practice and reflective

dialogue in either an individual or group session. Figure 3 outlines the frequency of themes discussed throughout the focus groups.

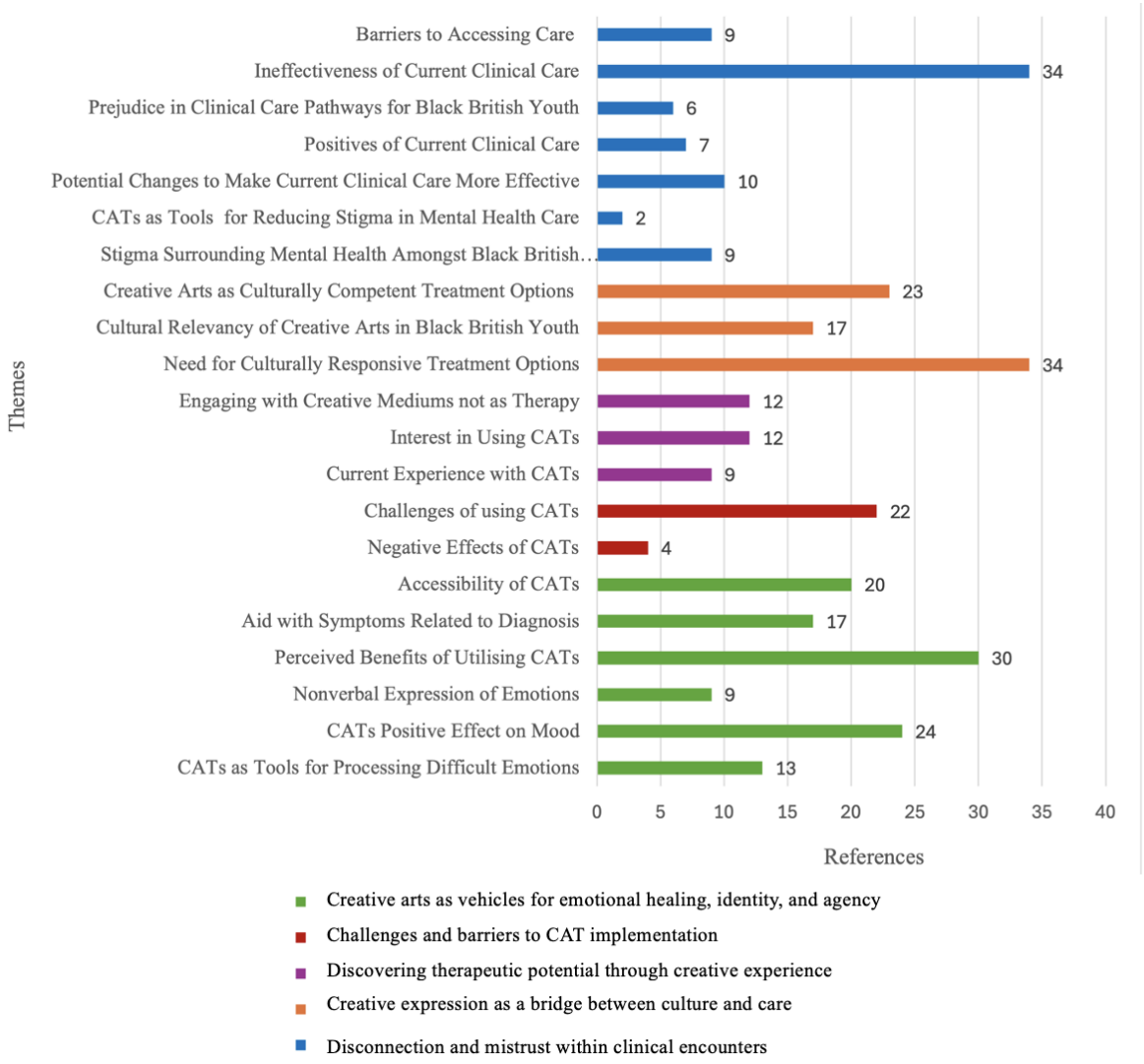


Figure 1: Frequency of Themes. This figure displays how many times each particular theme was referenced within the focus groups by service users and clinicians. Reference counts are displayed on the x axis and themes are displayed on the y-axis.

Although themes were developed across the dataset, variation in emphasis emerged between participant groups. Black youth more frequently foregrounded the emotional accessibility of CATs, and mistrust in clinical encounters, drawing on personal experiences of stigma and mistrust of traditional NHS services. In contrast, clinicians tended to frame CATs in relation to service feasibility, workforce limitations, and institutional barriers. Participant groups diverged also in how cultural competence was understood, with Black youth emphasising lived experience, while clinicians often discussed training and professional awareness.

The demographic profiles of both service user and clinician participants are included in Figure 2 and Figure 3.

Some participants (n=6 service users; n=6 clinicians) did not specify treatment setting. In several cases, service users were on waitlists or receiving care across multiple pathways, and clinicians worked across integrated service models, making categorisation difficult. Non-disclosure was also respected where participants chose not to provide this information.

Of the 20 service users, seven reported prior experience of formal creative arts therapy within NHS settings, while the remaining participants described engagement primarily through informal creative practices (e.g. listening to music, dancing recreationally). Among clinicians, five were trained creative arts therapists, with others working in psychology, psychiatry, or multidisciplinary roles.

Figure 2: Service User Demographics. This figure displays the sample characteristics of the service user participants (n=20).

Service User Demographics	n
Gender	
Female	14
Male	6
Age (years)	
Mean (SD)	20.8 (1.7)
Range	16–24
Ethnicity	
Black/African/Caribbean/Black British – Caribbean	5
Black/African/Caribbean/Black British – African	7
Black/African/Caribbean/Black British – Other	6
Mixed/Multiple ethnic groups – White and Black Caribbean	2
Treatment Setting	
CAMHS	5
IAPT	5
Adult Mental Health Services (AMHS)	2
Early Intervention Services (EIS)	1
Waitlist	1
Unspecified	6

Service User Demographics	n
Primary Psychiatric Diagnosis	
Depression	6
Generalised Anxiety Disorder (GAD)	5
Post-Traumatic Stress Disorder (PTSD)	3
Psychosis	2
Borderline Personality Disorder (BPD)	2
Autism Spectrum Disorder (ASD)	2
Attention Deficit Hyperactivity Disorder (ADHD)	1
Binge Eating Disorder	1
Comorbidities	Several participants reported comorbid diagnoses; percentages therefore not calculated.
Prior Experience with CATs	
Experience with CATs in NHS settings	7
Informal creative engagement only	13

Figure 3: Clinician demographics. This figure displays the sample characteristics of the clinician participants (n=15).

Clinician Demographics	n
Gender	
Female	14
Male	1
Age (years)	
Mean (SD)	32.5 (4.3)
Range	26–55
Ethnicity	
White – English/Welsh/Scottish/Northern Irish/British	6
Asian/Asian British – Chinese	1
Arab	1
Mixed/Multiple ethnic groups – White and Black Caribbean	1
Black/African/Caribbean/Black British – Other	3
Unspecified	3
Treatment Setting	
Child and Adolescent Mental Health Services (CAMHS)	3
Improving Access to Psychological Therapies (IAPT)	2

Clinician Demographics	n
Early Intervention Services (EIS)	2
Community Mental Health	1
Unspecified	7
Professional Background	
Creative Arts Therapist	5
Other Mental Health Professional	10

4.3.2 Creative arts as vehicles for emotional healing, identity, and agency

Participants consistently described CATs as supportive tools for emotional regulation and expression. Black youth emphasised the role of music, art, and movement in helping them manage anxiety and communicate feelings that were difficult to express verbally. Table 1 outlines participants' experience with CATs as connecting with lived experience, identity affirming tools, and preferred modes of expression.

"Music helps me calm down so much with my anxious thoughts." (SU07)

"When I dance or draw, I can get things out that I can't always explain with words." (SU11)

Clinicians echoed these accounts, highlighting CATs as accessible alternatives for young people who struggle with conventional talking therapies. Notably, several clinicians were trained creative arts therapists or worked within services where CATs were already embedded.

"It breaks barriers — almost every patient can relate to some form of art or music, regardless of background or religion." (CL02, Art Therapist)

Several clinicians described therapeutic breakthroughs emerging through creative engagement rather than verbal exploration.

"Sometimes being heard isn't about your voice. It can be through art, through your body, through music." (CL09, Clinical Psychologist)

Participants also emphasised the sense of agency afforded by creative approaches, describing CATs as flexible, empowering, and aligned with individual needs.

However, not all participants experienced CATs as inherently accessible. Some Black youth described discomfort with group sessions and fears of judgement, suggesting that creative modalities may not be equally supportive for all young people, particularly those with social anxiety or low confidence in group spaces.

"What if someone judges my dancing or the art that I'm making? That might make me feel worse." – (SU04)

Dimension	Description in Data	Participant Examples
Connection with lived experience	CATs described as reflecting everyday coping and emotional expression	SU03: "I already use music when I'm stressed to quiet my anxious thoughts" SU12: "It feels more natural than talking about my issues."
Identity affirmation	Creative practices linked to Black cultural identity and belonging	SU07: "(Music) connects us to our home and culture." SU14: "Music is part of who we are."
Preferred mode of expression	Non-verbal and embodied forms felt safer than traditional talking therapy	SU18: "I can get things out that I can't say in words." CL09: "Giving young people the tools to express themselves without words is essential."

Table 1: This table maps the dimensions of alignment between creative arts therapies and participant experiences with the data but specifically exemplified by quotes used by participants.

4.3.3 Challenges and barriers to CAT implementation

Despite strong interest in CATs, participants identified significant barriers to their implementation within NHS services. Clinicians described limited funding, insufficient staffing, and the marginalisation of creative approaches within clinical hierarchies.

"It's often devalued for its purpose. We (arts therapists) know the power of the intervention, but other clinicians are more likely to disrupt seeing somebody engaging in drama or music or art and thinking, oh,' I can disrupt that in the way that they wouldn't disrupt if it was a one-on-one conversation.' It's seems to be viewed as nonessential for our CBT therapists." (CL13, Music Therapist)

Black youth described personal barriers to engagement, including shyness and fear of judgement in group-based creative settings.

"I think for me the difficulty would be just interacting with new people. I always find it hard to make new friends. What if they're judging my dance movements or what I decide to create in an arts session?" (SU01)

Participants noted that these challenges were compounded by broader systemic constraints, including long waiting times and limited access to therapeutic options beyond talking therapies.

4.3.4 Discovering therapeutic potential through creative experience

Although not all Black youth had accessed formal CAT sessions, all reported engaging in creative practices in their everyday lives to support their mental health. Participants described

singing, dancing, and listening to music as coping strategies, particularly during periods of waiting for services.

"I would say I've used singing as like a coping strategy." (SU03)

"I sing and dance and it really helps to some extent. It's helped me deal with a lot of mental things on my own." (SU20)

Clinicians described recognising similar patterns in practice, noting that many young people already use creative expression as a form of self-regulation before entering therapy.

4.3.5 Disconnection and mistrust within clinical encounters

Black youth frequently described feelings of disconnection and dissatisfaction within conventional therapy settings. Talking therapies were often experienced as impersonal, repetitive, or misaligned with their lived experiences.

"I feel sometimes this therapy lacks some personal approaches. Generally, I don't feel they are addressing my issues. Sometimes I even end up treating my own self without the therapy. Sometimes it kind of feels like they're trying to put words in my mouth or explain my experience through their own." (SU06)

"Sometimes therapy just feels like another job I have to do. There was nothing personal about it and it seemed like false promises." (SU03)

Clinicians often framed Black young people's disengagement in terms of systemic barriers. While clinicians acknowledged structural racism, their accounts tended to focus on training gaps and resource limitations, reflecting their positioning within NHS systems. Clinicians acknowledged that Black young people often enter services following crisis or coercive experiences, which can undermine trust and engagement.

"We expect young people to dive straight into heavy therapy, but for many, especially if they've had bad experiences, it's too much too soon." (CL12, Psychotherapist)

Black youth also discussed stigma surrounding mental health within Black communities, which contributed to delayed help-seeking.

"That's just not a thing. Talking about our emotions, I do think that has a lot to do with oppression and what we've been through as a as a people anyway in general. So we're told to keep quiet and things like that. I feel like that's just rippled on to now." (SU15)

4.3.6 Creative expression as a bridge between culture and care

Participants consistently described creative expression as deeply embedded within Black cultural identity. Music, art, and dance were framed as culturally familiar and meaningful forms of expression that could support engagement with mental health care. Participants described

identity alignment in several distinct ways. For some, creative expression connected them to diasporic heritage and cultural memory, particularly through music rooted in African or Caribbean traditions. For others, identity alignment referred less to cultural tradition and more to a sense of self-expression that felt authentic and self-directed, in contrast to structured clinical dialogue.

"It's something that's taught me something about myself and my roots. I know how much art, music, and dance means to us. It's ingrained. I would love to see that happening in our services." (SU11)

"I have a personal value of it by growing up in the Caribbean half my life and half my life in the UK, and I guess it helped to shape my identity as a Black person… it helped me to build a core anyway." (SU04)

"Growing up in the Caribbean, (music) is something that taught me about myself, about my roots. It's something that gave me a sense of self and it gives me a reenergised feeling like, ah, yes, I'm at home." (SU13)

"It's something my people need, especially growing up in a European place. I do think it helps connect us to our identity and could really help those that struggle growing up in a place that's so dissimilar to our home countries. And if there were creative arts offered at my service, I would definitely be signing up for it today." (SU17)

While many participants described creative expression as culturally meaningful, this was not presented as a wholly ubiquitous experience. Cultural identity was diverse and layered, and some young people's relationship to the arts was shaped also by generational or personal experience not by racial identity alone. Cultural resonance therefore appeared contingent rather than automatic.

"(Music (is) definitely something I find helpful, but I don't tie any cultural meaning to it personally." (SU08)

Clinicians emphasised the importance of cultural competence in building therapeutic relationships.

"Just being aware of different cultures and experiences is really important. We cannot expect a one-size-fits-all model to work for everyone, especially in therapy. If we're naïve to cultural competence, we're not going to build relationships with patients and they're not going to get anything from our treatments. I try to learn from my patients just as they are trying to learn from me. But as clinicians, we should all be doing this." (CL09 Clinical Psychologist)

"When you understand more about their culture, where they come from, you will know where you're going. If you understand that culture and try to incorporate that into the session, you will probably get more information and a deeper connection with that client." (CL03, Clinical Psychologist)

Some Black youth described the emotional labour involved in addressing race within therapy.

"In the therapy where things have come up about race, it's like they don't know how to handle these situations, especially in a group setting… sometimes I have to explain it to them, which is a form of labour on my part. I have to educate people who should be helping and educating me. They need to educate themselves about our cultures before they can help us fully." (SU01)

4.4 Discussion

This study explored how Black young people with mental health challenges and NHS clinicians perceive Creative Arts Therapies (CATs) as culturally competent interventions within mental health care. The findings indicate that CATs are viewed as emotionally accessible, culturally resonant, and potentially effective alternatives or complements to traditional talking therapies. As outlined in Table 1, participants described creative arts therapy in either individual or group settings with reflective discussion, as aligning more closely with lived experience, and preferred modes of expression, particularly for Black youth who often feel misunderstood or alienated within conventional clinical encounters.

Although perspectives from clinicians are presented alongside those of Black service users, the analytic emphasis of this study is centered on the lived experiences of Black young people.

4.4.1 Creative arts therapies as accessible and culturally congruent care

Black youth consistently described CATs as tools for emotional regulation, expression, and agency, particularly when verbal communication felt limiting or inadequate. These findings align with existing evidence demonstrating the effectiveness of creative arts-based interventions in supporting emotional well-being and engagement among young people with mental health difficulties(Applewhite et al., 2025; Delattre et al., 2024). Recent literature focused on creative arts therapies specifically for Black youth populations globally has found leading evidence for creative arts' beneficial uses with this population, highlighting their usefulness as culturally aligning and accessible tools for Black young people struggling with mental health difficulties(Applewhite et al., 2025).

By offering non-verbal and embodied modes of expression, CATs may be particularly well suited to individuals who struggle with introspection-based or cognitively demanding therapeutic models. Importantly, CATs should not be positioned solely in opposition to traditional talking therapies. Participants' accounts suggest that creative approaches may function most effectively alongside broader psychosocial supports, including social prescribing initiatives, community-based wellbeing programmes, peer support networks, and recovery colleges.

The perceived value of CATs was not simply that they supported emotional regulation, but that they offered an alternative relational dynamic to traditional NHS encounters. For many Black youth, creative approaches disrupted the interrogative structure of clinical dialogue, enabling more embodied forms of participation. In this sense, CATs were experienced not only as therapeutic tools, but as altering the power dynamics of care.

Participants framed CATs not simply as therapeutic techniques, but as culturally meaningful practices. Music, dance, and visual art were described as embedded within Black cultural identity and everyday coping, suggesting that CATs may offer a form of cultural congruence often lacking in standardised NHS therapies. This cultural alignment may help explain why participants viewed CATs as more engaging and authentic than conventional talking therapies, supporting the argument that therapeutic effectiveness is closely tied to cultural relevance.

However, it's important to note that a minority of participants expressed uncertainty about whether creative approaches would feel therapeutic in formal clinical contexts, suggesting that everyday engagement with music or art does not automatically translate into comfort within structured therapeutic settings.

4.4.2 Addressing disengagement and mistrust in mental health services

The study also highlights persistent experiences of disconnection and mistrust within NHS mental health services. Consistent with recent reporting, (NHS Race and Health Observatory, 2023),(Arundell et al., 2021; Kapadia et al., 2018; Keating & Robertson, 2004; Kim et al., 2019; McLean et al., 2003; NHS Race and Health Observatory, 2023) , Black youth frequently described feeling unheard, misunderstood, or burdened by impersonal therapeutic approaches, echoing wider evidence that Black young people often experience mental health care as alienating or misaligned with their needs.

Clinicians acknowledged that many Black service users enter care through crisis pathways or after coercive experiences, which can undermine trust and engagement from the outset.

Within this context, CATs may offer a less threatening entry point into therapy by prioritising relationship-building, creativity, and emotional safety over immediate verbal disclosure. Participants suggested that creative approaches could support early engagement, particularly for young people who are hesitant to access services or who have disengaged from previous treatment. These findings reinforce the importance of flexibility and relational sensitivity in addressing engagement disparities within youth mental health care.

The significance of CATs in this study lies less in their novelty as therapeutic tools and more in how participants positioned them within a system marked by mistrust. CATs were framed as counterpoints to standardisatised NHS care. This suggests that their perceived effectiveness may derive not only from modality, but from the ways they reconfigure participation and agency within institutional contexts.

