

Racialised staff–patient relationships in inpatient mental health wards: a realist secondary qualitative analysis of patient experience data

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ABSTRACT

Background The current study is a secondary analysis of qualitative data collected as part of EURIPIDES, a study which assessed how patient experience data were used to improve the quality of care in National Health Service (NHS) mental health services.

Objective We undertook a detailed realist secondary qualitative analysis of 10 interviews in which expressions of racialisation were unexpectedly reported. This theme and these data did not form part of the primary realist evaluation.

Methods Interviews were originally conducted with the patients (18–65 years: 40% female, 60% male) from four different geographically located NHS England mental health trusts between July and October 2017.

Secondary qualitative data analysis was conducted in two phases: (1) reflexive thematic analysis and retrodution; (2) refinement of context–mechanism–outcome configurations to explore the generative mechanisms underpinning processes of racialisation and revision of the initial programme theory.

Findings There were two main themes: (1) absence of safe spaces to discuss racialisation which silenced and isolated patients; (2) strained communication and power imbalances shaped a process of mutual racialisation by patients and staff. Non-reporting of racialisation and discrimination elicited emotions such as feeling othered, misunderstood, disempowered and fearful.

Conclusions The culture of silence, non-reporting and power imbalances in inpatient wards perpetuated relational racialisation and prevented authentic feedback and staff–patient rapport.

Clinical implications Racialisation in mental health trusts reflects lack of psychological safety which weakens staff–patient rapport and has implications for authentic patient engagement in feedback and quality improvement processes. Larger-scale studies are needed to investigate racialisation in the staff–patient relationships.

INTRODUCTION

A recent study, ‘Evaluating the Use of Patient Experience Data to Improve the Quality of Inpatient Mental Health Care’ (EURIPIDES), was the first to evaluate how inpatient experience data were used.¹ Initial analyses revealed references to racial discrimination. However, the mechanisms through which these experiences emerged and how they impact on

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Previous research suggests racialisation and racial discrimination are prevalent in inpatient mental health wards, although few studies have investigated how or for whom it prevents patients giving authentic feedback.

WHAT THIS STUDY ADDS

⇒ To our knowledge, this is the first study to conduct realist secondary qualitative data analysis of an existing realist evaluation. Through this method, this study makes an important methodological contribution as it offers insight into potential new realist methodology for secondary analysis of open-access qualitative data resources.

⇒ This is the first realist evaluation study to provide examples of the inpatient setting (contexts) interaction with mechanisms of racialisation. We concluded that racialisation prevents authentic patient feedback through a culture of non-reporting and silence (outcome). Using the principles of realist evaluation, we found staff and patient power imbalances, neglect and prominent stereotypes of race/ethnicity strained interactions between staff and patients.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ National Health Service trusts could receive further training on the effects of racialisation on authentic patient feedback. Future research could be used to validate the programme theory of racialisation that was produced in this study and explore its relevance and generalisability to other contexts, with a view to developing preventive interventions.

patient feedback were not an explicit aim, nor were they explored in the EURIPIDES Study.

Previous studies of racial discrimination identified in recent reviews^{2,3} were conducted across multiple healthcare settings, mostly in the USA, the UK and Australia. These documented racially motivated interactions such as microaggressions, attacks, exclusion and bullying towards ethnic minority groups. However, silence and denial of