4.4.3 Cultural competence beyond individual awareness

Participants' accounts underscore that cultural competence must extend beyond individual clinician awareness to encompass systemic and organisational change. While clinicians expressed commitment to culturally responsive practice, many also described limited training, institutional constraints, and a lack of support for implementing creative approaches within NHS services. Black service users, in turn, described the emotional labour of explaining cultural or racial experiences to clinicians who felt unprepared to engage with these topics.

CATs alone cannot resolve structural inequities in mental health care; however, they may function as one component of a broader culturally competent system. By embedding creative approaches within standard care pathways and supporting clinicians through training and reflective practice, services may be better equipped to meet the needs of Black young people. Importantly, participants did not present CATs as a solution to structural racism or systemic failures within NHS care. Experiences of coercive pathways and mistrust were understood as institutional problems that require policy-level reform. CATs may improve engagement and emotional accessibility, but they cannot substitute for structural change.

Within current NHS pathways, CATs may function as relational and engagement-enhancing interventions rather than structural remedies. Their contribution appears most evident in improving emotional accessibility, strengthening therapeutic alliance, and fostering identity affirmation. However, their implementation remains contingent on institutional support, and integration within existing service models.

These findings align with calls from national policy bodies and recent research to move beyond "one-size-fits-all" models and develop culturally informed, community-grounded mental health services (Arundell et al., 2021; NHS Race and Health Observatory, 2023).

4.4.4 Implications for NHS mental health services

The findings have several implications for service design and delivery within the NHS. First, CATs could be integrated in early intervention services, CAMHS and NHS Talking Therapies, particularly for young people referred through crisis social care routes who many be hesitant to engage in verbally dominant therapies. Integrating CATs earlier in care pathways may support engagement, reduce dropout, and foster trust among Black young people who are less likely to benefit from conventional approaches. Additionally, CATs could be integrated not only within clinical services but also within social prescribing frameworks, recovery colleges, and community-led mental health initiatives. Embedding CATs within these relational and non-clinical spaces may reduce stigma and support early engagement without requiring immediate entry into formal psychotherapy.

Finally, meaningful co-production with Black communities is essential. Involving Black youth in the design, delivery, and evaluation of creative interventions may help ensure that services are not only culturally sensitive but also responsive to lived experience. Such approaches align with broader NHS commitments to reduce health inequalities and promote person-centred care.

However, implementing CATs at scale requires structural change. This includes 1) commissioning recognition of CATs within NHS service specifications, 2) increased resources for creative arts therapist posts, 3) integration of CATs into NICE care pathways where appropriate, and 4) mandatory training in cultural competence for multidisciplinary teams.

Responsibility for these changes lies at multiple levels: NHS Trust leadership and service managers in workforce planning and service design; commissioners and Integrated Care Boards in funding decisions; and national bodies such as NHS England and NICE in recognising culturally congruent modalities within formal guidance frameworks.

4.5 Strengths & Limitations

A key strength lies in the study's inclusion of both service user and clinician perspectives across multiple NHS Trusts, which enabled a more holistic understanding of how cultural factors, systemic barriers, and therapeutic engagement intersect in practice. The focus group format fostered collective reflection, allowing participants to build on one another's experiences and

identify shared challenges in accessing and delivering culturally competent care. Conducting separate focus groups for clinicians and Black service users also helped ensure that participants could speak freely without fear of judgement or professional repercussions.

However, qualitative research of this nature carries inherent limitations. Focus group discussions may be influenced by social desirability bias, with participants potentially presenting views they believe to be acceptable to others in the group. Given the sensitive nature of race and mental health, some participants, particularly those in mixed-ethnicity clinician groups, may have moderated their responses.

The sample size, while appropriate for qualitative inquiry, limits generalisability. Participants were drawn from NHS Trusts in England, and their views may not represent the full diversity of Black young people's experiences across the UK.

Furthermore, while there are clear benefits of creative arts therapies, outlined by both Black youth and clinicians, there were expressed limits on who these therapies may not work well for, namely those with social anxieties when group creative arts sessions are conducted. Services users expressed the fear of being judged for the art they created or their movements in dance sessions, highlighting the unease some individuals might have in using these methods. Clinicians highlighted the lack of resources allocated to creative arts therapists within the NHS and also convincing other clinical staff to see the value in these interventions and how these would be carried out.

Additionally, while clinician perspectives aligned closely with those of Black service users, these accounts must be interpreted cautiously. Several clinician participants were trained creative arts therapists or worked within services where CATs were embedded. Their enthusiasm may therefore reflect both experiential knowledge and professional commitment to the legitimacy of creative modalities. This underscores that clinician endorsement should not be interpreted as independent validation of effectiveness.

Future research should build on these findings using mixed-method or longitudinal designs to assess the sustained impact of CATs on engagement, well-being, and treatment outcomes among Black youth. Quantitative studies could complement this qualitative evidence by measuring the effectiveness of culturally adapted CATs in comparison to standard talking therapies. Further, participatory and community-led research models would help ensure that interventions are co-produced with Black communities, fostering authenticity, accessibility, and trust.

4.6 Conclusion

This study provides new evidence that creative arts therapies are experienced by Black young people as culturally meaningful and emotionally accessible in contrast to traditional talking therapies offered NHS mental health services. A key finding of this study is that CATs are therapeutically effective and have the capacity to reconfigure the relational dynamics of care for both service users and clinicians.

Participants described talking therapies as ineffective due to their impersonal methods and cultural misalighnment that would often require service users to translate their experiences in way that did not reflect their current lived realities. Contrastingly, creative approaches were described as enabling non-verbal expression, which allowed participants for incentive to engage and connect with the therapist and therefore foster a greater sense of agency, trust and safety. Therefore, CATs were shown to not function only as an alternative therapeutic methods ,but as relational shaping interventions that encourage stronger participation positive therapeutic outcomes.

However, the findings show that creative interventions and cultural competence training cannot solve the structural and organisational barriers that NHS clinical settings have posed. Specifically, the barriers related to broader issues of mistrust and coercive pathways show how services are experienced by Black young people. Furthermore, commissioning CATs into NHS settings currently poses issues due to limited funding in place for CAT programmes nationwide, along with workforce constraints, and limited understanding of the importance of these services amongst non-creative arts therapist staff members. While CATs may improve engagement and emotional accessibility for Black service users, they cannot solve the systemic inequities that currently exist.

It is also important to note that many participants did not think creative arts would be replacement therapies for current treatments but moreso complementary approaches valuable in early intervention and engagement services and also for supporting individuals who may find talking therapies inaccessible. These findings are congruent with the results of the meta-analytic findings that show creative arts therapies are culturally grounded and identity affirming methods that support the non-verbal expression of emotions and relational safety and trust building between the service user and clinicians.

However, this chapter identifies a gap between the value of creative arts interventions and scalable and practical delivery. While CATs were widely viewed as beneficial therapeutic tools, the delivery and implementation in NHS systems remains constrained. These findings raise an important applied question: what happens when a culturally grounded creative intervention is

delivered outside formal NHS pathways, in a community-based setting designed to prioritise accessibility, identity affirmation, and participant experience?

The next chapter addresses this question through a mixed-methods pilot study of a community-based music programme for Black young people, examining feasibility, acceptability, and experiential outcomes to explore how insights from NHS settings translate into practical real-world community settings.

Chapter 5

Spotlight: A Mixed-Methods Pilot Study of a Community-Based Music Intervention: Feasibility, Acceptability, and Preliminary Signals of Change

Chapter Summary

Previous qualitative findings have highlighted the value of creative arts as emotionally accessible and culturally resonant approaches to mental health support, particularly in contrast to traditional talking therapies. However, there remains limited evidence on how such approaches can be implemented in real-world, community-based settings.

This chapter presents *Spotlight*, a mixed-methods pilot study examining the feasibility, acceptability, and preliminary mental health outcomes associated with a community-based music intervention for Black young people. The programme was delivered in partnership with a South London youth arts organisation and involved an eight-week series of music and artist development workshops, culminating in a live community showcase.

A mixed-methods design was employed. Quantitative self-report measures of depression (PHQ-8), anxiety (GAD-7), trauma (PCL-5), and wellbeing (SWEMWBS) were collected at four time points: baseline, mid-intervention, post-intervention, and six-week follow-up. Qualitative data were gathered through post-intervention focus groups and analysed using reflexive thematic analysis.

Findings indicate that the intervention was both feasible and acceptable, with strong retention and engagement across the programme. Descriptive quantitative results showed consistent reductions in depression, anxiety, and trauma symptoms, alongside improvements in wellbeing across participants. Qualitative findings highlighted the role of creative engagement in supporting emotional regulation, confidence, and identity development. However, participants also identified challenges related to performance-related pressure and the need for independent emotional support within programme structures.

Overall, this pilot provides preliminary evidence that community-based, culturally grounded creative interventions may offer meaningful and culturally resonant benefits for Black young people. It also highlights key implementation and ethical considerations for future research and

scale-up, contributing to the development of more accessible and culturally responsive mental health support.

5.1 Introduction

The previous chapter on the qualitative work explored the perspectives of Black young with psychiatric disorders and clinicians working within NHS mental health services, and how creative arts as therapies could potentially serve as effective and culturally competent mental health solutions. In both service users and clinicians, creative modalities were consistently described as beneficial for greater emotional wellbeing, emotional accessible, culturally resonant, and supportive of identity, agency, and emotional expression, particularly in contrast to traditional NHS talking therapies. Black young people expressed how creative approaches aligned more closely with their cultural forms of expression and offered non-verbal pathways for processing emotions.

Clinicians echoed these findings citing their potential to enhance further engagement among their patient population and utilizing creative arts as a cultural bridge to mutual understanding throughout sessions.

Despite the advantages highlighted surrounding using creative arts therapies, the qualitative findings highlighted substantial structural and organisational barriers to the delivery of creative interventions within NHS services, including limited availability, inconsistent commissioning, insufficient cultural competence in clinical staff, and broader issues of mistrust and power within clinical encounters.

As a result of NHS limitations, many young people have turned to informal services and community organisations to seek assistance with their mental health needs (White et al., 2024). Community organisations provide an intermediary bridge often when young people do not know how to access more formalized services like those through the NHS, or for those that simply prefer a more relaxed approach to servicing their mental health needs, namely through creative expression and community building.

While these qualitative findings provide critical insight into *why* creative approaches may be valued and where existing services fall short, they also raise an important question regarding *how* culturally grounded creative interventions might be enacted in practice. To bridge the gap between the theoretical findings and practical evidence, there is a need to examine what happens when a culturally congruent creative intervention is delivered in a real-world, community-based setting outside formal clinical pathways. Such translational work is essential for assessing feasibility, identifying implementation challenges, and generating early empirical

knowledge that can inform the development of scalable, ethically grounded interventions responsive to the needs articulated by Black young people themselves.

Based on these conceptions, the present chapter reports on a mixed-methods pilot study, *Spotlight*, an eight-week community-based music programme delivered in partnership with Grounded Sounds, a music youth arts charity based in Brixton, South London. The purpose of this pilot was not to evaluate clinical effectiveness, but to examine the feasibility and acceptability of delivering a culturally grounded creative intervention for Black young people, alongside exploratory assessment of participants' mental health and emotional wellbeing outcomes. What's central in this pilot is the role of Black youth's voice in co-creating creative interventions that are culturally resonant for them, something that is explored within a small focus group where the qualitative insights of the programme are investigated in detail. By situating the intervention within a community context and prioritising participant experience, this study aimed to generate practical insights to inform future intervention development, implementation strategies, and larger-scale evaluative research.

5.2 Objectives

The key objectives of the *Spotlight* pilot study were:

1. To examine the feasibility and acceptability of delivering a community-based, culturally grounded music intervention for Black young people outside formal clinical pathways.
2. To explore participants' experiences of the intervention, including perceived emotional, social, and creative impacts, as well as reflections on cultural relevance and support needs.
3. To explore preliminary patterns of change in self-reported mental health symptoms and wellbeing across the intervention period and follow-up
4. To identify practical and ethical considerations relevant to the design, delivery, and evaluation of creative arts-based interventions for Black young people, including implications for future research and potential scale-up.

5.3 Methods

5.3.1 Study Design

This pilot study employed a mixed-methods pilot design to examine the feasibility, acceptability, and experiential impact. Throughout the programme, symptoms of psychological and emotional well-being were measured at week 1, week 4, week 8 and at 6 weeks post showcase follow up. In addition, qualitative data were collected to capture participants'

experiences of the programme, the perceived cultural resonance of creative arts as therapies specifically in Black young people and finally, the perceived benefits and challenges of utilsing creative arts. It's important to note that this study was designed as exploratory and hypothesis-generating rather than evaluative of clinical effectiveness.

5.3.2 Setting and Intervention

Spotlight was delivered in partnership with Grounded Sounds, a South London youth arts charity specialising in music education and creative development. The programme consisted of weekly group sessions delivered over an eight-week period and was hosted within the Grounded sounds facilities as well as the final showcase at the Ton of Brix venue, associated with the charity.

Sessions focused on collaborative music-making, creative expression, and artist development, including songwriting, vocal and musicianship skills, and opportunities to engage with the professional music industry. Participants worked collectively to create original pieces of music, culminating in a public showcase where they performed their work for members of their community, including friends, family members, and carers. Workshops were facilitated by three Disclosure and Barring Service (DBS)-checked musicians with experience in youth work and music education. The programme was not delivered as a clinical intervention and did not involve formal psychotherapy or therapeutic facilitation. However, for safeguarding purposes, we employed a clinical psychologist on the research team to assist with neuropsychological testing of participants, pastoral care and crisis management.

5.3.3 Participants and Recruitment

Participants were recruited via Grounded Sounds' website, social media channels, and word of mouth. Recruitment materials invited Black young people aged 18–24 to take part in a creative music programme exploring wellbeing and creative expression. Participation was voluntary, and no prior musical training was required. Participant Information Sheets were distributed to prospective participants which outlined the purpose of the research, the nature of the study, overall aims, and the benefits of taking part. Eligibility screening was conducted online using REDCap (The REDCap consortium, 2019.) Prospective participants first provided informed consent to complete the screening process and then confirmed that they met the inclusion criteria.

***Inclusion criteria**:*

1. Black young people aged 18 to 24 years at the time of consent with symptoms of a common mental disorder who reach mid/at the threshold level for diagnosis (depression, anxiety, PTSD
2. Black young people aged 18-24 years at the time consent with NO symptoms of a common mental disorder (low/mild threshold scores) (depression, anxiety, PTSD)
3. Participant is willing and able to give informed consent for participation in the study
4. The ability to read, write, and speak in English

Individuals were not excluded for a formal diagnosis of depression, PTSD, or anxiety from a GP or other mental healthcare provider; for being presently or formerly on medication for depression, anxiety, PTSD; or for presently or formerly attending talk therapies.

Exclusion criteria:

1. Individuals with a PHQ-8 score of greater than 19
2. Individuals who self-report a current or recent diagnosis of any psychotic disorder (e.g., bipolar, schizophrenia, schizoaffective disorder), substance use disorders, eating disorders, or personality disorders
3. individual with active suicidality
4. Individuals for whom the Principal Investigator determines that the study is not suitable

As part of screening, participants completed the Patient Health Questionnaire (PHQ-8) (Kroenke & Spitzer, 2018) to assess current depressive symptoms. Completion of screening did not oblige participation in the study.

Eligible participants were subsequently contacted by the researcher to answer any outstanding questions and to review the Participant Information Sheet. Written informed consent for study participation was then obtained electronically via REDCap. Following consent, participants provided demographic information including age, gender, ethnicity, an initial PHQ-8 assessment, and self-reported psychiatric diagnoses.

5.3.4 Procedure

Following enrolment, participants completed two weekly music sessions in the Spotlight programme (24 sessions total), and a series of online self-report questionnaires at four time points: baseline (T0), mid-intervention (T1), post-intervention (T2), and six-week follow-up (T3). Data collection was conducted remotely to minimise participant burden and maximise accessibility.

In addition to quantitative data collection, participants were invited to take part in an online focus group approximately six weeks after completion of the programme (T3). Focus groups were designed to explore participants' experiences of the intervention, perceived benefits and challenges, and reflections on the cultural relevance of music-based approaches for mental wellbeing.

5.3.5 Quantitative Measures

Self-reported mental health symptoms and wellbeing were assessed using validated measures commonly employed in youth mental health research:

1. Depressive symptoms were assessed using the Patient Health Questionnaire (PHQ-8) (Kroenke & Spitzer, 2018)
2. Anxiety symptoms were assessed using the Generalised Anxiety Disorder scale (GAD-7) (Spitzer et al., 2006)
3. Trauma-related symptoms were assessed using the PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (PCL-5) (Blevins et al., 2015)
4. Wellbeing and quality of life were assessed using the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) (Tennant et al., 2007)

5.3.6 Data Collection Time Points

- **T0 (Baseline):** PHQ-8, GAD-7, PCL-5, SWEMWBS
- **T1 (Week 4):** PHQ-8, GAD-7, PCL-5
- **T2 (Week 8):** PHQ-8, GAD-7, PCL-5, SWEMWBS
- **T3 (Six-week follow-up):** PHQ-8, GAD-7, PCL-5, semi-structured online focus group

5.3.7 Qualitative Data Collection

Focus groups were conducted online with Microsoft Teams and comprised up to five participants per group. A semi-structured topic guide was used to explore participants' experiences in the *Spotlight* programme, perceived emotional and social impacts, current uses of creative arts before participation in the programme (if any) and reflections on cultural relevance and support needs. Discussions also invited feedback on programme structure and suggestions for future development.

All focus groups were audio-recorded using a digital recorder with participants' consent and transcribed verbatim by the research team. Transcripts were anonymised, with any identifying information removed prior to analysis.

5.3.8 Qualitative Data Analysis

Qualitative data were analysed using reflexive thematic analysis following the six-phase framework outlined by Braun and Clarke (Braun & Clarke, 2006). This analytic approach was selected due to its flexibility, suitability for applied health research, and alignment with the exploratory aims of the pilot study. NVivo 12 software was used to support data management and organization (QSR International, 2017).

Analysis proceeded through the following phases. First, transcripts were read repeatedly to support familiarisation with the data and to note initial impressions. Second, inductive open coding was conducted, with codes generated to reflect participants' language and experiential accounts rather than pre-existing theoretical categories. Coding was conducted at a semantic level, focusing on participants' explicit descriptions of their experiences of the programme.

In the third phase, codes were reviewed and organised into potential themes through an iterative process of comparison and refinement. Candidate themes were examined in relation to both the coded data and the full dataset to ensure coherence, internal consistency, and conceptual distinctiveness. In the fourth phase, themes were refined and defined, with attention to how they related to the study aims and to insights generated in the preceding qualitative chapter. The final phase involved selecting illustrative data extracts and producing a narrative account of the themes that captured both shared experiences and points of divergence within the data.

Given the pilot nature of the study and the small number of focus group participants, the aim of the qualitative analysis was not thematic saturation but depth of insight and analytic coherence. Findings are therefore presented as exploratory and illustrative, intended to complement the quantitative data and to inform future intervention development rather than to generate generalisable claims.

5.3.9 Reflexivity and Analytic Rigour

Consistent with reflexive thematic analysis, reflexivity was integral to the analytic process. The lead researcher (B.A.) identifies as part of the Black community and has professional experience in mental health research, which facilitated rapport and sensitivity to cultural

nuance but also required ongoing reflexive awareness of positionality and potential interpretive assumptions. Reflexive notes were maintained throughout data collection and analysis to document analytic decisions and evolving interpretations. The second analyst (S.B.) is a doctoral researcher with experience in creative arts-based research and training in culturally competent and trauma-informed approaches. Regular peer debriefing and collaborative analysis supported transparency and methodological rigour.

5.3.9.1Ethical Approval

Ethical approval for the study was obtained from the University of Oxford Central University Research Ethics Committee (CUREC 1: R95288/RE001).

5.4 Results

Five participants took part in the data collection component of the Spotlight pilot study. All participants self-identified as Black British based on the 2021 ONS categories (Office for National Statistics, 2018), including Black African, Black Caribbean, or Mixed Black ethnic backgrounds. Participants were aged between 18 and 24 years.

Three participants reported a current formal diagnosis of a common mental disorder at baseline: one reported generalised anxiety disorder, one reported post-traumatic stress disorder, and one reported depression. The remaining two participants did not report a current mental health diagnosis. Given the exploratory nature of the pilot and the small sample size, participants were not assigned to comparison groups; rather, analyses considered individual trajectories across time points.

All participants who enrolled in the study completed baseline and 6-week post-intervention questionnaires. 4/5 participants completed the questionnaires at week 4 (T1), and 2/5 completed the self-report questionnaires at week 8 (T2). This reflects high retention across the intervention and follow-up period, specifically at baseline and after intervention follow up periods supporting the feasibility of repeated data collection in this setting.

5.4.1 Quantitative Outcomes: Individual Symptom Trajectories

Given the pilot design and small sample size, quantitative results are presented descriptively and visually, focusing on individual trajectories and patterns of change across the intervention and follow-up period. No inferential statistical analyses were conducted. Figure 1 illustrates

individual-level trajectories for depression, anxiety, PTSD symptoms, and wellbeing across baseline, mid intervention, post-intervention, and follow-up assessments.

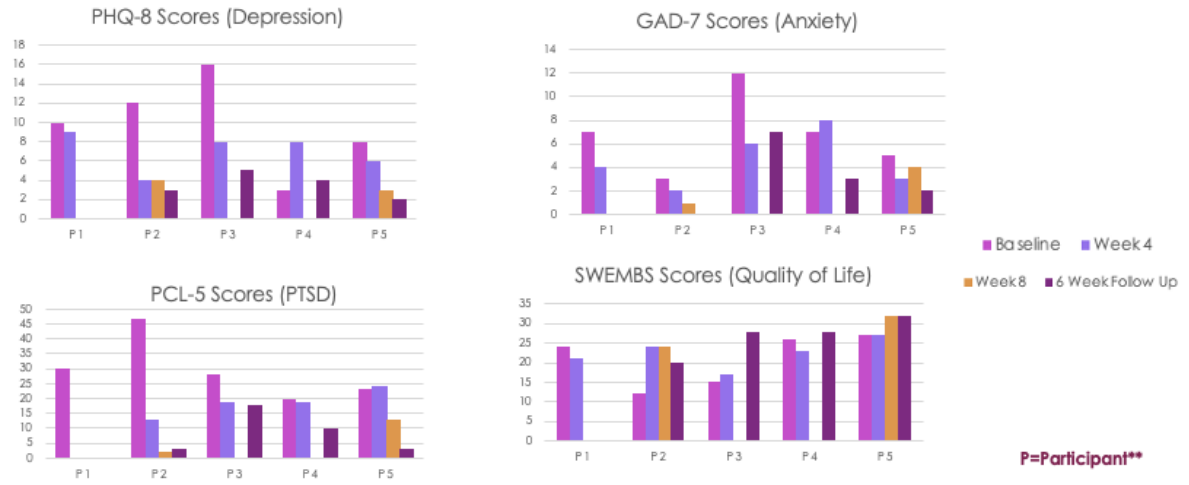


Figure 1: Results of the self-reported mental health symptoms. This bar graph shows the mental health scores of all 5 participants. PHQ-8 scores align with symptoms of depression; GAD-7 scores align with symptoms of anxiety; PCL-5 scores align with symptoms of PTSD; SWEMBS scores align with quality of life scores.

In terms of participant characteristics, participant two (P2) had a formalised GAD diagnosis; participant four (P4) had a formalized PTSD diagnosis, and participant five (P5) had a formalised diagnosis of depression. Participant one (P1) and Participant 3 (P3) had no formal psychiatric disorder diagnosis and no presenting symptoms. Across participants, self-reported symptoms of depression (PHQ-8), anxiety (GAD-7), and trauma-related symptoms (PCL-5) showed a consistent downward trajectory from baseline to six-week follow-up.

While the magnitude and timing of change varied between individuals, all participants demonstrated a reductions in symptom scores by the final follow-up time point at six weeks. This pattern was observed both among participants with self-reported mental health diagnoses and those without a reported diagnosis at baseline.

In contrast, scores on the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) showed an upward trajectory across participants, indicating improvements in self-reported wellbeing and quality of life over the course of the programme and follow-up period. As with symptom measures, increases in wellbeing were observed across participants regardless of diagnostic status.

These descriptive patterns suggest that changes observed during the programme were directionally consistent with hypothesised benefits of creative, community-based interventions, though causal inferences cannot be drawn. Additionally, symptoms of mental health and wellbeing symptoms declined not only in those formalised diagnoses, but also for

participants without any presenting symptoms of a psychiatric disorder, suggesting the universal benefit of creative arts on an individuals overall emotional wellbeing.

5.4.2 Qualitative Findings: Participant Experiences and Implementation Insights

The qualitative analysis identified three interrelated themes that capture participants' experiences of the *SPOTLIGHT* programme and highlight key considerations for the delivery of community-based creative interventions. Given the pilot nature of the study and the small number of focus group participants, these themes are presented as exploratory and illustrative rather than exhaustive. The analysis focuses on experiential and implementation-related insights, rather than theory generation.

5.4.3 Theme 1: Creative engagement as regulating emotions and confidence-building

In the focus groups, participants described Spotlight as a meaningful opportunity for creative growth, identity development, and confidence-building. Engagement in music-making and artist development workshops was experienced as both challenging and affirming, with participants highlighting pride in producing original work and developing new skills within a collaborative environment.

Several participants described the fast-paced nature of sessions as motivating, emphasising the sense of accomplishment associated with learning and creating within a relatively short timeframe. Creative engagement was frequently linked to broader emotional benefits, including increased self-belief and a sense of agency.

"It was intense, but in a good way. I learned so much in such a short time, about music and what it takes to be a real musician, but also about myself and how I can develop skills to lead me to that path."

These accounts suggest that creative participation functioned not only as skill development but also as a source of emotional validation and identity affirmation, reinforcing the perceived value of creative modalities beyond symptom-focused outcomes.

5.4.4 Theme 2: Pressure and emotional demand in the lead-up to the showcase

While participants valued the programme's final culminating showcase as a meaningful and motivating goal, they also described the final stages of Spotlight leading up to the event as emotionally and logistically demanding. The period leading up to the performance was

described as "hectic," with increased pressure to rehearse, refine material, and prepare for public presentation.

Participants experienced this time intensely, and while it contributed to a sense of achievement, it also introduced stress that was sometimes difficult to manage, particularly alongside existing mental health difficulties.

"Those last weeks were a lot it was exciting, but also stressful. It felt like so much to do with little time but we pulled it off in the end, so that felt great."

This theme highlights the dual role of performance-based elements within creative interventions. While showcases may enhance motivation, visibility, and meaning, they may also amplify emotional demand, underscoring the need for careful pacing and supportive structures within programme design.

5.4.5 Theme 3: The need for independent emotional support and safe spaces

Participants raised concerns about limited opportunities to discuss emotional challenges or programme-related difficulties during the intervention. Because programme staff were directly involved in delivering the sessions, participants described uncertainty about where to raise concerns without fear of negative consequences or disruption to group dynamics.

"Everyone you could talk to was part of the programme, so it didn't always feel easy to say when something was hard."

Participants recommended that future iterations of the programme include access to independent support, such as third-party facilitators or on-site mental health professionals, to provide confidential spaces for reflection and emotional processing. This was viewed as particularly important given that several participants reported living with ongoing mental health difficulties.

This theme points to broader considerations around power, trust, and emotional safety within community-based interventions, and highlights the importance of clear support pathways that sit alongside, but are not embedded within, programme delivery.

5.5 Discussion

This chapter examined the feasibility, acceptability, and experiential impact of a community-based music intervention delivered to Black young people, using a mixed-methods pilot design. Rather than evaluating clinical effectiveness, the study aimed to explore preliminary patterns of change in mental health and wellbeing, alongside participants' experiences of programme

delivery, in order to inform future intervention development. The quantitative and qualitative findings provide exploratory evidence that community-based creative interventions may offer meaningful psychosocial benefits while also raising important considerations for ethical and supportive implementation.

5.5.1 Preliminary patterns of change in mental health and wellbeing

Across participants, self-reported symptoms of depression, anxiety, and trauma showed a consistent downward trajectory from baseline to six-week follow-up; wellbeing scores demonstrated an upward trajectory over the same period. These descriptive patterns were observed both among participants with self-reported mental health diagnoses and those without a formal diagnosis at baseline. Although causal inferences cannot be drawn from a pilot study with a small sample size, the consistency in direction of change across individuals suggests that participation in the programme coincided with improvements in both symptom-related and broader wellbeing outcomes.

Importantly, observed changes were not limited to participants with existing mental health diagnoses. Participants without reported diagnoses also demonstrated improvements in wellbeing and reductions in distress, suggesting that community-based creative programmes may offer benefits that extend beyond treatment-focused models and potentially function as preventive or early-support interventions. This aligns with broader evidence indicating that creative engagement may support emotional regulation, confidence, and psychosocial functioning in youth populations (Fancourt & Finn, 2019).

5.5.2 Feasibility and acceptability of community-based delivery

High retention across assessment time points and completion of follow-up measures indicate that repeated data collection within a community-based arts setting was feasible and acceptable to participants. Week 8 experienced low engagement in self-report mental health measures; however, this timepoint coincided with the showcase week, so much of the participants time was going towards preparing for the event. However, engagement with the programme and willingness to reflect on experiences during post-intervention focus groups further support the acceptability of this approach.

Delivering the intervention outside formal clinical pathways may have reduced barriers associated with stigma, clinical gatekeeping, and mistrust of services, which have been widely documented among Black young people (Mansfield et al., 2021b)While this study did not

directly assess service avoidance or stigma reduction, the feasibility of recruitment and sustained participation suggests that community-based creative settings may represent accessible entry points for mental health support, particularly for individuals who are less likely to engage with traditional services.

5.5.3 Interpreting cultural relevance of music in the programme

Although participants did not explicitly frame their experiences in terms of "cultural relevance," the qualitative findings nonetheless align closely with mechanisms identified in the preceding qualitative chapter exploring CATs within NHS mental health services. In both contexts, creative engagement was associated with increased confidence, identity affirmation, and a sense of agency, as well as emotional accessibility that contrasts with verbally dominant therapeutic models.

The absence of explicit references to cultural relevance in the Spotlight focus groups may reflect the fact that cultural congruence was embedded rather than foregrounded within the programme. Music, as a familiar and valued mode of expression, may have functioned as a culturally affirming medium without requiring participants to articulate this explicitly. It's also important to note that all of the Grounded Sounds staff working with these young people identified as Black British, which for participants, may have provided a congruent space of cultural safety and understanding. This interpretation is supported by participants' emphasis on creative identity, pride in original work, and emotional engagement, all of which mirror themes identified Chapter 4 in the broader qualitative study of Black young people's experiences within mental health services.

5.5.4 Implementation and ethical considerations

Qualitative findings also highlighted important implementation challenges, particularly regarding power dynamics and access to independent support. Participants described the final stages of the programme as intense and, at times, overwhelming, underscoring the need for careful pacing and support structures when incorporating performance-based elements into creative interventions. This theme also highlights the need for a longer lead up time for such an important performance, calling into question the 8-week structure of the programme and in future redesigning it to be longer to account for more preparation of the showcase performance.

Concerns regarding limited opportunities to raise difficulties with staff directly involved in programme delivery point to broader ethical considerations around trust, confidentiality, and

safety within community-based interventions. Participants' recommendations for independent support, including access to psychological professionals, echo concerns raised in NHS contexts regarding emotional safety and power imbalances. These findings suggest that while community-based delivery may enhance accessibility, it does not obviate the need for clear safeguarding and support frameworks, particularly when working with young people experiencing mental health difficulties.

5.5.5 Linking Spotlight Findings with the Broader Qualitative Evidence Base

The qualitative findings from the *Spotlight* pilot closely mirror and extend the themes identified in the preceding qualitative study (Chapter 4) conducted within NHS mental health services. In both datasets, creative engagement was described as emotionally accessible, identity-affirming, and supportive of agency, particularly in contrast to traditional talking therapies. Participants' emphasis on confidence, expression, and cultural alignment in Spotlight echoes broader accounts from Black young people in NHS settings, who described creative arts as resonant with cultural forms of expression and less stigmatising than conventional care.

At the same time, the *Spotlight* findings provide applied insight into how these perceived benefits manifest within a real-world intervention context. Concerns regarding emotional containment, power dynamics, and access to safe spaces for disclosure parallel clinicians' and service users' reflections in the NHS study regarding trust, cultural safety, and structural constraints within care systems. By situating these themes within a community-based pilot intervention, the present findings demonstrate how issues identified at the level of service experience translate into practical considerations for programme design and delivery.

Together, the convergence of findings across the NHS qualitative study and the *Spotlight* pilot strengthens the case for creative arts interventions as culturally meaningful approaches for Black young people, while also underscoring the necessity of embedding clear ethical, emotional, and support structures when such interventions are implemented outside formal clinical settings.

5.6 Limitations and future directions

This study has several limitations. The small sample size and absence of a comparison group preclude conclusions regarding effectiveness or generalisability. Qualitative findings are based on a limited number of participants and are therefore illustrative rather than representative. In addition, reliance on self-reported measures may be subject to response bias.

Despite these limitations, the study provides valuable translational insight by demonstrating how themes identified in larger qualitative and epidemiological studies manifest within a real-world intervention context. Future research should build on these findings through larger, adequately powered studies, incorporating comparison conditions and formal process evaluations to examine mechanisms of change. Embedding independent emotional support within programme design should be prioritised in future iterations.

5.7 Conclusion

This chapters examines how a creative arts intervention can be culturally grounded and enacted in a community-based setting in practice outside of formalised clinical pathways. This chapter builds on the global evidence supporting the utilization of creative arts interventions for psychiatric disorders in non-Western populations (Chapter 2), the population level evidence of the inequalities experienced by Black young people when accessing care (Chapter 3), and the qualitative insights into current clinical care experiences in NHS settings and how creative interventions could be enacted into such services. The final chapter and *Spotlight* pilot represents the thesis findings translated into accessible and practical solutions and tests how these insights could be operationalized in real-world community settings.

As a mixed-methods pilot study, Spotlight, demonstrates the feasibility of delivering a culturally grounded, community-based music intervention for Black young people and provides preliminary evidence of beneficial patterns in mental health and wellbeing outcomes. Descriptive psychological outcomes reveal reductions in psychological distress throughout participation, and increased emotional wellbeing, while qualitative insights from the pilot reveal the importance of creative expression and these processes supporting emotional regulation, confidence and identity formation. These patterns were observed across participants, whether they had a formal mental health diagnosis or not which suggests that creative interventions could be effective not only for those with psychiatric disorders, but also as interventions that could be beneficial for overall wellbeing and could act as preventative, early support modalities.

However, the study revealed challenges related to implementation, namely in tertiary emotional support that should be provided independently from programme leads. Also, while community-based support appeared to reduce barriers related to stigma and mistrust of formalised services, there were new complexities introduced about safeguarding, namely with participants concern to have independent spaces for emotional disclosures related to the

programme, highlighting the need for embedded safeguarding support structures into creative programmes, especially when working with individuals with ongoing mental health challenges.

These findings reinforce the value of creative arts interventions as not only a therapeutic modality but as tools that create relational safety and build trust along with creating culturally congruent spaces for Black young people. Similarly to the findings of Chapter 4, creative interventions functioned as a tool for non-verbal expression and as less intense therapeutic modalities in comparison to traditional talking therapies, allowing participants to engage in therapies that feel culturally congruent to them. Although, these findings also highlight that while creative arts were culturally relevant and accessible modalities, cultural relevance does not eliminate the needs for careful programme design, pacing and ethical oversight.

This chapter provides applied evidence that show creative arts-based interventions as positive and culturally relevant tools for Black young people, while also highlighting the conditions that are necessary to deliver scalable and responsible delivery. Findings suggest that the success of create interventions relies on how they are structured, supported and embedded within broader care systems.

The *Spotlight* pilot bridges the gap between theoretical understandings of the effectiveness and benefits of creative arts and demonstrates how creative interventions can be culturally relevant mental health interventions for Black young people. These findings inform the final chapter of this thesis, which integrates evidence across all studies and considers the implication of this research for future studies, services designs across the NHS, policy implications and outlined pathways toward more equitable and culturally responsive mental health care globally.

Chapter 6
General discussion and conclusions

6.1. Overview

This thesis set out to examine the persistent mental health inequalities experienced by Black young people in the United Kingdom, adding to the limited evidence for this population, with particular attention to barriers to accessing and benefiting from formal mental health services offered through GP services or the NHS. Drawing on population-level data, global quantitative evidence, qualitative inquiry within NHS services, and a community-based pilot intervention, this thesis adopted a multi-level mixed-methods approach to explore the use of creative arts interventions as potentially viable and culturally resonant options for these young people.

Despite the overrepresentation of Black populations within NHS inpatient mental health services and the harrowing mental health statistics related to the prevalence and poor outcomes for these individuals, there is a large gap in the literature specifically in the UK on how best to rehabilitate these people for lifetime prosperity and overall flourishing. Patients have often cited that their voices within mental health services and their preferences on care for themselves have often times been largely ignored. This thesis includes patient-centred voices from Black young people with lived experience in how they would like to shape their mental health care, what they deem helpful for their overall wellbeing, and also what they would like to access in the future within services.

The aim of this thesis was to bridge the gap between identifying mental health inequities experienced by Black young people in the UK and exploring practical, culturally grounded responses to them and exploring the practical and culturally grounded responses to them, namely with the use of creative arts.