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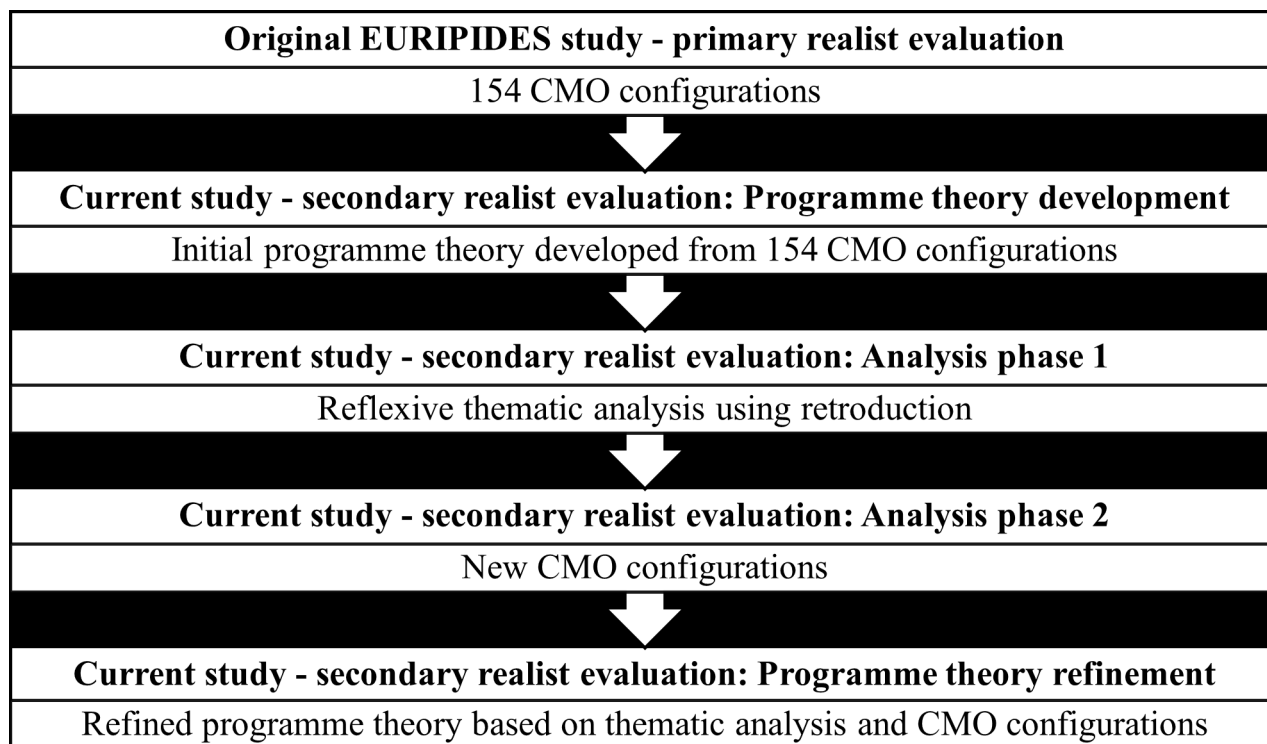


Figure 1 Research design of the current study (secondary realist evaluation) which follows on from the original EURIPIDES Study (primary realist evaluation). CMO, context–mechanism–outcome.

racism persist in healthcare contexts.⁴ Thus, concerns about racism or diversity are unaddressed at management levels. The absence of a complex evaluation of such matters and the silence around racism are in part why the status quo persists, prolonging systemic racism.⁵ Given ethnic inequalities in the experiences of severe mental illness,⁶ and the over-representation of ethnic minorities involuntarily admitted to psychiatric inpatient settings,⁷ we undertook realist secondary qualitative data analyses of a small sample of patients across several mental health wards.

We expected to generate preliminary results on how racialisation potentially operates in this setting. The sample were those reporting experiences where race or racism influenced their care. Sixteen per cent of the overall sample in the original study reported such incidents, so they are not uncommon. Based on previous research and the EURIPIDES Study, the initial programme theory suggested racial discrimination in the adult inpatient mental health setting (context) would impact willingness or ability (mechanism—reasoning/resources) to give authentic feedback on inpatient experience (outcome).

Aims and objectives

The aims of this study were twofold: (1) conduct realist secondary qualitative analysis of patient interviews from the original EURIPIDES Study data; (2) use principles of realist evaluation, including retroductive theorising to explore the circumstances in which racialisation may present itself, who it may impact and how it may influence authentic feedback.