The thesis addressed the overarching research question: **"how might creative arts–based approaches contribute to more culturally competent, accessible, and effective mental health support for Black British young people in the UK?"** answered sequentially first examining the epidemiological patterns in the wider population, then with evidence synthesis of current uses of creative arts for mental health in Global Majority populations, to then the lived experience of Black service users in NHS mental health settings and the adaptability of creative arts within these services, and finally, to the application of these interventions in a real-world community-based pilot intervention.

While this thesis is grounded in the UK context, its findings speak to a broader global challenge: the mismatch between dominant, Western-derived models of mental health care and the needs of culturally diverse populations. The inclusion of global evidence through the meta-analysis demonstrates that this is not an isolated national issue, but part of a wider pattern in which interventions developed and validated in Western contexts do not translate equally across populations.

In countries such as the United States, Canada, and across Europe, Black populations consistently experience poorer access to care, lower engagement with services, and worse mental health outcomes, despite comparable or greater levels of need (Burkett, 2017; Cloos & Bilsen, 2021; Fante-Coleman & Jackson-Best, 2020; Gaston et al., 2016; Harrell et al., 2011). These disparities are shaped by structural racism, mistrust of institutions, and the dominance of therapeutic models that are often culturally misaligned with the lived experiences of minoritised communities.

As such, the challenges observed within NHS services should not be understood as isolated system failures, but as part of a wider global issue in which Western mental health care models have limited cross-cultural validity. The findings of the meta-analysis reinforce this perspective, demonstrating that creative arts–based interventions show stronger effects in non-Western and Global Majority contexts, where they align more closely with culturally embedded forms of expression and healing.

This raises a critical implication: addressing mental health inequalities for Black young people in the UK requires not only local service reform, but a broader rethinking of the cultural assumptions underpinning mental health care across Western systems. This thesis therefore positions the UK not as an exception, but as a case study within a global system that requires rethinking how evidence, culture, and care intersect in mental health provision.

6.2 Summary of Key Findings

6.2.1 Global evidence for creative arts interventions (Chapter 2: Meta-analysis)

The meta-analysis synthesised evidence from 33 quantitative studies examining creative arts–based interventions, including music, dance, art, drama, and poetry, for trauma and PTSD in children and adolescents. The meta-analysis presented in Chapter 3 provides a critical evidentiary anchor for this work, demonstrating that creative arts–based interventions are associated with large reductions in PTSD and trauma-related symptoms among children and adolescents across diverse global contexts.

Importantly, the meta-analysis revealed systematic variation in effectiveness by region, with particularly strong effects observed in West African and Middle Eastern samples, and weaker or non-significant effects in predominantly Western samples. These findings suggest that cultural context is integral to how creative arts interventions function therapeutically. These findings challenge assumptions embedded in Western evidence-based practices that treatment efficacy is culturally neutral, and instead highlights the need to consider cultural, non-verbal modalities, and community-embedded practices as active mechanisms of change.

In terms of the creative arts intervention that produced the largest effect in the reduction of PTSD scores, a mixture of creative arts had the strongest effect (e.g., music, art, dance) showed the strongest effects (Hedge's g = 1.01), pointing to the usefulness of arts-based methods as a whole.

It was also shown that delivery by trained facilitators, not necessarily licensed creative arts therapists, were associated with slightly greater symptom reductions, highlighting that community-led creative arts interventions may be similarly accessible and psychologically beneficial as creative arts therapies delivered by a licensed creative arts therapist and the impact on symptoms would remain impactful.

While the meta-analysis did not include studies conducted specifically with Black British young people, it provided robust global evidence that creative arts interventions are effective for Global Majority youth who are structurally and culturally marginalised by dominant mental health systems. This finding justified the subsequent qualitative and applied chapters, which examined how such interventions are understood and enacted within UK mental health services.

6.2.2 Population-level inequalities (Chapter 3: OxWell)

To begin the UK population analysis phase of epidemiological evidence, this thesis analysed the Black and Black Mixed secondary school student results from the 2023 OxWell Student Survey. The OxWell Survey is a repeated cross-sectional survey of schools and further education colleges (FECs) in England, examining their health and wellbeing, life experiences and behavior of young people. Analyzing survey data from secondary school students that were Black and Black Mixed ethnicity, this thesis demonstrated that Black and Mixed Black adolescents in England experience clear disparities in mental health support access and perceived helpfulness of services.

Compared with their White British peers, Black adolescents were less likely to access formal mental health services, through their GP, a social worker, private counselor, or CAMHS, and relied more frequently on informal supports, like parents, carers, friends, siblings, and also through school-& community-based supports, such as school/college/nurse/other pastoral staff, EMPHs, peer mentors or charity services.

In terms of how helpful Black and Black Mixed adolescents found support, individuals cited that informal support was most helpful to these individuals, followed by school and community assistance. Again, formal support was rated not as helpful for these young people and also sought less frequently. These findings suggest that existing service models are not optimally aligned with the needs or preferences of Black young people, despite comparable or greater mental health need.

Black and Black Mixed ethnic adolescents also reported heightened barriers related to trust, confidentiality, and perceptions of care provision.

Many reported not wanting people in their life to know about them seeking mental health support due to stigma and not wanting to burden anyone with their mental health needs. Many also reported not seeking support due to long wait times and a large fear of not being taken seriously by care staff when they would seek support.

These findings show that while informal and community-based supports are valued and frequently perceived as helpful, they may also represent a compensatory pathway in contexts where formal mental health services are perceived as less helpful, less accessible, or insufficiently culturally responsive.

6.2.3 Lived experience within NHS services (Chapter 4: The BLACK-ARTS study)

The qualitative study explored how Black young people with psychiatric disorders and NHS clinicians understand and experience creative arts therapies within UK mental health services, while exploring the views on current mental health services offered by the NHS, and some of the barriers experienced in accessing and offering care.

Participants described creative arts as emotionally accessible, identity-affirming, and supportive of agency, particularly in contrast to conventional talking therapies that were often experienced as alienating or culturally misaligned. Creative arts were viewed by both clinicians and service users as modalities that naturally align with Black cultural expressions, and tools that hold deep cultural significance. Unlike traditional talking therapies that rely heavily on verbal expression, creative arts were described as providing nonverbal routes for emotional healing.

The study identified substantial structural barriers to implementation, including commissioning constraints, limited availability of creative therapies within NHS services, and broader issues of mistrust and power within clinical encounters.

When service users were asked about their care within the NHS, participants highlighted the persistent barriers within NHS mental health services, including long wait times to be seen times, being viewed as a number within the system, a lack of cultural understanding among clinicians. Clinicians echoed these barriers, often citing the need for more resources dedicated to cultural competence training to assist in building trusting relationships Black service users and also the need for more patient centered approaches to aid the understanding of their clients. Clinicians also expressed frustrations with the current "one-size-fits-all" therapy models employed by the NHS and expressed an openness in utilizing creative arts to bridge the gap between in relating and understanding these patients for greater service outcomes.

This study provides new evidence that creative arts therapies may offer a culturally relevant and emotionally accessible approach to improving mental well-being among Black young people with psychiatric disorders. By combining clinical efficacy with cultural congruence, creative arts have the potential to address persistent inequities in engagement and outcomes within NHS services. Embedding culturally competent and creative approaches into standard care pathways could represent a critical step toward more equitable, responsive, and person-centred mental health provision for Black youth.

6.2.4 Applied feasibility of creative arts in the community (Chapter 5: Spotlight pilot)

The mixed-methods pilot study examined the feasibility and acceptability of a community-based music intervention delivered outside formal clinical pathways. Findings suggested high engagement and acceptability, alongside exploratory improvements in wellbeing and reductions in distress. Additionally, these descriptive patterns were observed both in participants with self-reported mental health diagnoses (Depression, Anxiety, and PTSD) and those without any presenting symptoms or a formal diagnosis. The consistency in trajectory for the improvement of wellbeing across individuals suggests that participation in a creative arts intervention can improve both symptom-related and broader wellbeing outcomes.

Qualitative insights highlighted the importance of creative engagement for community and confidence building, and emotional regulation, while also identifying ethical and implementation considerations such as the need for independent emotional support outside of the study team and clear safeguarding structures. Young people also expressed the intensity of

the programme on the final days leading up to the final showcase, often leading to added stress associated with performing. However, participants described an overall feeling of fulfilment after participating in Spotlight and cited it's benefit for emotional regulation and identity formation, namely with building and individualized presences as an artist.

The *Spotlight* pilot study represents the most applied component of this thesis and provides critical insight into the feasibility of putting into practice creative and culturally grounded approaches. The pilot, delivered in partnership with a community-based youth arts charity, Grounded Sounds, demonstrated high engagement, retention, and acceptability among participants, suggesting that creative programmes situated outside formal clinical settings may overcome some of the access and trust barriers identified in earlier chapters.

Importantly, *Spotlight* did not aim to evaluate clinical effectiveness, but to explore how such an intervention is experienced by Black young people in real-world contexts. Exploratory quantitative findings indicated consistent improvements in wellbeing and reductions in depression, anxiety, and trauma across participants, while qualitative insights highlighted creative engagement as supportive of confidence, identity, and emotional regulation. At the same time, the study surfaced critical ethical and implementation considerations, including the need for independent emotional support, clear safeguarding structures, and careful management of power dynamics within community-based programmes and those that were participating.

6.3 Importance of Creative Arts and Culturally Competent Interventions

The findings across chapters underscore the importance of culturally competent approaches that extend beyond superficial adaptations of existing talking therapies. Creative arts–based interventions appear particularly well suited to addressing several of the barriers identified in this thesis, including mistrust of services, stigma, and difficulties with verbal emotional expression.

The findings of this thesis suggest that cultural competence should not be understood solely as clinician knowledge of cultural practices or beliefs. Rather, participants consistently described culturally competent care in relational terms: feeling understood, feeling safe to disclose experiences, having aspects of identity recognised, and engaging with forms of expression that felt meaningful within their social and cultural worlds. In this sense, cultural competence emerged less as a set of practitioner skills and more as a characteristic of relationships, services, and systems that foster trust, agency, and recognition.

Informal and community approaches have served as intermediary pathways to care, and several UK-based organisations provide illustrative examples of how culturally competent and community-grounded approaches to mental health support can be operationalised in practice. Initiatives such as Black Minds Matter UK (Black Minds Matter UK, 2019.), The Ubele Initiative (The Ubele Initiative, 2021.), and Black Thrive (Black Thrive, 2022) have developed models of care that center cultural affirmation, relational healing, and community accountability, particularly for Black communities who have historically been marginalised within mainstream mental health services.

Black Minds Matter UK (Black Minds Matter UK, 2019) facilitates access to Black therapists, explicitly recognising the role of racial congruence and shared cultural understanding in building trust and therapeutic safety. The Ubele Initiative adopts participatory and co-design methodologies, working alongside communities to shape mental health interventions that reflect lived experience rather than deficit-based assumptions (The Ubele Initiative, 2021). Black Thrive operates through a systems-change model, integrating mental health with education, employment, housing, and public health to address the structural determinants of psychological distress.

In addition to community-led models such as Black Minds Matter UK, The Ubele Initiative, and Black Thrive, recent strategic initiatives such as MYRIAD: A Global Majority Spotlight on Creative Health, illustrate how workforce development and infrastructure can be aligned with culturally grounded approaches to mental health support (MYRIAD, 2025). Commissioned by NHS Greater Manchester, MYRIAD aims to increase the diversity and range of creative health support available to global majority communities by building training, professional development, and peer networks for creative health practitioners and by articulating a Core Competency Framework for practice in mental health contexts.

MYRIAD's focus on strengthening the creative health workforce, particularly practitioners from global majority backgrounds, resonates with this thesis's emphasis on cultural competence as a systemic issue, not merely an individual clinician attribute. By identifying the skills, knowledge and abilities needed to work effectively with culturally diverse communities, MYRIAD contributes to a broader ecosystem in which creative, culturally attuned approaches can be ethically and sustainably implemented. In doing so, it exemplifies how strategic capacity building, ongoing professional development, and networked support systems may be necessary complements to programme-level interventions such as *Spotlight*, if creative health is to be meaningfully integrated into mental health care pathways.

As exemplified in this thesis and throughout community organisations like Grounded Sounds and MYRIAD, creative arts modalities foreground non-verbal, embodied, and relational forms of engagement that align with cultural practices and expressive traditions familiar to many Black young people. Importantly, their potential value lies not only in symptom reduction but also in supporting identity affirmation, agency, and emotional safety, factors that are central to sustained engagement with care. This thesis therefore positions creative arts interventions not as alternative or "adjunctive" therapies alone, but as culturally grounded approaches with the capacity to reshape how mental health support is delivered and experienced.

Collectively, these initiatives illustrate that culturally competent mental health support requires more than individual-level adaptations. They highlight the importance of ethical safeguards, including cultural safety, informed consent, transparency, and accountability to the communities served. While these models are not presented as evaluative evidence within this thesis, they demonstrate how the principles identified across the chapters, cultural congruence, trust, and safety, are already being enacted within UK community contexts, offering practical insights for future service development.

Finally, these findings suggest that creative arts–based approaches should not be positioned as supplementary or alternative therapies, but as interventions that reveal the limitations of verbally dominant, Western-derived models of care.

6.4 Strengths and Limitations

Alongside these implications, it is important to consider the methodological strengths and limitations that shape interpretation of the findings.

6.4.1 Strengths

A central strength of this thesis lies in its mixed-methods design, integrating epidemiological data, global quantitative evidence, qualitative inquiry within NHS services, and an applied community-based pilot intervention. This design enables the thesis to move beyond descriptive accounts of inequality to examine mechanisms, meanings, and practical implications across the mental health care pathway. By combining methods, the thesis provides a comprehensive account of both the problem of mental health inequity and potential avenues for response through creative arts interventions.

A second major strength is the integration of global and local evidence. The meta-analysis synthesised robust quantitative evidence demonstrating the effectiveness of creative arts–based interventions for trauma-related symptoms among children and adolescents, particularly in non-Western and Global Majority populations. Rather than treating this global evidence as directly transferable, the thesis critically situates it within the UK context through qualitative and applied research with Black British young people. This careful handling of generalisability strengthens the credibility of the thesis and avoids overextending findings across cultural contexts.

Third, the thesis is strengthened by its centering of Black young people's voices. Through qualitative focus groups and elements of the Spotlight pilot study, Black young people are positioned not merely as research subjects but as knowledge holders whose perspectives shape interpretation and intervention design. This approach addresses longstanding gaps in the literature, where Black youth are often underrepresented, aggregated into broad ethnic categories, or excluded from research altogether. By foregrounding lived experience, the thesis advances a more ethically just model of mental health research.

A further strength of this thesis lies in comprehensively analyzing epidemiological data in both Black *and* Black Mixed adolescents across all five ONS categories for Black and Black Mixed ethnic groups, something that is often foregone in modern studies for an aggregated BAME category. Instead, the OxWell study assesses all five ethnic categories to account for the nuanced differences experienced between Black and Mixed Black adolescents. This thesis deliberately varies its use of ethnic categorisation across chapters, reflecting the analytic demands of different methodologies.

While population-level survey analysis requires fine-grained ethnic disaggregation to identify structural inequalities, the qualitative, meta-analysis, and intervention chapters explore the lived experience, cultural meaning, and feasibility over statistical comparison. This approach avoids over-interpretation of small samples and recognises that identity operates differently across epidemiological, qualitative, and applied research.

Additionally, the concept that cultural competence is integral to therapeutic effectiveness, rather than as a peripheral concern. Across chapters, the thesis demonstrates that cultural relevance, trust, identity affirmation, and emotional safety are not simply engagement issues but are closely linked to outcomes. The convergence of findings from the meta-analysis, qualitative study, and pilot intervention supports the argument that culturally grounded approaches can influence both how interventions are experienced and how effective they are.

The translational focus of the thesis represents another key strength. The Spotlight pilot moves the research beyond critique and theory by testing the feasibility and acceptability of a community-based creative intervention in practice. It is important to note that the pilot does not present feasibility as unproblematic; instead, it surfaces ethical, relational, and governance challenges that must be addressed in real-world delivery.

Ethical reflexivity is also a notable strength. The thesis engages explicitly with issues of power, trust, safeguarding, and responsibility when working with Black young people in both clinical and community contexts. Rather than assuming that community-based delivery is inherently benign, the thesis critically examines how new power dynamics can emerge and how these must be managed responsibly.

Finally, this thesis makes a clear and original contribution to knowledge by bridging literatures that are often treated separately: mental health inequalities, cultural competence, creative arts therapies, and youth mental health intervention research. By positioning creative arts–based approaches as both evidence-based and culturally grounded, the thesis challenges dominant hierarchies of evidence in mental health care and opens new pathways for research, service design, and policy aimed at reducing inequities for Black young people.

6.4.2 Limitations

Several limitations should be acknowledged. The OxWell analysis relied on self-reported survey data, which may be subject to reporting bias. Also, as OxWell is a cross-sectional survey, there was with limited context as to what types of support were available in each student's school and region Sample sizes for Black and Black Mixed Ethnic adolescents were substantially smaller than those for White British adolescents, so comparisons about the groups should be analysed with caution.

The meta-analysis, while comprehensive, did not include studies conducted specifically with Black British youth, limiting the ability to draw direct conclusions about effectiveness in UK contexts. Another limitation of the meta-analysis was the heterogeneity of the studies regarding how creative arts interventions were administered. Additionally, research in the area of creative arts-based interventions is still in its infancy, so there were a limited number of studies in this meta-analysis to draw firm conclusions related to the subgroup analysis comparing creative arts effectiveness in different regions of the world. In addition, many studies lacked standardized control groups or did not specify the control conditions used

(including treatment as usual, waitlist, evidence-based psychotherapy and EMDR, among others). Furthermore, many studies did not have long-term follow-up periods, which meant that the durability of treatment benefits could not be fully ascertained.

The qualitative study, though rich in depth and appropriate for qualitative inquiry, may not be representative of all Black young people or NHS settings and the views may not represent the full diversity of Black young people's experiences across the UK limiting generalizability. Finally, the small sample size of the pilot study and the lack of comparison group made it exploratory, and therefore, limiting generalisability. Qualitative findings in the pilot include a small number of participants and are therefore illustrative rather than representative. Also, self-reported measures used in the data collection time points may be subject to response bias.
However, these limitations should not be viewed as substantial weaknesses of the thesis, but rather as reflections of the structural challenges inherent in researching underserved populations and emerging intervention models.

A further consideration concerns the heterogeneity of the populations discussed throughout the thesis. The term "Black young people" addresses the intersection of racialisation and age. The thesis focused specifically on Black young people, recognising that experiences of mental health support during adolescence and emerging adulthood differ from those of older Black adults.

Findings from the OxWell chapter demonstrated that Black and Black Mixed adolescents relied more heavily on informal and school-based support, suggesting that developmental stage shapes how racialised experiences of mental health care are navigated. However, it also encompasses highly diverse cultural, ethnic, and social experiences. Similarly, the reflexive account presented in the prologue further highlighted how race intersected with gender and institutional position. My experiences as a Black woman researcher within predominantly White academic and NHS institutions shaped both how the research was received and how relationships with participants developed. These experiences reinforced the importance of considering how authority, expertise, and legitimacy are experienced differently across intersecting social locations.

In addressing an under researched area, the present studies in this thesis did not foreground intersectional differences. No single study can fully encompass the complexity of all possible intersections shaping mental health experiences. Rather than attempting a comprehensive intersectional analysis, this thesis used intersectionality as a conceptual lens to consider how race interacted with other dimensions of identity and social position across the findings.

Future research could usefully explore intersections that were beyond the scope of the present thesis. In particular, there remains limited understanding of how gender, socioeconomic position, migration history, religion, disability, and neurodiversity interact with race to shape mental health experiences among Black young people in the UK. Similarly, larger-scale studies may be able to explore differences between Black African, Black Caribbean, mixed Black, and other diasporic groups while simultaneously considering gender and socioeconomic inequalities. Such work would contribute to a more nuanced understanding of mental health inequities and inform the development of more responsive and culturally grounded interventions.

6.5 Beyond Services: Structural Determinants of Mental Health

While much of this thesis focuses on experiences within mental health services and the potential role of creative arts interventions, the findings also point toward the importance of understanding mental health inequalities through a broader social determinants perspective. Across chapters, participants' experiences could not be fully explained through clinical encounters alone. Patterns of mistrust, disengagement, stigma, and unequal access occurred within wider social contexts shaped by structural racism, educational inequalities, socioeconomic disadvantage, and differential access to resources and opportunities.

The social determinants framework proposed by Dahlgren and Whitehead (1991) provides a useful lens through which to interpret these findings. From this perspective, mental health outcomes are influenced by multiple interacting layers of social, economic, environmental, and political conditions rather than individual characteristics alone. The findings of the present thesis suggest that many of the challenges experienced by Black young people emerge not solely from the organisation of mental health services, but from broader structural conditions that shape mental health long before young people encounter formal systems of care.

This interpretation is consistent with the work of Nazroo, Bhui and Rhodes (2020), who argue that racial inequalities in mental health arise through the interaction of structural, institutional, and interpersonal forms of racism. The OxWell findings demonstrated inequalities in help-seeking and trust in services, while the **BLACK-ARTS** study highlighted experiences of being misunderstood, dismissed, or disconnected from care. Although these experiences were often described at the level of individual interactions, they can also be understood as manifestations of wider social structures that shape access to resources, exposure to adversity, and relationships with institutions.

An intersectional perspective further suggests that these structural influences are not experienced uniformly. The experiences of Black young people are shaped by the interaction of race with age, gender, socioeconomic position, migration history, and other dimensions of identity and social location. Throughout this thesis, inequalities in mental health care emerged not as isolated outcomes of racial identity alone, but as experiences situated within broader social contexts that influence how young people navigate support systems and understand their own mental health.

Creative arts interventions should therefore not be viewed as solutions to structural inequalities in themselves. Rather, they represent one potential component of a broader response to mental health inequities. Their value may lie in creating culturally meaningful, relationally safe, and emotionally accessible forms of support that help mitigate some of the consequences of wider structural disadvantage. However, improving mental health outcomes for Black young people ultimately requires action beyond mental health services alone, including attention to education, employment, housing, community resources, and the broader social conditions that shape wellbeing across the life course.

From this perspective, the contribution of creative arts interventions is not simply therapeutic. They may also function as community-level resources that strengthen connection, belonging, identity, and resilience within contexts where wider structural inequalities continue to influence mental health outcomes.

6.6 Clinical, Service, and Policy Implications

Clinically, these findings demonstrate that reliance on conventional talking therapies alone is insufficient to address the mental health needs of many Black young people. The findings of this thesis demonstrate that current mental health systems are not failing Black young people solely due to access or availability, but due to a fundamental misalignment between dominant therapeutic models and culturally grounded ways of understanding and responding to their distress.

The global evidence presented in the meta-analysis demonstrates that creative arts–based interventions are not simply culturally appealing alternatives, but clinically effective approaches in contexts where cultural alignment is present. When considered alongside the UK findings in Chapter 3 and 4, this leads to a critical implication: the underperformance of conventional services for Black young people should not be understood as a problem of

engagement or compliance, but as a predictable outcome of systems built on culturally narrow assumptions of care.

Addressing this requires more than adapting existing therapies; it requires a reconfiguration of mental health systems to incorporate culturally grounded modalities as central, rather than peripheral, components of care. Creative arts interventions, particularly when delivered through community-based and co-produced models, offer a viable pathway toward this shift. However, their integration must be accompanied by structural change, including commissioning reform, workforce diversification, and the development of ethical frameworks that address power, trust, and accountability across both clinical and community settings.

The population level results from the OxWell student survey suggest that informal and school-based mental health support are often relied on as helpful support options by Black young people; however more resources are divided into formal mental health support options through GP services, or the NHS like talking therapies and CAMHS. There is a clear and urgent need to strengthen informal, school, and community service options as legitimate points of care, rather than positioning them as precursors to formal services. This finding is mirrored in both the qualitative study and pilot intervention where Black young people responded positively to creative arts therapies and interventions being integrated in both existing care pathways, particularly within CAMHS, and NHS Talking Therapies but also in community-based settings like creative arts charities. By expanding therapeutic choices and delivery settings, creative arts should be positioned as culturally congruent modalities that align with the lived experiences of Black young people and function as both clinically and socially responsive interventions.

The meta-analysis findings have significant implications for clinical practice and service design. First, they provide quantitative evidence that creative arts–based interventions can produce clinically meaningful improvements in trauma-related symptoms, placing them within the category of interventions that warrant serious consideration alongside established treatments such as CBT and EMDR.

Additionally, the finding that effectiveness varies by cultural and regional context has direct relevance for UK mental health services. It suggests that poor outcomes for Black young people in conventional services may not reflect treatment resistance or disengagement, but rather a mismatch between traditional therapeutic models and culturally congruent modes of healing. From this perspective, the underperformance of Western services for Black youth is not an anomaly, but a predictable outcome of culturally narrow evidence hierarchies and creative arts could be an effective bridge in culturally resonant care.

At a policy level, these findings support the need to broaden definitions of evidence-based practice to include interventions demonstrating effectiveness in non-Western and Global Majority contexts. Policy frameworks that rely exclusively on Western-dominated RCT evidence risk perpetuating inequalities by excluding interventions that are effective for marginalised populations. The meta-analysis therefore provides a strong empirical basis for investing in creative arts–based approaches as part of a more equitable mental health system.

At the service level, improving cultural competence requires organisational change, not only individual clinician awareness. This includes commissioning decisions, workforce diversification, training that addresses power and racism, and the creation of psychologically safe spaces for Black service users. Community-based partnerships, as illustrated by the *Spotlight* pilot, may offer viable pathways for extending support beyond formal NHS settings.

Findings from the *Spotlight* pilot underscore the critical role of community-based creative interventions as complements to formal mental health services, particularly for Black young people who experience NHS pathways as inaccessible or unsafe. The feasibility and acceptability of the programme suggest that partnerships with trusted community organisations may provide an important intermediary layer of mental health support, offering engagement points and early intervention outside clinical settings.

However, *Spotlight* also illustrates that community-based delivery does not eliminate ethical or psychological risk but instead introduces new forms of responsibility. Participants' reflections on the absence of independent support highlight the importance of safeguarding and accountability even in non-clinical contexts. These finding challenge assumptions that community delivery is inherently safer or less hierarchical, and emphasises the need for robust governance structures, access to psychological expertise, and clearly defined support pathways for accessing care.

At a service level, *Spotlight* suggests that creative arts interventions should not be viewed as adjunct activities, but as psychologically meaningful programmes that require appropriate resourcing. For NHS services, this points to the potential value of commissioning or co-producing creative programmes in partnership with community organisations, while maintaining clear responsibilities for risk management and continuity of care.

From a policy perspective, the thesis supports calls for investment in culturally responsive and preventative mental health approaches, particularly for young people from minoritised backgrounds who are overrepresented in crisis care but underrepresented in early intervention services. However, achieving this requires structural changes to how the NHS system works,

including training that addresses power, privilege, and institutional racism, alongside workforce diversification and sustained investment in culturally grounded interventions.

Recruitment of creative arts therapists from diverse backgrounds in both formal and community settings that incorporate these cultural competence standards is essential in to integrating these services into viable settings establishing trust and safety within Black adolescents. Finally, patient-centred perspectives from Black young people are key in creating meaningful change within established mental health services reflect the need and wants of this population; therefore, meaningful co-production with Black communities to ensure that services reflect the voices and needs of those they intend to serve are crucial in creating actionable change.

These findings demonstrate that achieving equity in mental health care requires not only improving access to services but fundamentally rethinking the models of care on which those services are based.

6.7 Recommendations for Future Research

The findings of this thesis point to several important directions for future research. First, there is a clear need for UK-based evaluative studies of creative arts–based interventions involving Black British young people. While the meta-analysis demonstrated robust effects of creative arts interventions for trauma-related symptoms among Global Majority youth in non-Western contexts, there remains a lack of high-quality trials conducted within UK mental health systems. Future research should prioritise well-powered mixed-methods trials that examine both outcomes and mechanisms of change, with particular attention to how cultural congruence, non-verbal expression, and trust contribute to therapeutic impact. Such studies should avoid treating creative arts therapies as uniform interventions and instead explore how modality, setting, facilitation style, and participant involvement interact to shape outcomes.

Second, future research should place greater emphasis on implementation rather than focusing solely on efficacy. The NHS qualitative study and the Spotlight pilot both highlight that even when creative approaches are valued by service users and clinicians, their delivery is constrained by lack of resources and workforce capacity. A focus on implementation research could be used to examine how creative arts interventions can be integrated sustainably within NHS pathways or delivered through hybrid models that link community organisations with formal services.

Third, future work should continue to center the voices of Black young people in intervention design and evaluation. Across this thesis, young people consistently articulated the importance of agency, identity affirmation, and cultural safety in mental health support. Co-production should therefore be embedded not as an add-on, but as a core methodological principle in future research and service development. Participatory and community-led approaches can help ensure that creative interventions are responsive to lived experience and avoid reproducing the exclusions and power imbalances identified in traditional mental health systems.

Fourth, there is scope for future research to explore creative arts–based interventions for overall wellbeing, not just for those with symptoms or diagnoses, Findings from both the meta-analysis and the *Spotlight* pilot suggest that creative approaches may benefit young people with and without formal diagnoses, indicating potential value as preventive and early intervention services or wellbeing-focused interventions.

Fifth, future directions should include workforce development, namely for practitioners from Global Majority backgrounds. Initiatives such as MYRIAD highlight the importance of training and cultural competency frameworks in enabling culturally competent creative health practice. Research is needed to evaluate how such workforce initiatives influence service quality in minoritised communities, and how they can be scaled across regions.

Finally, future policy-oriented research should examine how definitions of evidence-based practice might be broadened to better account for cultural context and non-Western evidence. The findings of this thesis challenge the assumption that effectiveness demonstrated primarily in White Western populations can be universally generalised. Developing more inclusive evidence that recognises global and culturally grounded research will be essential for reducing inequalities in mental health care and ensuring that effective interventions are not excluded from policy decisions based on narrow evidence.

6.8 From Evidence to Scale: Next Steps and Future Directions

This thesis does not conclude with the identification of culturally grounded approaches to mental health care for Black young people but instead provides the empirical foundation for a larger-scale RCT exploring these implications on a national level. Building directly on the findings presented across chapters, I would like to conduct a national study that involves multi-site creative arts interventions (BLACK-ARTS+), designed to test the effectiveness, scalability, and mechanisms of change of creative arts therapies for Black young people across England.

At present, I'm applying for funding through the Wellcome Accelerator and National Lottery Reaching Communities fund with the hope of beginning this research in the autumn of 2026.

This programme represents a critical progression from pilot feasibility to a national system-level intervention. In its current plan, the study will be delivered across multiple cities including London, Birmingham, Manchester, Oxford, and Bristol. The BLACK-ARTS + study will engage 400 young people in in community-based creative programmes co-designed with local community organisations and with participants. Crucially, this next phase moves beyond psychosocial outcomes alone by incorporating neurobiological measurement through fMRI scanning to examine how creative engagement influences brain-based processes associated with emotion regulation, trauma processing, and resilience. This next phases of this research will further ground the efficacy of creative arts-based interventions in underrepresented groups and offer new solutions for rehabilitation in these populations.

The integration of neurobiological data represents a significant advancement in the field, enabling a deeper understanding of the mechanisms through which creative arts interventions not only change psychosocial symptoms, but neurological changes as well. While existing evidence demonstrates improvements in wellbeing and symptom reduction, the addition of neural data will allow this work to move beyond outcome-based evaluation toward identifying how and why these interventions work, providing a critical and necessary bridge between culture, psychological change, and brain function.

More broadly, this next phase positions creative arts therapies not as alternative or niche approaches, but as scalable, evidence-generating interventions capable of reshaping mental health systems. This progression marks a shift from questioning whether creative arts–based approaches are effective, to demonstrating how they can be implemented at scale, and embedded within systems as core components of equitable mental health care.

6.9 Final Conclusions

This thesis demonstrates that mental health inequalities experienced by Black young people are not simply a reflection of unmet need, but of a deeper structural and cultural misalignment between mental health systems and the populations they are intended to serve. Across chapters, the findings show that Black young people are not disengaged from support but are actively navigating systems that often fail to recognise, reflect, or respond to their lived experiences.

By integrating global quantitative evidence, population-level analysis, qualitative insight, and applied intervention, this thesis provides a multi-level account of how these inequalities

are produced and how they can be addressed. The meta-analysis establishes that creative arts–based interventions produce substantial clinical benefits, particularly in non-Western and Global Majority contexts. The qualitative findings demonstrate that these approaches resonate with Black young people not only because of their cultural relevance, but because they transform how care is experienced, and also reshape power dynmaics, communication, and engagement within therapeutic settings. The *Spotlight* pilot shows that such approaches can be implemented in practice, but that their success depends on the presence of appropriate ethical, relational, and structural supports.

These findings indicate that improving mental health outcomes for Black young people requires moving beyond adaptation of existing models toward a more fundamental rethinking of what constitutes effective and equitable care. This is not solely a UK challenge but reflects a broader global limitation in the cultural validity of Western mental health models when applied across diverse populations. The findings of this thesis therefore contribute to a growing body of evidence calling for more inclusive, culturally grounded, and contextually responsive approaches to mental health care.

The question is no longer whether creative arts–based interventions can work, but how mental health systems can be designed to support their sustainable implementation. The next phase of this work must move beyond demonstrating effectiveness toward building the infrastructures and policy frameworks required to embed creative arts interventions at scale. In doing so, there is an opportunity not only to reduce inequalities for Black young people in the UK, but to contribute to a broader reimagining of mental health care that is responsive to cultural diversity at a global level

This work is also grounded in a personal understanding of the role that creative expression can play in navigating trauma and emotional distress. Early experiences of witnessing the impact of PTSD within my own family, and the ways in which music provided a non-verbal space for emotional processing, shaped both the direction and the urgency of this research.

These experiences were later reinforced through academic and clinical work across diverse contexts, including research with refugee populations and therapeutic engagement within inpatient settings, where creative approaches consistently emerged as accessible and meaningful forms of support.

While this thesis is positioned within an academic and empirical framework, it is also informed by the recognition that the mechanisms explored throughout this work are not abstract, but reflect real-world experiences of coping, expression, and healing across cultural contexts. These experiences underscore a central argument of this thesis: creative expression

is not merely an adjunct to mental health care, but a fundamental and culturally embedded pathway through which individuals across contexts make sense of trauma, restore agency, and heal.

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Appendix

Supplementary Materials – Meta-analysis Chapter 2

Table 2: Quality assessment of studies included in the meta-analysis (n = 33) using the Joanna Briggs Institute Checklists for Randomized Controlled Trials, Quasi-Experimental Studies, and Cross-Sectional Studies. *Each row represents an individual study. "Y" indicates Yes, "N" indicates No, and "U" indicates Unclear. No statistical tests were applied; quality appraisal was conducted once per study according to the checklist criteria.*

Experimental Studies

Checklist for Randomized Controlled Trials

Reference	Q1: Was true randomization used for assignment of participants to treatment groups?	Q2: Was allocation to treatment groups concealed?	Q3: Were treatment groups similar at the baseline?	Q4: Were participants blind to treatment assignment?	Q5: Were those delivering treatment blind to treatment assignment?	Q6: Were treatment groups treated identically other than the intervention of interest?	Q7: Were outcomes assessors blind to treatment assignment?	Q8: Were outcomes measured in the same way for treatment groups?	Q9: Were outcomes measured in a reliable way?	Q10: Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	Q11: Were participants analyzed in the groups to which they were randomized?	Q12. Was appropriate statistical analysis used?	Q13: Was the trial design appropriate, and any deviations from the standard RCT design (individual randomisation, parallel groups) accounted for in the conduct and analysis of the trial?	Overall Quality (%)	Overall Appraisal:
Anichebe et al. 2024, Nigeria	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	84.60%	INCLUDED
Colegrove et al. 2018	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	84.60%	INCLUDED
Culver et al.2015	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	92.30%	INCLUDED
Decosimo et al. 2019	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	84.60%	INCLUDED
Ezeh et al. 2023	Y	Y	Y	N	N	Y	U	Y	Y	Y	Y	Y	Y	84.60%	INCLUDED
Gordon et al. 2008	Y	Y	Y	N	Y	Y	U	Y	Y	Y	Y	Y	Y	92.30%	INCLUDED
Iyendo et al. 2024	Y	Y	Y	N	N	Y	U	Y	Y	Y	Y	Y	Y	84.60%	INCLUDED
Kalthom et al. 2023	Y	Y	Y	N	U	Y	U	Y	Y	Y	Y	Y	Y	92.30%	INCLUDED
Lyshak-Stelzer et al. (2007)	Y	Y	Y	N	N	Y	U	Y	Y	Y	Y	Y	Y	84.60%	INCLUDED
O'Callaghan et al. (2014)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	92.30%	INCLUDED
Tol et al. 2008	Y	Y	Y	N	U	Y	N	Y	Y	Y	Y	Y	Y	84.60%	INCLUDED
Zhang et al. 2023	Y	Y	Y	N	U	Y	U	Y	Y	Y	Y	Y	Y	92.30%	INCLUDED