METHODS

Research design

A realist qualitative secondary data analysis methodology was implemented. This process is illustrated in [figure 1](#). The use of realist methodology to undertake secondary qualitative data

analysis is novel and becoming increasingly important given: (1) the increasing move for archival storage of qualitative datasets from studies; (2) the burden to participants of discussing highly sensitive topics could potentially be reduced through making use of existing qualitative data to develop and refine programme theories ahead of further field research. The current study is a pilot analysis to demonstrate the feasibility of applying realist principles to secondary data analysis. A primary realist evaluation had been conducted,¹ and the realist principles which framed this study were reapplied to the current analysis.

Data sourced in the original study

In the original EURIPIDES Study (NIHR HS&DR: 14/156/20), purposive sampling was used to recruit participants across six mental health trusts in England to partake in semistructured interviews as part of a realist evaluation. Participants were eligible if they were adults of working age (18–65 years), currently admitted to an acute adult mental health ward in the National Health Service (NHS) and assessed as having capacity to provide informed consent to take part in research.

Sixty-two patient interviews (average duration 32 min) were conducted, among which 25% (n=16) identified as belonging to ethnic minority groups and 51.6% identified as white British or did not feel comfortable to disclose their ethnicity (21.0%) (see online supplemental appendix 1).

Of these patient interviews, 10 were selected for the current study (agreed by all authors) as they made references to race, racialisation or racism in experiences of patient care. An initial programme theory was developed based on the 154 context–mechanism–outcome (CMO) configurations and a recent review on racial discrimination in mental health wards⁸ (see online supplemental appendix 2). However, we did not know for which patients this might operate, in what circumstances or why. We

explored this theory through a realist secondary qualitative data analysis of the primary realist evaluation.

Data source and methodology for the secondary qualitative data analysis

We initially read all interviews from the EURIPIDES Study ($n=62$). Interviews that were selected for analysis ($n=10$) made explicit or implicit references to race, racialisation or racial discrimination that were relevant to patient care or experience (eg, addressed keywords or concepts like microaggressions, name calling, insults, attacks, exclusion, being refused service, bullying, harassment and hate crimes). Given this topic was not specifically asked about in relation to patient experience, the proportion of one in six patients who referenced racialisation and the limited evidence of how racialisation works, this was considered sufficient to undertake a secondary data analysis to iterate a programme theory. Of the 10 participants, 50% ($n=5$) self-identified as white British, 30% ($n=3$) identified as mixed race and 20% ($n=2$) did not disclose their ethnicity (see online supplemental appendix 3). The 10 participants were recruited across four out of the six sites involved in the EURIPIDES Study suggesting experiences of racialisation were not confined to one area. All interviews were conducted between July and October 2017. The results remain relevant as there are persistent ethnic disparities in patient care including restraint and involuntary mental health treatment.⁷

The 10 transcripts (approximately 5.3 hours of interview data) that referred to racialisation or discrimination were reanalysed using qualitative software (NVivo V.2020) via a two-step process. First, the interviews were thematically analysed based on guidelines by Braun and Clarke,⁹ while using retroduction, consistent with the principles of realist research. Retroduction uses both inductive and deductive reasoning to understand generative causation by exploring the underlying psychological and social drivers which influence programme outcomes.¹⁰ We recognise ongoing debate about the epistemological and ontological positioning of different types of thematic analysis.¹¹ There is tension between use of reflexive thematic analysis,¹² that is data led and seeks to uncover semantic (explicit) and latent (implicit) codes to explore experience or narrative, and critical realist approaches to thematic analysis such as the work of Wiltshire and Ronkainen,¹³ which uses thematic analysis to engage with the three domains of reality: experiential (empirical), inferential (actual) and dispositional (real). We did not consider this a useful approach for this study because the original data were from a *realist evaluation* rather than a critical realist framed methodology. We used an initial reflexive thematic analysis to surface the experiential codes, to then rework the data applying retroductive reasoning across *all three domains* to identify underpinning generative mechanisms that were influencing the reasoning and resources. The original EURIPIDES Study conceived of this approach as using the three ears of listening: what was said (real domain), what was implied (actual), and what was unsaid or felt (real). The research question and the fact that we were working on secondary qualitative data meant that retroduction within a reflexive thematic analysis framework allowed for the narrative experience to be foremost and for us to uncover generative mechanisms, both of which were central to the methodological approach of this work.