Checklist for Cross Sectional Studies

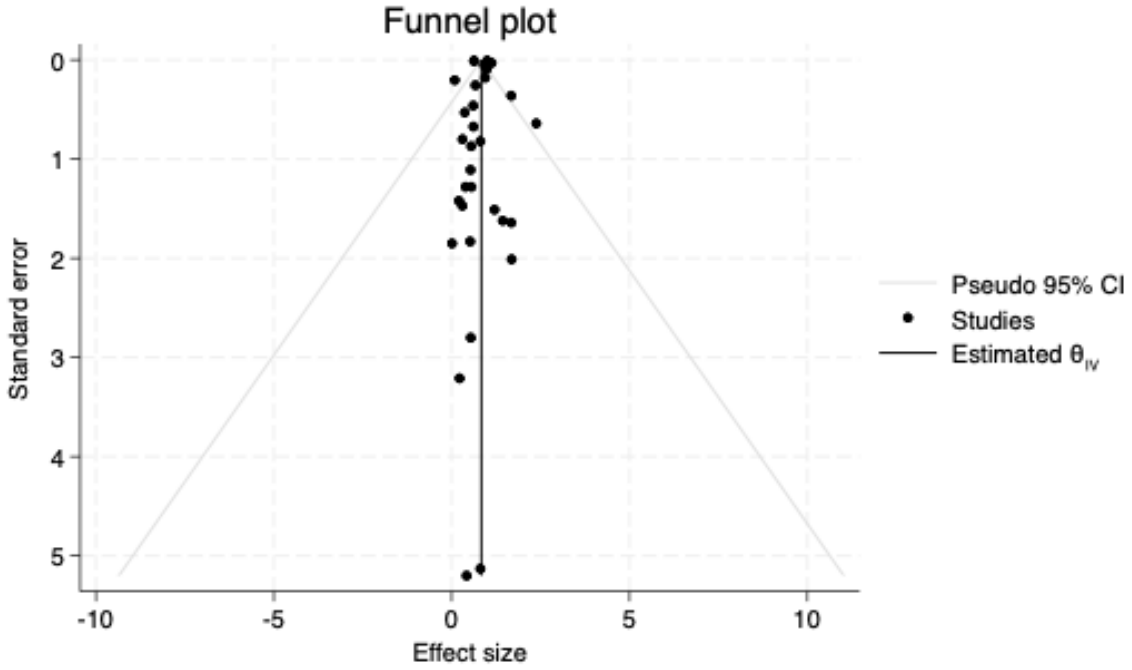
Reference	Q1: Were the criteria for inclusion in the sample clearly defined?	Q2:Were the study subjects and the setting described in detail?	Q3: Was the exposure measured in a valid and reliable way?	Q4: Were objective, standard criteria used for measurement of the condition?	Q5: Were confounding factors identified?	Q6: Were strategies to deal with confounding factors stated?	Q7: Were the outcomes measured in a valid and reliable way?	Q8: Was appropriate statistical analysis used?	Overall Quality (%)	Overall appraisal
Feen-Calligan et al. 2020	Y	Y	Y	Y	N	U	Y	Y	87.50%	INCLUDED

Checklist for Quasi Experimental Studies

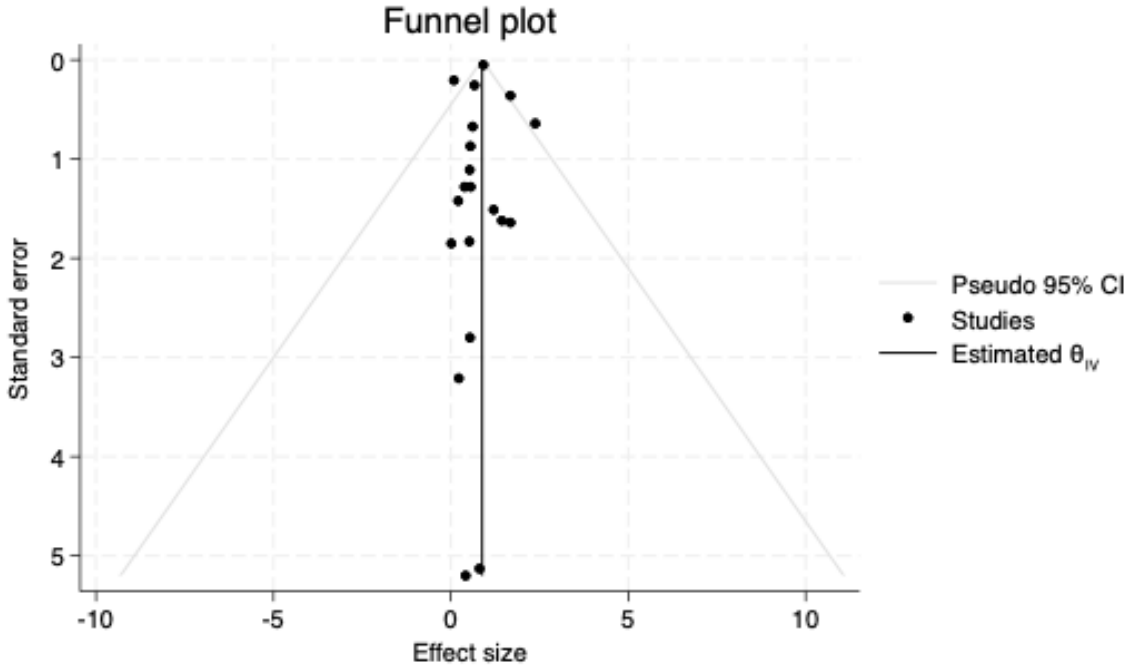
Reference	Q1:Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	Q2: Were the participants included in any comparisons similar?	Q3: Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	Q4: Was there a control group?	Q5: Were there multiple measurements of the outcome both pre and post the intervention/exposure?	Q6: Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	Q7: Were the outcomes of participants included in any comparisons measured in the same way?	Q8: Were outcomes measured in a reliable way?	Q9: Was appropriate statistical analysis used?	Overall Quality (%)	Overall Apraisal:
Anazor et al. 2023	Y	Y	Y	Y	U	Y	Y	Y	Y	100%	INCLUDED
Bleile et al. 2024	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	INCLUDED
Brillantes-Evangelista et al. 2013	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	INCLUDED
Burruss et al. 2021	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Dauber et al. 2015	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Ewulu et al. 2024	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	INCLUDED
Grasser et al. 2019	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Hylton et al. 2019	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Momartin et al. 2019	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Moosa et al. 2017	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Pifalo, 2002	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Pilao 2006	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Pretorius & Pfeifer, 2017	Y	Y	Y	Y	Y	U	Y	Y	Y	100%	INCLUDED
Quinlan et al. 2016	Y	Y	Y	Y	Y	N	Y	Y	Y	88.89%	INCLUDED
Staples et al 2011	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
Thabet et al. 2005	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	INCLUDED
Truppi, 2001	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	INCLUDED
Ugurlu et al. 2016	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED
van Westrhenen et al. 2019	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%	INCLUDED
Woollett et al. 2020	Y	Y	Y	N	Y	Y	Y	Y	Y	88.89%	INCLUDED

Reference Category	Comparison Group	Coefficient (β)	Std. Error	95% CI	p-value
Art	Dance	0.029	0.44	[-0.834, 0.892]	0.947
	Drama	0.199	0.411	[-0.606, 1.004]	0.628
	Music	-0.012	0.148	[-0.301, 0.278]	0.936
	Poetry	-0.141	0.216	[-0.565, 0.282]	0.513
Music	Art	0.012	0.148	[-0.278, 0.301]	0.936
	Dance	0.24	0.217	[-0.186, 0.665]	0.269
	Drama	0.211	0.411	[-0.595, 1.017]	0.608
	Poetry	-0.13	0.218	[-0.556, 0.297]	0.552
Dance	Art	-0.029	0.44	[-0.892, 0.834]	0.947
	Drama	-0.029	0.44	[-0.892, 0.834]	0.947
	Music	-0.24	0.217	[-0.665, 0.186]	0.269
	Poetry	-0.369	0.268	[-0.895, 0.156]	0.168
Poetry	Art	0.141	0.216	[-0.282, 0.565]	0.513
	Dance	0.369	0.268	[-0.156, 0.895]	0.168
	Drama	0.34	0.44	[-0.523, 1.204]	0.44
	Music	0.13	0.218	[-0.296, 0.556]	0.552
Drama	Art	-0.199	0.411	[-1.004, 0.606]	0.628
	Dance	-0.24	0.217	[-0.665, 0.186]	0.269
	Music	-0.211	0.411	[-1.017, 0.595]	0.608
	Poetry	-0.34	0.44	[-1.204, 0.523]	0.44

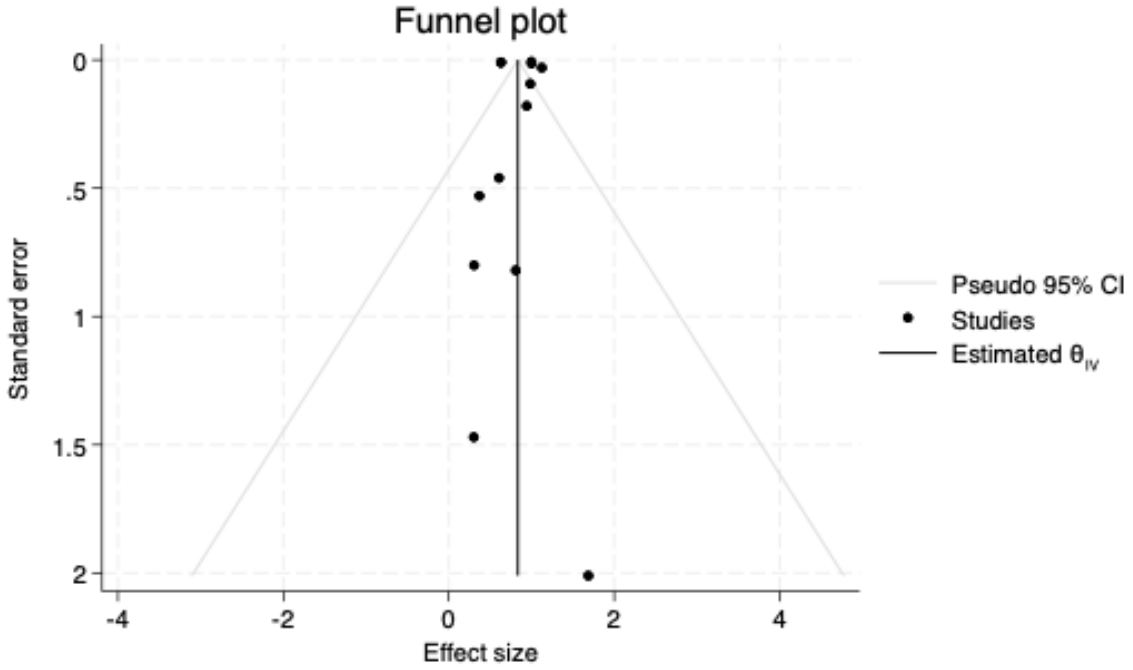
Table 3: Meta-regression analysis of within-study differences by intervention type (n = 6 studies). This analysis compares which creative arts intervention had the strongest effect for studies that included multiple creative arts interventions. Reported values are Hedge's g coefficients with corresponding standard errors (SE), 95% confidence intervals (CI), and p-values. Qb refers to the test of between-group heterogeneity.



Supplementary Figure 1: Funnel plot of effect sizes from the pre-post meta-analysis (n = 33 studies). The funnel plot is symmetrical around the 0 indicating no evidence of small study effects (z = –0.31, p = 0.756). (Each dot represents an individual study effect size plotted against its standard error. The vertical line indicates the pooled effect size from the random-effects model, and the grey triangle represents the pseudo 95% confidence limits.



Supplementary Figure 2: Funnel plot of effect sizes from the pre-post meta-analysis (n = 20 studies). The funnel plot is symmetrical around the 0 indicating no evidence of small study effects (z = –0.31, p = 0.756). (z = –0.05, p = 0.9566). Each dot represents an individual study effect size plotted against its standard error. The vertical line indicates the pooled effect size from the random-effects model, and the grey triangle represents the pseudo 95% confidence limits.



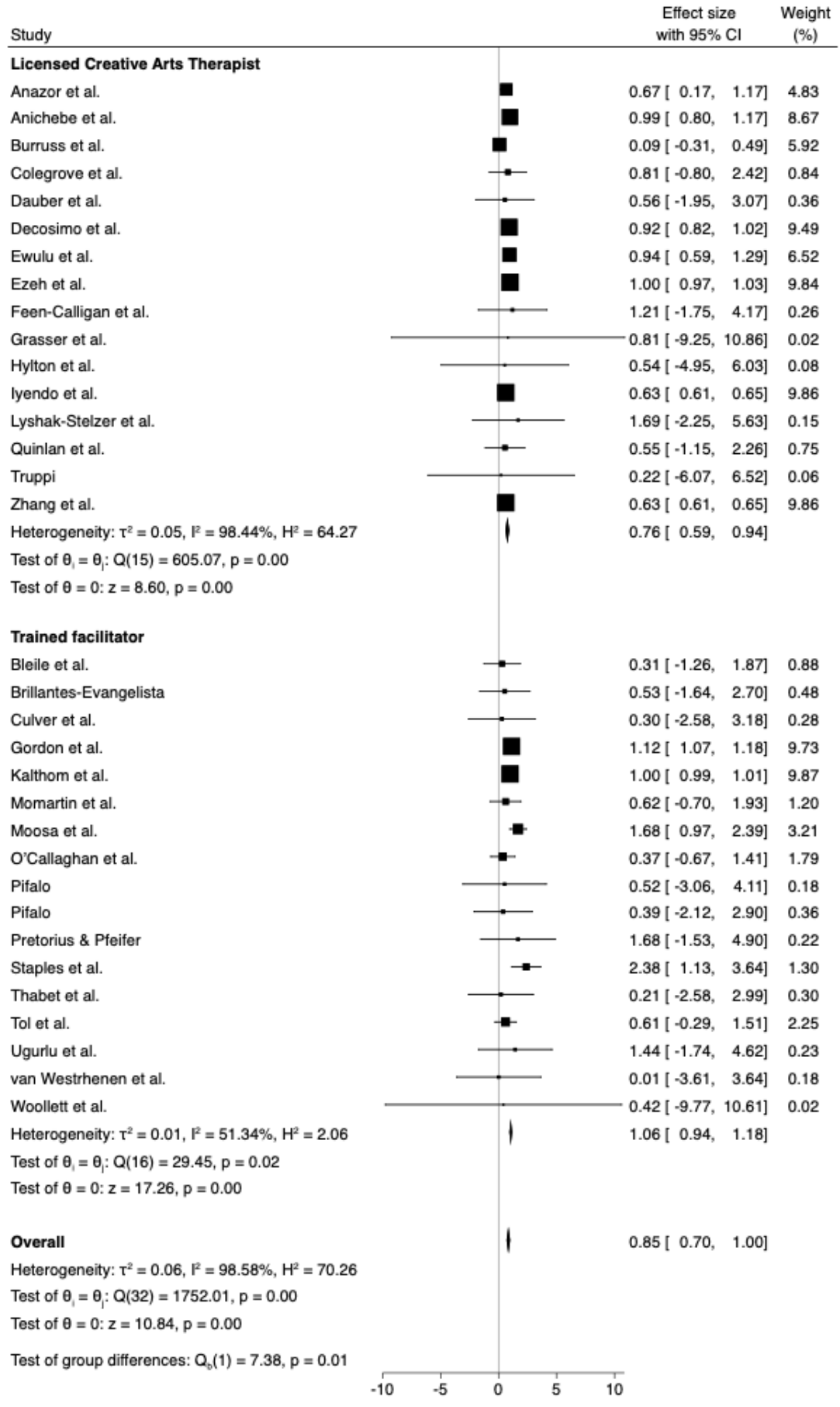
Supplementary Figure 3 Funnel plot of effect sizes from the pre-post meta-analysis (n = 13 studies). The funnel plot is symmetrical around the 0 indicating no evidence of small study effects (z = –0.67, p = 0.5052).Each dot represents an individual study effect size plotted against its standard error. The vertical line indicates the pooled effect size from the random-effects model, and the grey triangle represents the pseudo 95% confidence limits.

Effectiveness of Interventions by Therapist Qualification

To examine whether the effectiveness of creative arts-based interventions differed based on the qualifications of the interventionist, we conducted an uncontrolled, pre-post comparison subgroup analysis in 32 studies comparing interventions delivered by licensed creative arts therapists and those delivered by trained facilitators (one study was excluded as it contained a mixture of licensed creative therapists and trained facilitators (Dauber et al., 2015)(Dauber et al., 2015)(Dauber et al., 2015). Licensed creative arts therapists typically possess graduate-level training and professional certification, while trained facilitators undergo more focused, intervention-specific training.

Both groups demonstrated significant reductions in PTSD symptoms from pre- to post-intervention. Interventions delivered by licensed creative arts therapists (Anazor et al., 2023;

Anichebe et al., 2024; Burruss et al., 2021; Colegrove et al., 2018; Dauber et al., 2015; Decosimo et al., 2019; Ewulu et al., 2024; Ezeh et al., 2023; Feen-Calligan et al., 2020; Grasser et al., 2019; Hylton et al., 2019; Iyendo et al., 2024; Lyshak-Stelzer et al., 2007; Quinlan et al., 2016; Truppi, 2001; Zhang et al., 2023) (n = 2,307, Hedge's g = 0.76, $p < 0.001$, 95% CI [0.59, 0.94]) and those delivered by trained facilitators (Bleile et al., 2025; Brillantes-Evangelista, 2013; Culver et al., 2015; Gordon et al., 2008; Kalthom et al., 2025; Mom et al., 2019; Moosa et al., 2017; O'Callaghan et al., 2014; Pifalo, 2002, 2006; Pretorius & Pfeifer, 2010; Staples et al., 2011; Thabet et al., 2005; Tol et al., 2008; Ugurlu et al., 2016; Van Westrhenen et al., 2019; Woollett et al., 2020) (n = 1,678, Hedge's g = 1.06, $p < 0.001$, 95% CI [0.94, 1.18]) were both effective in reducing PTSD symptoms. However, the pooled effect size was significantly larger for interventions delivered by trained facilitators compared to licensed creative arts therapists Qb = 7.28, $p = 0.01$), suggesting that trained facilitators may deliver creative arts-based interventions with comparable or even greater efficacy.