The second process of realist secondary analysis involved revising the CMO configurations developed in the original EURIPIDES Study. The reflexive codes from thematic analysis in the current study were categorised based on whether

they related to: (1) context—events or stressors that are indicative of racial discrimination; (2) mechanisms (both reasoning and resources)—constraints and the absence of resources that generate changes in behaviour¹⁴ and (3) outcomes—patients' engagement in feedback processes.

Reasoning referred to internal psychological processes that captured cognitive mechanisms (eg, use of logic), values, emotions and a combination of these processes.¹⁵ Resources referred to external opportunities that were available to patients on the ward to mitigate the effects of contextual moderators. Outcomes referred to the impact on the patient and on their responses to giving feedback about their experiences.

RESULTS

We found that racialisation and racial discrimination are directed at both staff and patients through mechanisms which reflect a lack of psychological safety in inpatient mental health wards. We uncovered mechanisms that perpetuated racialisation. These are reported as two separate themes, discussed below with illustrative quotes from patient interviews (see online supplemental appendix 4 for further examples).

Theme A: absence of safe spaces to discuss racialisation which silenced and isolated patients

The absence of psychological safety on the ward was perpetuated by racially motivated attacks similar to the example below.

One resident ... she actually targeted me for her physical, verbal, racially motivated abuse...distressed me because her husband being black African...his suggestion was if only I was Nigerian. As a white person I wasn't good enough. (white Namibian/German, female, 50s)

There was evidence that staff members did not directly address racialisation or partake in de-escalating racist attacks. The following British-Pakistani patient described repeated racially charged verbal and physical attacks from a white female patient. Staff members did not intervene to de-escalate the situation and treated it as an individual responsibility.

Basically when I got attacked by this other girl who, who tried to take my eye out on two occasions, there were people who wouldn't even...it was none of their business it was between me and this girl. (Asian/Pakistani British, female, age unknown)

This participant also revealed that they were blamed by ward staff for provoking the racially charged attack. The excerpt below suggests the patient felt invalidated, othered, unheard, disbelieved and distrusted.

... every time someone attacked me, it was like, 'Oh,[name], you go', or 'move out the way, you're provoking her,' and, 'you're preaching.' I was considered the perpetrator...troublemaker...at the end of the day you just want someone to believe you.

When asked how they would provide feedback to staff about the management of racist incidents, the same patient expressed disengagement and lack of faith in the feedback system. The suggestion that 'there's no point' in providing feedback indicates that the participant may still be experiencing distress but lack belief that it will be resolved by speaking up.

It's, it's water under the bridge now, so there's no point...

The patient also felt a sense of injustice when they perceived that staff did not respond to racially derogatory language from a patient who was white. The patient perceived that staff members had racial prejudices themselves.

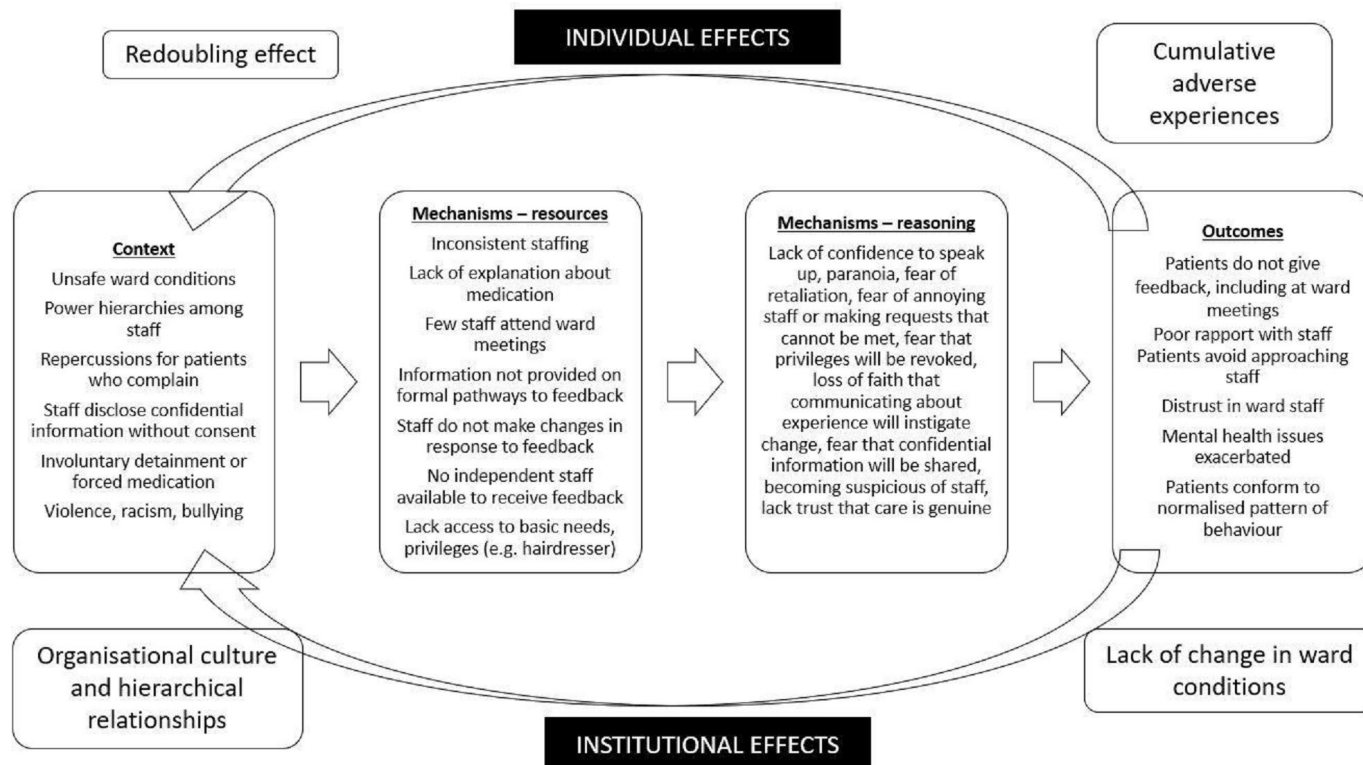


Figure 2 Logic model showing the context, mechanisms and outcomes that explain how patients were deterred from providing feedback in the wider EURIPIDES Study based on 62 patient interviews.

I would have liked to have them to be fair...but they're racist... because the other girl was white, they were ignoring me... I noticed the other girl who was white...called her a nigger...they don't (tackle the racism amongst patients)...cause they're racists themselves.

The following excerpt reveals the experience of being a bystander in the ward and observing fellow patients struggle with the responsibility of addressing racialisation and discrimination.

...one gentleman was sharing the fact that people had been, a certain patient had been racist towards him... Now (ward manager) was fully aware of these racist incidents... he should be addressing, approaching the individual pre them even expressing it for a second time in the community meeting... There needs to be a timeline and a commitment to getting back to people. (white British, male, 40s)

The same interview suggested that patients lacked private and confidential places to express their complaints.

...it took these individuals to have to say it in this setting, in the canteen... where it's not private, people in and out, and you've got patients expressing racism.

Theme B: strained communication, rapport and power imbalances contributing to racialisation

Some patients racialised the behaviours of ward staff, weakening the staff–patient rapport. One white participant mentioned that they avoided white staff in favour of black staff based on perceptions about their different qualities.

If I need something that is the person I would go to, whether male or female. But always here, black, always...I don't go to any white staff for anything. I've never encountered, in my life, any African people until I've come to this place and I realise how hard-working, how lovely ...they are. (white British, female, 40s)

In contrast to the former patient, one white British patient revealed that they avoided talking to ethnic minority staff who they perceived as unqualified. Ethnic minority staff may face unique barriers to building rapport with patients compared with white staff, for example, diminishing attitudes as in this example. Race here is being linked to competence and trust in the staff member.