Study
Effect size with 95% CI
Weight (%)
Licensed Creative Arts Therapist
Anazor et al. 0.67 [0.17, 1.17] 4.83
Anichebe et al. 0.99 [0.80, 1.17] 8.67
Burruss et al. 0.09 [-0.31, 0.49] 5.92
Colegrove et al. 0.81 [-0.80, 2.42] 0.84
Dauber et al. 0.56 [-1.95, 3.07] 0.36
Decosimo et al. 0.92 [0.82, 1.02] 9.49
Ewulu et al. 0.94 [0.59, 1.29] 6.52
Ezeh et al. 1.00 [0.97, 1.03] 9.84
Feen-Calligan et al. 1.21 [-1.75, 4.17] 0.26
Grasser et al. 0.81 [-9.25, 10.86] 0.02
Hylton et al. 0.54 [-4.95, 6.03] 0.08
Iyendo et al. 0.63 [0.61, 0.65] 9.86
Lyshak-Stelzer et al. 1.69 [-2.25, 5.63] 0.15
Quinlan et al. 0.55 [-1.15, 2.26] 0.75
Truppi 0.22 [-6.07, 6.52] 0.06
Zhang et al. 0.63 [0.61, 0.65] 9.86
Heterogeneity: τ² = 0.05, I² = 98.44%, H² = 64.27 0.76 [0.59, 0.94]
Test of θi = θj: Q(15) = 605.07, p = 0.00
Test of θ = 0: z = 8.60, p = 0.00
Trained facilitator
Bleile et al. 0.31 [-1.26, 1.87] 0.88
Brillantes-Evangelista 0.53 [-1.64, 2.70] 0.48
Culver et al. 0.30 [-2.58, 3.18] 0.28
Gordon et al. 1.12 [1.07, 1.18] 9.73
Kalthom et al. 1.00 [0.99, 1.01] 9.87
Momartin et al. 0.62 [-0.70, 1.93] 1.20
Moosa et al. 1.68 [0.97, 2.39] 3.21
O'Callaghan et al. 0.37 [-0.67, 1.41] 1.79
Pifalo 0.52 [-3.06, 4.11] 0.18
Pifalo 0.39 [-2.12, 2.90] 0.36
Pretorius & Pfeifer 1.68 [-1.53, 4.90] 0.22
Staples et al. 2.38 [1.13, 3.64] 1.30
Thabet et al. 0.21 [-2.58, 2.99] 0.30
Tol et al. 0.61 [-0.29, 1.51] 2.25
Ugurlu et al. 1.44 [-1.74, 4.62] 0.23
van Westrhenen et al. 0.01 [-3.61, 3.64] 0.18
Woollett et al. 0.42 [-9.77, 10.61] 0.02
Heterogeneity: τ² = 0.01, I² = 51.34%, H² = 2.06 1.06 [0.94, 1.18]
Test of θi = θj: Q(16) = 29.45, p = 0.02
Test of θ = 0: z = 17.26, p = 0.00
Overall 0.85 [0.70, 1.00]
Heterogeneity: τ² = 0.06, I² = 98.58%, H² = 70.26
Test of θi = θj: Q(32) = 1752.01, p = 0.00
Test of θ = 0: z = 10.84, p = 0.00
Test of group differences: Qb(1) = 7.38, p = 0.01
-10
-5
0
5
10
Random-effects REML model

Supplementary Figure 4: Forest plot showing the uncontrolled pre–post effects of creative arts-based interventions on post-traumatic stress disorder (PTSD) symptoms, stratified by therapist qualification. Each square represents the effect size (Hedge's g) of an individual study, with square size proportional to its weight in the random-effects model. Horizontal lines denote 95% confidence intervals (CI), and diamonds represent pooled effect estimates for each subgroup and overall. n = 3,985 participants. Weights are from random-effects restricted maximum likelihood (REML) models. Between-group heterogeneity was significant (Q_b(1) = 7.38, p = 0.01).

Supplementary Materials - OxWell Chapter 3

Table A1. Ethnicity classification used in analyses by the ethnicity 6 and ethnicity 3 variable.

Analytic variable	OxWell variable	OxWell question wording	Coding / classification
Ethnicity 6category)	X1040	*What is your ethnic group?*	Classified using ONS ethnicity categories. Responses grouped into: White British; Black African; Black Caribbean; Black Other; Mixed White–Black African; Mixed White–Black Caribbean.
Ethnicity (3category)	X1040	*What is your ethnic group?*	Categories collapsed into: White British; Black; Black Mixed.

Note: Ethnicity classifications followed ONS guidance.

Table A2. Mental health support access domains (RQ1 & RQ2)

OxWell question wording:

"In the last 12 months, have you tried to ask for support for a mental health problem from the following friends or family / school services / NHS, online and/or other services? (Tick all that apply)/ Regarding this support was it helpful?"6/9/2026 6:54:00 PM6/9/2026 6:54:00 PM

Support domain	OxWell variables	Included response options
Informal support	X2190–X2195	Parent/carer; siblings; other family members; in-person friends; online friends; trusted adults outside school
School & community-based support	X2200–X2204	School mental health staff; education mental health practitioners (EMHP); mentors; other school staff; community or charity organisations
Formal support	X2210–X2213	GP; social worker; CAMHS; private counsellor or therapist
Phone&online support	X2215–X2217	Telephone helplines; mental health websites; anonymous online services

Table A3. Preferred future mental health support (RQ3)

OxWell question wording:

"Is there any support you would have liked to have accessed, or people you wish you could have talked to? (Tick all that apply)"

Support domain	OxWell variables	Included response options
Informal support	X2220a–X2220e, X2220n	Parent/carer; siblings; other family members; in-person friends; online friends; trusted adults outside school
School & community-based support	X2220h–X2220j, X2220i, X2220m	School mental health staff; education mental health practitioners (EMHP); mentors; community or charity organisations
Formal support	X2220f–X2220l	GP; social worker; CAMHS; private counsellor or therapist
Phone & online support	X22200–X2220q	Telephone helplines; mental health websites; anonymous online services

Table A4. Perceived barriers to accessing mental health support (RQ4)

OxWell question wording:

"Is there anything that prevented you from accessing support? (Tick all that apply)"

Barrier domain	OxWell variables	Included response options
Wider networks	X2230f–X2230h	Not wanting parents to know; concerns about peers; concerns about school staff
Responses to disclosure	X2230c, X2230m, X2230n	Feeling unsafe; stigma; fear of negative reactions
Perceptions of care provision	X2230b, X2230d, X2230e, X2230l	Did not like previous help; support not taken seriously; involvement of strangers; not wanting to burden others
Practical & logistical concerns	X2230a, X2230i, X2230j, X2230k	Not knowing who to ask; not being a priority; long waiting times; difficulty accessing services

Table A5. Perceived helpfulness of mental health support (RQ2)

OxWell question wording:

"Regarding this support, was it helpful?"

Analytic variable	OxWell variables	Description
Perceived helpfulness of support	X2190b–X2217b	Participants rated the helpfulness of each support type previously accessed. Analyses examined perceived helpfulness across support domains.

Ethnicity	Informal support N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)	School & community support N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)	Formal support N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)	Phone & online support N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)
White British	3500 (32.5)	Ref	Ref	1560 (14.5)	Ref	Ref	1171 (10.9)	Ref	Ref	354 (3.3)	Ref	Ref
6-category ethnicity												
Black African	184 (22.1)	0.59 (0.50–0.70), p < 0.001	0.63 (0.52–0.76), p < 0.001	65 (7.8)	0.50 (0.38–0.64), p < 0.001	0.53 (0.40–0.69), p < 0.001	40 (4.8)	0.42 (0.30–0.57), p < 0.001	0.45 (0.32–0.63), p < 0.001	24 (2.9)	0.88 (0.56–1.31), p = 0.107	1.09 (0.70–1.71), p = 0.695
Black Caribbean	33 (24.6)	0.68 (0.45–1.00), p = 0.050	0.75 (0.48–1.17), p = 0.204	18 (13.4)	0.92 (0.54–1.48), p = 0.751	0.96 (0.55–1.67), p = 0.880	14 (10.4)	0.97 (0.53–1.63), p = 0.903	0.85 (0.44–1.66), p = 0.838	9 (6.7)	2.15 (1.00–4.04), p = 0.049	2.54 (1.19–5.43), p = 0.016
Black Other	28 (24.6)	0.68 (0.43–1.03), p = 0.068	0.82 (0.51–1.32), p = 0.414	9 (7.9)	0.51 (0.24–0.96), p = 0.037	0.63 (0.31–1.29), p = 0.206	N.R.	0.31 (0.09–0.74), p = 0.005	0.39 (0.14–1.08), p = 0.063	N.R.	N.R.	N.R.
Mixed White–Black African	73 (28.4)	0.82 (0.62–1.08), p = 0.164	0.84 (0.62–1.13), p = 0.243	31 (12.1)	0.81 (0.55–1.17), p = 0.274	0.89 (0.60–1.32), p = 0.551	15 (5.8)	0.51 (0.29–0.84), p = 0.006	0.57 (0.33–0.98), p = 0.032	7 (2.7)	0.84 (0.35–1.67), p = 0.649	0.83 (0.36–1.90), p = 0.652
Mixed White–Black Caribbean	110 (33.0)	1.03 (0.81–1.29), p = 0.835	0.94 (0.72–1.22), p = 0.628	57 (17.1)	1.22 (0.91–1.62), p = 0.186	1.12 (0.82–1.54), p = 0.479	46 (13.8)	1.32 (0.95–1.79), p = 0.099	1.21 (0.85–1.73), p = 0.377	21 (6.3)	1.99 (1.23–3.07), p = 0.007	1.61 (0.95–2.70), p = 0.074
3-category ethnicity												

Black	245 (22.7)	0.61 (0.52–0.71), p < 0.001	0.66 (0.59–0.78), p < 0.001	92 (8.5)	0.55 (0.44–0.68), p < 0.001	0.58 (0.46–0.74), p < 0.001	58 (5.4)	0.47 (0.35–0.61), p < 0.001	0.49 (0.36–0.66), p < 0.001	37 (3.4)	1.05 (0.73–1.46), p = 0.793	1.32 (0.91–1.91), p = 0.145
Black Mixed ethnic	183 (31.0)	0.93 (0.78–1.12), p = 0.454	0.89 (0.73–1.09), p = 0.262	88 (14.9)	1.04 (0.82–1.30), p = 0.765	1.02 (0.79–1.31), p = 0.879	61 (10.3)	0.95 (0.71–1.23), p = 0.694	0.93 (0.69–1.26), p = 0.644	28 (4.7)	1.47 (0.97–2.15), p = 0.067	1.29 (0.82–2.01), p = 0.267

Table A6. Mental health support sought in the past 12 months by ethnicity included unadjusted odds ratios including unadjusted odds ratios. Percentages represent the proportion of adolescents within each ethnic group who reported seeking at least one support type within each category. Adjusted odds ratios (aORs) and 95% confidence intervals [,] are from logistic regression models controlling for year group, gender, and mental health symptom severity, with White British adolescents as the reference group. N.R. indicates estimates based on fewer than five respondents and therefore not reported.

	Informal support			School & community support			Formal support			Phone & online support		
Ethnicity	N (%) accessed	Unadjusted OR [95% CI, p value]	aOR [95% CI, p value]	N (%) accessed	Unadjusted OR [95% CI, p value]	aOR [95% CI, p value]	N (%) accessed	Unadjusted OR [95% CI, p value]	aOR [95% CI, p value]	N (%) accessed	Unadjusted OR [95% CI, p value]	aOR [95% CI, p value]
White British (n =)	*32.5%*	*Ref*	*Ref*	*14.5%*	*Ref*	*Ref*	10.9%	*Ref*		3.3%	*Ref*	*Ref*
					6-category ethnicity							
Black African (n =)	22.1%	0.59 [0.50, 0.70, p=<0.001]	0.63 [0.52,0.76, p=0]	7.8%	0.50 [0.38,0.64, p=<0.001]	0.53 [0.4, 0.69]	4.8%	0.42 [0.30,0.57, p=<0.001]	0.45 [0.32,0.63, p=0]	2.9%	0.88 [0.56,1.31, p=0.11]	1.09 [0.7,1.71, p=0.70]
Black Caribbean (n =)	24.6%	0.68 [0.45,1.00, p=0.05]	0.75 [0.48,1.17, p=0.204]	13.4%	0.92 [0.54,1.48, p=0.75]	0.96 [0.55,1.67	10.4%	0.97 [0.53,1.63, p=0.90]	0.85 [0.44, 1.66, p=0.84]	6.7%	2.15 [1.00, 4.04, p=0.05]	2.54 [1.19,5.43, p=0.02]
Black Other (n =)	24.6%	0.68 [0.43,1.03, p=0.07]	0.82 [0.51,1.32, p=0.414]	7.9%	0.51 [0.24,0.96, p=0.04]	0.63[0.31,1.29]	3.5%	0.31 [0.09,0.74, p=0.01]	0.39 [0.14, 1.08, p=0.06]	N.R.	N.R.	N.R.
Mixed – White & Black African (n =)	28.4%	0.82 [0.62, 1.08, p=0.16]	0.84[0.62,1.13, p=0.243]	12.1%	0.81 [0.55,1.17, p=0.27]	0.89 [0.6,1.32]	5.8%	0.51 [0.29,0.84, p=0.01]	0.57[0.33, 0.98, p=0.03]	2.7%	0.84 [0.35,1.67, p=0.65]	0.83 [0.36– 1.90, p=0.65]

Mixed – White & Black Caribbean (n =)	33.0%	1.03 [0.81,1.29, p=0.84]	0.94 [0.72,1.22, p=0.63]	17.1%	1.22 [0.91,1.62, p=0.19]	1.12 [0.82,1.54]	13.8%	1.32 [0.95,1.79, p=0.10]	1.21 [0.85, 1.73, p=0.38]	6.3%	1.99 [1.23,3.07, p=0.01]	1.61 [0.95,2.7, p=0.07]
3-category ethnicity												
Black (n =)	22.7%	0.61 [0.52,0.71, p= <0.001]	0.58[0.46,0.74, p=0]	8.6%	0.55 [0.44,0.68]	0.58 [0.46,0.74, p= <0.001]	5.4%	0.47 [0.35,0.61, p<0.001]	0.49 [0.36,0.66, p=0]	3.4%	1.05 [0.73,1.46, p=0.79]	1.32 [0.91,1.91, p=0.15]
Black Mixed ethnic (n =)	31.0%	0.93 [0.78,1.12, p=0.45]	1.02 [0.79,1.31, p=0.26]	14.9%	1.04 [0.82,1.30]	1.02 [0.79,1.31, p=0.76]	10.3%	0.95 [0.71,1.23, p=0.694]	0.93 [0.69,1.26, p=0.64]	4.7%	1.47 [0.97 ,2.15, p=0.07]	1.29 [0.82,2.01, p=0.27]

Table A7. Mental health support adolescents would have liked to access in the future by ethnicity including unadjusted odds ratios. Percentages represent the proportion of adolescents within each ethnic group who reported wanting to access at least one support type over the past year. Adjusted odds ratios (aORs) and 95% confidence intervals are from logistic regression models controlling for year group, gender, and mental health symptom severity, with White British adolescents as the reference group. N.R. indicates estimates based on fewer than five respondents and therefore not reported.

Ethnicity	Wider networks N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)	Response to disclosures N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)	Perceptions of care provisions N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)	Practical & logistical concerns N (%)	Unadj OR (95% CI, p)	aOR (95% CI, p)
White British	2295 (21.3)	Ref	Ref	2590 (24.1)	Ref	Ref	2888 (26.8)	Ref	Ref	2658 (24.7)	Ref	Ref
6-category ethnicity												
Black African	155 (18.6)	0.85 (0.70–1.01), p = 0.065	1.03 (0.83–1.26), p = 0.776	179 (21.5)	0.87 (0.73–1.03), p = 0.096	1.07 (0.87–1.30), p = 0.521	196 (23.6)	1.07 (0.87–1.30), p = 0.521	1.00 (0.82–1.22), p = 0.958	165 (19.8)	**0.76 (0.63–0.90), p = 0.001**	0.89 (0.72–1.08), p = 0.254
Black Caribbean	29 (21.6)	1.02 (0.66–1.53), p= 0.912	1.26 (0.77–2.07), p = 0.308	29 (21.6)	0.88 (0.57–1.31), p = 0.525	1.12 (0.69–1.81), p = 0.532	35 (26.1)	1.05 (0.64–1.73), p = 0.843	1.12 (0.69–1.81), p = 0.532	26 (19.4)	0.74 (0.47–1.12), p = 0.155	0.79 (0.48–1.32), p = 0.449
Black Other	20 (17.5)	0.79 (0.47–1.26), p = 0.331	1.04 (0.59–1.83), p = 0.982	28 (24.6)	1.03 (0.66–1.56), p = 0.886	0.93 (0.54–1.60), p = 0.716	24 (21.1)	1.49 (0.90–2.48), p = 0.124	0.93 (0.54–1.60), p = 0.716	24 (21.1)	0.82 (0.51–1.26), p = 0.376	1.13 (0.67–1.90), p = 0.615
Mixed White–Black African	67 (26.1)	1.30 (0.98–1.72), p = 0.071	**1.59 (1.15–2.21), p = 0.008**	64 (24.9)	1.05 (0.78–1.39), p = 0.745	1.15 (0.83–1.59), p = 0.511	70 (27.2)	1.18 (0.85–1.65), p = 0.320	1.15 (0.83–1.59), p = 0.511	71 (27.6)	1.17 (0.88–1.53), p = 0.282	1.36 (0.99–1.88), p = 0.067

Mixed White–Black Caribbean	69 (20.7)	0.97 (0.73–1.26), p = 0.804	0.84 (0.61–1.15), p = 0.271	75 (22.5)	0.92 (0.70–1.19), p = 0.525	0.78 (0.58–1.05), p = 0.109	86 (25.8)	0.77 (0.57–1.05), p = 0.103	0.78 (0.58–1.05), p = 0.109	94 (28.2)	1.20 (0.94–1.53), p = 0.144	1.17 (0.88–1.55), p = 0.286
3-category ethnicity												
Black	204 (18.9)	0.86 (0.73–1.01), p = 0.061	1.05 (0.87–1.27), p = 0.590	236 (21.9)	0.88 (0.76–1.03), p = 0.104	1.01 (0.85–1.20), p = 0.925	255 (23.6)	**0.84 (0.73–0.98), p = 0.022**	1.01 (0.85–1.20), p = 0.925	215 (19.9)	**0.76 (0.65–0.88), p < 0.001**	0.90 (0.75–1.07), p = 0.235
Black Mixed ethnic	136 (23.1)	1.11 (0.91–1.34), p = 0.317	1.12 (0.89–1.41), p = 0.338	139 (23.6)	0.97 (0.80–1.18), p = 0.790	0.93 (0.74–1.16), p = 0.506	156 (26.4)	0.98 (0.81–1.18), p = 0.845	0.93 (0.74–1.16), p = 0.506	165 (28.0)	1.19 (0.98–1.42), p = 0.075	**1.25 (1.01–1.55), p = 0.044**

Table A8. Perceived barriers to accessing mental health support by ethnicity (RQ4). Percentages represent the proportion of adolescents within each ethnic group endorsing each barrier domain. Adjusted odds ratios (aORs) and 95% confidence intervals are from logistic regression models controlling for year group, gender, and mental health symptom severity, with White British adolescents as the reference group. Barrier domains include concerns related to privacy and confidentiality within wider networks, anticipated responses to disclosure, perceptions of care provision, and practical or logistical constraints.