Oh I talk to all the staff... apart from, well this isn't racist but I don't talk to the Africans that are unqualified...you can tell the moment they open their mouth... (white British, male, 50s)

The above white British patient further suggested that their racial biases were related to previous encounters with African staff on the ward which left them feeling patronised and disrespected.

They talk down to me, well to everyone who's got mental illness. One said to me last night as I was going to get my medication 'come' and gestured at me... I said to her 'what am I a dog'.

Ethnic minority staff were also perceived as having different expectations of courtesies and respectful communication which contributed to social awkwardness among patients.

If there are many ethnic minorities, then you've got to approach them with, with courtesy but then not with the upfrontness [sic] but with the courtesy, saying, 'Please', and 'Thank you', can move mountains. (male, age and ethnicity unknown)

Analysis of CMOs and discussion

Here, we report analysis and discussion combined as is common in qualitative research. To our knowledge, this is the first secondary qualitative data analyses study to explore the influence of racialisation and racial discrimination on patient

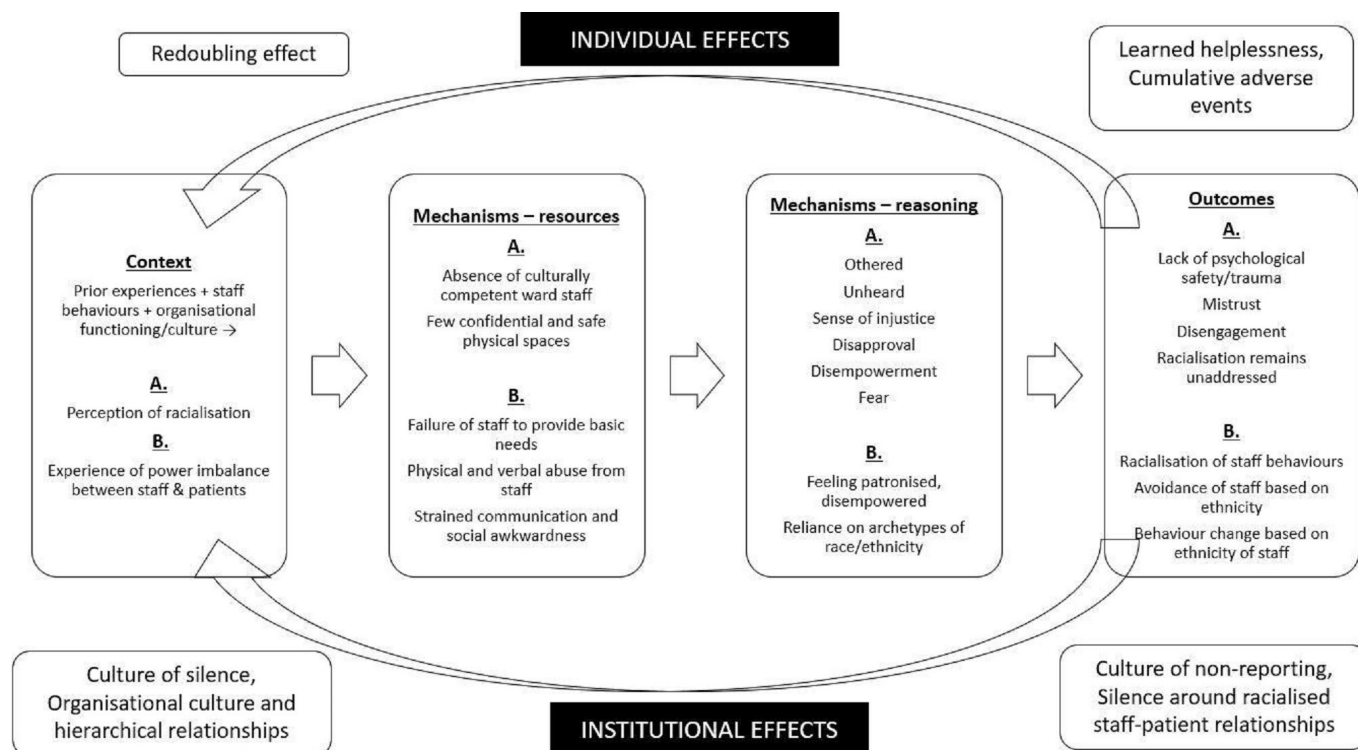


Figure 3 Logic model showing the context, mechanisms and outcomes related to two themes (A and B) in the inpatient ward culture which perpetuate racialisation. 'A' represents the context, mechanisms and outcomes of *patients* being racialised. 'B' represents the context, mechanisms and outcomes of *staff* being racialised.

feedback and care. The refined programme theory (see online supplemental appendix 2) makes two key contributions. First, it suggests that if people experience racial discrimination, directly or as a bystander, in adult inpatient mental health settings (context), this would impact their willingness or ability, due to a culture of silencing and power imbalances (mechanism—reasoning/resources), to give authentic feedback on their inpatient experience (outcome). Second, racialisation is directed at both staff and patients and consequently impacts the nature of staff–patient relationships on mental health wards, with wider implications such as authentic patient feedback. The process of mutual racialisation warrants more investigation and may be based entirely on ungrounded prejudices that are provoked by feeling unsafe, or actual differences in skills, qualifications and competencies. Or they may be grounded in differing styles of communication and empathy between staff and patients across race divides.

The key findings can be understood in the context of earlier results from the wider EURIPIDES Study (figure 2). The results of the realist secondary analysis suggest the mechanisms and outcomes identified in the wider study (psychologically unsafe ward conditions) were reproduced through racialisation, which perpetuated cultures of silence¹⁵ resulting in less authentic feedback in some instances. As supported by previous literature, the narratives from patients suggested that ward staff may have had conscious or unconscious racial biases, such that they did not address racialisation between inpatients. There was also evidence that patients racialised staff behaviours, which may be indicative of their own racial biases and assumptions. Figure 3 captures the two themes (represented as A and B) which show how both staff and patients were exposed to racialisation and racial discrimination.

Patient experience of racialisation and racial discrimination

Component A of figure 3 explains how a patient's experience or perception of racialisation from ward staff or other inpatients can deter authentic patient feedback through a range of mechanisms, learnt helplessness and a redoubling effect that repeats the cycle.

Context

The culture of non-reporting towards racialisation and discrimination was evident through the lack of response from ward staff towards patient complaints about racialisation or racist incidents. This could be an example of a racial microaggression defined as subtle and/or unintentional racial slights towards racialised groups.¹⁵ It could also be an example of 'racial fault lines'—more subtle cultural barriers which can escalate into severe racial tensions and conflicts.¹⁶ Patients who reported racialisation could be ignored, or even blamed for provoking conflict, echoing previous studies where providers denied the prevalence of racialisation, perceiving that ethnic minorities were oversensitive.¹⁷ Practitioners have also felt that addressing racialisation and racial discrimination was outside the bounds of their role.¹⁸ This clearly needs better training and support to address racialisation and racism, rather than compound it.

Mechanisms

Non-reporting of racialisation and discrimination elicited emotions such as feeling othered, misunderstood, disempowered and fearful. These findings are similar to a previous study with ethnic minority inpatients who felt disempowered from reporting racialisation, or overpowered when they attempted to resist the attacks.¹⁹

Outcomes

The outcomes related to poor staff–patient rapport (eg, mistrust), worsening mental health outcomes (eg, retraumatisation) and less patient feedback. These findings align with previous research²⁰ which revealed ethnic minority patients' mistrust towards mental health professionals, particularly due to ethnic disparities in the use of coercive practices.

Racialisation of staff behaviours

Component B of figure 3 explains how a patient's experience of power imbalances in favour of staff can perhaps contribute to racialisation of staff behaviours or reveal patients' racial biases towards ward staff.