Supplementary Materials Chapter 4 – BLACK-ARTS

Codebook

Code	Definition / Description	Illustrative Quote
1. Creative arts as vehicles for emotional healing, identity, and agency	Perceived benefits and positive impacts of creative arts therapies for emotional regulation, connection, and healing among Black British young people.	
1.1 CATs as Tools for Processing Difficult Emotions	Participants describe CATs as helping them explore and release emotions that are hard to articulate verbally.	"It helps me express things I can't really say out loud."
1.2 CATs Positive Effect on Mood	CATs improve mood and reduce distress through creative engagement and self-expression.	"As soon as I start listening to music, my whole mood changes."
1.3 Nonverbal Expression of Emotions	Arts, movement, and music allow for communication beyond words, supporting self-expression.	"Sometimes being heard isn't about talking—it's through the body or through art." *(Clinician)*
1.4 Perceived Benefits of Utilising CATs	Participants report improved confidence, emotional awareness, and self-understanding.	"It gives you another way to understand yourself."
1.5 Aid with Symptoms Related to Diagnosis	CATs help to reduce anxiety, depression, and trauma symptoms.	"When I draw, it calms my thoughts—it's like my brain slows down."
1.6 Accessibility of CATs	CATs are seen as inclusive, approachable, and more engaging than talking therapies.	"It's easier to join in something creative than to sit and talk about my problems."
2. Challenges and barriers to CAT implementation	Challenges or limitations of CATs, including discomfort, limited access, and emotional risk.	
2.1 Challenges of Using CATs	Participants express fear of judgment, lack of confidence, or logistical barriers (e.g., funding, availability).	"I'd be worried about people judging my dance moves."
2.2 Negative Effects of CATs	Some activities trigger difficult memories or emotional distress.	"Certain songs can bring back bad memories."
3. Discovering therapeutic potential through creative experience	Prior experiences and everyday use of creative arts for mental well-being.	
3.1 Current Experience with CATs	Service users and clinicians with direct experience of CATs within NHS or community settings.	"I've had art therapy before—it really helped me open up."
3.2 Interest in Using CATs	Expressed interest and enthusiasm for participating in CATs.	"If it was offered at my service, I'd sign up straight away."
3.3 Engaging with Creative Mediums Not as Therapy	Use of art, dance, or music for self-care outside formal therapy.	"I sing and dance when I'm stressed—it helps me deal with things."
4. Creative expression as a bridge between culture and care	The extent to which creative arts therapies align with cultural identity, values, and lived experience.	
4.1 Cultural Relevancy of Creative Arts in Black British Youth	The arts reflect Black British and diasporic traditions, providing a sense of cultural continuity.	"Art and music are part of who we are—it's in our culture."

Code	Definition / Description	Illustrative Quote
4.2 Creative Arts as Culturally Competent Treatment Options	CATs are perceived as congruent with Black cultural practices and more engaging than Eurocentric therapy models.	"It connects us to our identity—it feels like home."
4.3 Need for Culturally Responsive Treatment Options	Calls for culturally informed interventions and improved cultural competence in services.	"Therapists should understand our culture before they can really help us."
5. Disconnection and mistrust within clinical encounters	Perceptions of NHS mental health services, including barriers, discrimination, and stigma.	
5.1 Ineffectiveness of Current Clinical Care	Services viewed as repetitive, impersonal, or mismatched with young people's needs.	"Sessions felt repetitive, like ticking boxes."
5.2 Prejudice in Clinical Care Pathways for Black British Youth	Experiences of bias, stereotyping, or being misunderstood within mental health care.	"They see you a certain way because you're Black—it changes how they treat you."
5.3 Barriers to Accessing Care	Structural barriers such as waiting lists, mistrust, or difficulty navigating services.	"It took months just to be seen—it puts you off asking for help."
5.4 Potential Changes to Make Current Clinical Care More Effective	Recommendations for more inclusive and culturally sensitive approaches.	"Services should ask what works for us instead of assuming."
5.5 Positives of Current Clinical Care	Recognition of supportive clinicians and positive therapeutic relationships.	"My therapist actually listened and took time to understand me."
5.6 Stigma Surrounding Mental Health Amongst Black British Youth	Cultural stigma and reluctance to engage in therapy within Black communities.	"In our community, you're told to keep it in and stay strong."
5.7 CATs as Tools for Reducing Stigma in Mental Health Care	The use CATs as entry points into NHS services since they're deemed as relatable and fun options.	"If it was offered to me as a fun service, like with music, versus, a daunting therapy, it would make me want to join more."

Service User Focus Group Questions

Script: What are creative arts therapies? In the UK, creative arts therapies are categorized as music therapy, dance movement therapy, drama therapy, and art therapy.

Arts and creative therapies are treatments which involve art activities within therapy sessions. These sessions are supported by a trained professional.

You do not need to have any skills or experience in art. And people of any age can benefit from them. Different people will have different experiences of arts and creative therapies, but in general they aim to:

- allow you to communicate thoughts and feelings that you find difficult to put into words
- help you make sense of things and understand yourself better
- give you a safe time and place with someone who will not judge you
- help you find new ways to look at problems or difficult situations
- help you to talk about complicated feelings or difficult experiences

- give you a chance to connect with other people.

Therapy sessions can take place in a one-to-one setting or group. They may be offered in a range of settings including charities such as local Minds, day centres, hospitals and therapy centres.

Dance movement therapy

Dance movement therapy (also known as dance therapy) involves using body movement and dance. For example, you might explore different types of movements and rhythms. You do not need to have any dance skills or experience.

Dramatherapy

Dramatherapy involves using different types of drama and performance activities that might be helpful for you.

For example, you might invent characters, tell stories, play games or do mimes.

Music therapy

Music therapy involves exploring music and sound. You do not need to have any musical knowledge or experience to do music therapy – for example, you do not need to know how to play any instruments, read music or be a good singer.

Together with your therapist, you might listen to music or use different types of instruments to explore ways of communicating and expressing your feelings.

Visual art therapy

Visual art therapy (also known as 'art therapy') involves using visual art materials. For example, you might use pens, pencils, crayons, paint, chalk, clay or collaging. You might also use digital media, such as photos or video. You do not need to have any art skills or experience.

Opinions on creative arts therapies:

1) As a whole, what are your opinions on creative arts therapies?
2) Are you interested in them and if so which ones? (music/ dance/ art/ drama)
3) What do you know about creative arts therapies?

Current uses/experiences of creative arts therapies:

4) Have you had an experience with creative arts therapies in the past? If so which ones?
5) For those that have, how was the experience?
6) Do you use any art forms in your day-to-day life? (music, watching films, making art, dance)
    a. Did you find them enjoyable, or did you think the opposite?
    b. What about the experience made you feel the way it did?
7) If you haven't engaged with these mediums as therapy, have you used these mediums in other ways? (i.e. For fun? For expression? For tranquillity/peace?)

Creative arts as a therapeutic strategy for improving well-being:

8) How could utilizing creative arts be helpful to cope with difficult emotions or problems in your life?

9) Do you feel that there could be an effect of creative arts in your life? Do you think it would be positive or negative?

10) What do you think are the benefits of using creative arts therapies?

11)How do you think an art-based intervention could help you with your mental health?

12) Would you like to participate in a creative arts therapy intervention? If so, which one interests you the most?

Perceived challenges of using creative arts therapies:

13) Do you think there could be any challenges in using creative arts as therapy? What would these challenges be?

14) In your opinion, would there be any negative effect of using an arts-based intervention? What would it be?

Opinions about current mental health treatments

15) What do you think about your current treatments?

16) Do you think they are helpful? If so, in what way?

17) If they haven't been helpful, what about the treatment would you like to change?
18) What do you think could be improved in your current treatment/care?

Culturally competency:

Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviours.

19) Could creative arts therapies be culturally competent treatments for you?
    a. If so, why?
    b. If not, why?
20) In what ways do you engage with creative arts currently? Do you find them therapeutic?
21) As a person of African and Caribbean descent, do you think music, dance, art or drama has any significance in your day-to-day life?
    a. If so, how?
22) In your opinion, what makes a creative arts intervention culturally competent for you?

Clinicians Focus Group Questions

Script:

"This focus group aims to investigate the attitudes and opinions of Black racial minority young people, and clinicians on the use of creative arts therapies for the improvement of mental-wellbeing and potentially culturally relevant treatment options. We aim to understand how to improve mental health services for Black racial minority young people and explore if creative arts therapies can be a helpful intervention that is culturally competent.

Your participation is voluntary, and you are free to withdraw at any time without giving a reason. This would not affect your employment rights. If you feel discomfort or unease, answering any of the questions is completely voluntary so you may decide to skip questions as you see fit. Additionally, you may withdraw from participating in the study at any time during this focus group or after."

- Length of interview – around 1 hour. Will finish on time – clock to keep on time
- Recording of interview – this interview will be audio recorded. All audio recordings will be destroyed immediately after focus groups are transcribed.
- Confidentiality and how findings will be reported – anonymity, transcribing
- Explain that there are no right or wrong answers – interested in a range of views, opinions and experiences
- Basic ground rules
- Mobile phones off (or on silent/vibrate)

- Any questions?

Overview of creative arts therapy:

What are creative arts therapies? In the UK, creative arts therapies are categorized as music therapy, dance movement therapy, drama therapy, and art therapy.

Arts and creative therapies are treatments which involve art activities within therapy sessions. These sessions are supported by a trained professional.

You do not need to have any skills or experience in art. And people of any age can benefit from them. Different people will have different experiences of arts and creative therapies, but in general, they aim to:

- allow you to communicate thoughts and feelings that you find difficult to put into words
- help you make sense of things and understand yourself better
- give you a safe time and place with someone who will not judge you
- help you find new ways to look at problems or difficult situations
- help you to talk about complicated feelings or difficult experiences
- give you a chance to connect with other people.

Therapy sessions can take place in a one-to-one setting or group. They may be offered in a range of settings including charities such as local Minds, day centres, hospitals and therapy centres.

Dance movement therapy

Dance movement therapy (also known as dance therapy) involves using body movement and dance. For example, you might explore different types of movements and rhythms. You do not need to have any dance skills or experience.

Dramatherapy

Dramatherapy involves using different types of drama and performance activities that might be helpful for you.

For example, you might invent characters, tell stories, play games or do mimes.

Music therapy

Music therapy involves exploring music and sound. You do not need to have any musical knowledge or experience to do music therapy – for example, you do not need to know how to play any instruments, read music or be a good singer.

Together with your therapist, you might listen to music or use different types of instruments to explore ways of communicating and expressing your feelings.

Visual art therapy

Visual art therapy (also known as 'art therapy') involves using visual art materials. For example, you might use pens, pencils, crayons, paint, chalk, clay or collaging. You might also use digital media, such as photos or video. You do not need to have any art skills or experience.

Opinions on creative arts therapies:

8) What are your opinions on creative arts therapies?
9) Are you interested in them and if so which ones? (music/ dance/ art/ drama)
10) Do you see them as effective interventions? If so, for which psychiatric disorders?
11) Which of them do you think could be most effective for the population that you work with?

Current uses/experiences of creative arts therapies:

12) Have you had experience with creative arts therapies in the past? If so which ones?
13) For those that have, how was the experience specifically for the patients?
    a. Did they find them enjoyable, or did you think the opposite?
    b. What about the experience made you feel the way it did?
14) When your patients utilized them have they always been as adjunct treatment options?
15) Do you think arts-based interventions can be primary treatment options for certain patients?

Creative arts as a therapeutic strategy for improving well-being:

16) What do you think are the benefits of using creative arts therapies?
17) How do you think an art-based intervention could help patients with their mental health?
18) Do you think your patients would be interested in a creative arts therapy intervention? If so, which ones?

Perceived challenges of using creative arts therapies:

12) Do you think there could be any challenges in using creative arts as therapy? What would these challenges be?

13) In your opinion, would there be any negative effect of using an arts-based intervention? What would it be?

Opinions about current mental health treatments

14) How effective have evidence-based treatment options been for the current population of Black racial minorities that you work with?

15) If they haven't been effective, what about the treatments do you think need changing?

16) What do you think could be improved in your current treatment/care for Black racial minority groups?

Culturally competency:

Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviours.

17) Have you adopted any culturally competent practices within your current treatment methods?

18) How important do you view cultural competency in current psychological care? Why do you view it this way?

19) Could creative arts therapies be culturally competent treatments for Black racial minority groups?

a. If so, why?

b. If not, why?

20) If not creative arts therapies, do you have an idea of another tailored intervention specifically for people from Black ethnicities?

Supplementary Materials – Chapter 5 Spotlight

Preliminary Screening Questions

Online Preliminary Eligibility Screening Information

1) What is your ethnicity? (Black British, African, Caribbean, Mixed-Race)
2) What is your age?
3) Many young people have experienced symptoms of depression which include low mood or sadness, having no motivation or interest in things, and feeling anxious or worried or not getting enjoyment out of life.
   Do you feel you have been depressed or had symptoms of depression at some point? (Y/N)
   a. Have you struggled with these symptoms for more than 2 weeks?
   b. Do you have a formal diagnosis of depression? (Y/N)
4) Young people often experience anxiety which includes symptoms like consistent worrying that affects your daily life, including school, your job and your social life. Have you ever struggled with anxiety? (Y/N)
   a. Have you struggled with these symptoms for more than 6 months?
   b. Do you have a formal diagnosis of anxiety? (Y/N)
5) Many young people have experienced traumatic events such as psychological, physical, or sexual abuse or childhood adversity such as exposure to violence or economic family hardship. Do you feel you have experienced a traumatic event or adversity? (Y/N)
   a. After a traumatic experience or adversity, young people can develop Post Traumatic Stress Disorder (PTSD). Symptoms of PTSD include recurrent, involuntary, and intrusive memories, feelings of detachment or estrangement from others and irritable behavior.
   b. Have you felt any of these symptoms for more than 1 month?

c. Do you have a formal diagnosis of PTSD? (Y/N)

6) Have you been recently diagnosed with a psychotic disorder (e.g., bipolar, schizophrenia, schizoaffective disorder), substance use disorders, eating disorders, or personality disorders? (Y/N)

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Health Questionnaire –8 (PHQ-8)

Name:_____

Date of Birth: _____ Today's Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	☐	☐	☐	☐
2.	Feeling down, depressed, irritable or hopeless	☐	☐	☐	☐
3.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4.	Feeling tired or having little energy	☐	☐	☐	☐
5.	Poor appetite or overeating	☐	☐	☐	☐
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7.	Trouble concentrating on things, such as school work, reading or watching television	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Your worst event: _____

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
2. Repeated, disturbing dreams of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0 ○	1 ○	2 ○	3 ○	4 ○
4. Feeling very upset when something reminded you of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0 ○	1 ○	2 ○	3 ○	4 ○
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0 ○	1 ○	2 ○	3 ○	4 ○
8. Trouble remembering important parts of the stressful experience?	0 ○	1 ○	2 ○	3 ○	4 ○
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0 ○	1 ○	2 ○	3 ○	4 ○
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0 ○	1 ○	2 ○	3 ○	4 ○
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0 ○	1 ○	2 ○	3 ○	4 ○
12. Loss of interest in activities that you used to enjoy?	0 ○	1 ○	2 ○	3 ○	4 ○
13. Feeling distant or cut off from other people?	0 ○	1 ○	2 ○	3 ○	4 ○
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0 ○	1 ○	2 ○	3 ○	4 ○
15. Irritable behavior, angry outbursts, or acting aggressively?	0 ○	1 ○	2 ○	3 ○	4 ○
16. Taking too many risks or doing things that could cause you harm?	0 ○	1 ○	2 ○	3 ○	4 ○
17. Being "superalert" or watchful or on guard?	0 ○	1 ○	2 ○	3 ○	4 ○
18. Feeling jumpy or easily startled?	0 ○	1 ○	2 ○	3 ○	4 ○
19. Having difficulty concentrating?	0 ○	1 ○	2 ○	3 ○	4 ○
20. Trouble falling or staying asleep?	0 ○	1 ○	2 ○	3 ○	4 ○



The Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS)

Below are some statements about feelings and thoughts.
Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Focus Group Questions

Script:

"This focus group aims to investigate the experience of Spotlight participants in the 12 week programme and also gather insights into creative arts for the improvement of mental wellbeing.

Your participation is voluntary, and you are free to withdraw at any time without giving a reason. This would not affect the standard of care you receive or your employment rights. If you feel discomfort or unease, answering any of the questions is completely voluntary so you may decide to skip questions as you see fit. Additionally, you may withdraw from participating in the study at any time during this focus group or after."

  - Length of interview – around 1 hour. Will finish on time – clock to keep on time
  - Recording of interview – this interview will be audio recorded. All audio recordings will be destroyed immediately after focus groups are transcribed.
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- give you a safe time and place with someone who will not judge you
- help you find new ways to look at problems or difficult situations
- help you to talk about complicated feelings or difficult experiences

- give you a chance to connect with other people.

Therapy sessions can take place in a one-to-one setting or group. They may be offered in a range of settings including charities such as local Minds, day centres, hospitals and therapy centres.

Dance movement therapy

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Together with your therapist, you might listen to music or use different types of instruments to explore ways of communicating and expressing your feelings.

Visual art therapy

Visual art therapy (also known as 'art therapy') involves using visual art materials. For example, you might use pens, pencils, crayons, paint, chalk, clay or collaging. You might also use digital media, such as photos or video. You do not need to have any art skills or experience.

Opinions on Spotlight?

19) Overall, how did you find your experience in the programme?
20) What did you like? Favorite moment?
21) What did you dislike? Least favorite moment?
22) Do you think the programme improved your mental wellbeing? If so, how/in what way?
23) What symptoms do you think it helped with the most (anxiety, depression, trauma etc.)

24) If it did not help with these symptoms, why do you think that is?

Current uses/experiences of creative arts therapies:

25) Have you had an experience with creative arts in the past? If so which ones?
26) For those that have, how was the experience?
27) Do you use any art forms in your day-to-day life? (music, watching films, making art, dancing)
    a. Did you find them enjoyable, or did you think the opposite?
    b. What about the experience made you feel the way it did?
28) If you haven't engaged with these mediums as therapy, have you used these mediums in other ways? (i.e. For fun? For expression? For tranquillity/peace?)

Creative arts as a therapeutic strategy for improving well-being:

8) How could utilizing creative arts be helpful to cope with difficult emotions or problems in your life?

9) Do you feel that there could be an effect of creative arts in your life? Do you think it would be positive or negative?

10) What do you think are the benefits of using creative arts as therapies?

11)How do you think an art-based intervention could help you with your mental health?