Context

Most participants (n=7) revealed racialised views about ward staff. Some racial biases may have been activated as a response to physical/verbal abuse, neglect and dominance from ward staff directed towards patients—as one patient described, 'the doctors play God'. These findings are aligned with previous research on coercive practices among ward staff including forced medication²¹ and a failure to provide culturally sensitive explanations of mental illness.²⁰

Mechanisms

Emotional responses such as feeling patronised and dehumanised may have recruited specific explanations grounded in associating archetypes of race/ethnicity with a lack of caring behaviours or competence of ward staff. In the presence of stressors, individuals tend to rely on predetermined cognitive heuristics, including implicit racial biases, to protect their self-image.²² Literature on victimisation and powerlessness also suggests that the racialisation of abusive staff behaviours is a form of psychological resistance to oppression that allows the individual to make sense of their disadvantage.²³

Outcomes

There was evidence that patients approached or avoided ward staff based on their preconceived notions about the staff member's ethnicity. The examples of patient prejudice and cultural barriers reaffirmed previous research where practitioners reported exposure to racial microaggressions from inpatients, such as refusal to be treated and ethnic slurs, jokes or stereotypes.²⁴

Limitations

The primary qualitative data were not collected with these research questions in mind and consequently have provided partial data and results that are preliminary. Although it was clear that racialisation weakens staff–patient rapport, there was limited evidence of how it specifically prevents authentic patient feedback.

The nature of the study as a secondary data analysis with only 10 interviews limited the richness of the data. We cannot dismiss that within the 62 patient interviews, more than 10 patients may have experienced racial discrimination but did not disclose this, partly because they were not explicitly asked to. Due to our novel approach to realist secondary qualitative analysis, quality standards did not exist to guide our research. As the study was a secondary qualitative analysis, we did not record facial or behavioural expressions on transcripts or on video. There may be scope for video recording in future studies although with ethical issues to consider.

Implications and future research

The primary contribution of this study is that it has developed a refined theory (see online supplemental appendix 2) about racialisation in staff–patient relationships that can later be tested in larger-scale studies. We have also demonstrated the feasibility, novelty and value of applying realist methodology to secondary qualitative data analysis.

Further research is needed to dissect the organisational culture of mental health wards and how they perpetuate a culture of silence, power imbalances and racialisation in staff–patient communications and therapeutics. Intersectional experiences of marginalisation can also be explored given connotations of gender and religious discrimination across the interviews. The results from this study can also improve the recent implementation of the Patient and Carer Race Equality Framework²⁵ which seeks to eliminate racial disparities in the access, experience and outcomes of black communities.

Findings from the study can inform bystander or allyship training or programmes that address silence and denial of systemic racism. NHS trusts could also be aware that although they may implement feedback forms, some patients do not provide authentic feedback that can improve quality improvement processes.

CONCLUSION

The findings revealed that racialisation is directed at both staff and patients through a culture of silence, non-reporting and power imbalances between staff and patients. A programme theory was developed which can be further refined through larger-scale theory building. NHS trusts could be more cognisant of how racialisation prevents authentic patient feedback or weakens rapport between staff and patients.

Contributors PH, SS, S-JF, MF, SW, KB: conception and design of work, analysis and interpretation of data, draft of work, final approval for publication, accountability for all aspects of work. KB is guarantor.

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Competing interests SW was a member of the Health Technology Assessment (HTA) Mental, Psychological and Occupational Health Panel (2009–2015), the HTA Prioritisation Group (2009–2015) and the HTA Clinical Evaluation and Trials Committee (2015–2019).

Patient consent for publication Not required.

Ethics approval Ethics approval for the EURIPIDES Study was obtained from the West Midlands (South Birmingham) NHS Research Ethics Committee (reference number 16/WM/0223, Integrated Research Application System (IRAS) project identifier 181897). The study was co-sponsored by the University of Warwick and the University of Sheffield. While consent was obtained and confidentiality maintained, any disclosures made within the original study of harm to patients activated local NHS trust whistleblowing or safeguarding procedures.

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