**Exploring the experiences of Black Men through the decision-making process in secure settings: A qualitative study**

Chanae Mayers

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**THESIS PORTFOLIO: CANDIDATE DECLARATION**

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| **Candidate name** | **Chanae Mayers** |
| **Registration number** | **19024465** |
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| --- |
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| I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.  I confirm that the decision to submit this thesis is my own.  I confirm that except where explicitly stated, the work has not been submitted for another academic award.  I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.  Shape, arrow  Description automatically generated with medium confidence  Signed: Date:18.07.2022 |

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**"Be strong, be fearless, be beautiful. And believe that anything is possible when you have the right people there to support you." (Misty Copeland)**

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# **Thesis Abstract**

Paper 1 is a systematic literature review which aimed to explain the ethnic inequalities in compulsory admissions within the UK. 11 studies were included and narrative synthesis was used to explore the reasons for compulsory admission amongst Black Minority and Ethnic (BME) Groups Whilst themes highlighted that the majority of individuals from BME groups are referred through the criminal justice system, the reasons for compulsory admission to mental health hospitals amongst BME groups continues to be limited. The review emphasised the need for in-depth qualitative research to provide first-hand lived experiences of BME service users that are missed or excluded from research surrounding compulsory detention for Serious Mental Illness.

Paper 2 is an empirical research study which aimed to expand upon the research of Salla & Danso (2018) and Urquía & Salla (2019) through exploring Black men’s experiences of decision-making processes within forensic inpatient settings and their perceptions of these services. The study used a qualitative idiographic approach and Interpretative Phenomenological Analysis (IPA) was used to examine and understand personal lived experiences. Findings highlighted Black men’s lack of involvement in decisions around their care due to professionals not effectively communicating decisions during key aspects of their care. Future research is needed to explore professional and service user perspectives around compliance and the impact of family involvement in the treatment of Black males in secure settings.

Paper 3 is an executive summary which provides an overview of the empirical paper that is written in a way that is accessible for service users included within the study and to be distributed to the public. The executive summary was completed with an Expert by Experience and participant who took part in the study to check for readability and to follow through with service user involvement and co-production.

# **Paper 1: A systematic review of the ethnic inequalities in compulsory admission to psychiatric hospitals for Black and Minority Ethnic service users**

This literature review has been prepared for the BJPsych Open Journal and the author guidelines are in Appendix E

# **Abstract**

**Background**

Individuals from BME groups experience inequalities in health outcomes and access to/ experience of health services compared to those from white backgrounds.

**Aims**

Collect and synthesise evidence that aims to explain the ethnic inequalities with regards to compulsory admissions within the UK.

**Method**

Searches were completed from April 2021 to June 2021 using five databases. Additional hand searches were conducted via Google Scholar, Research Gate and EThOS e-theses online service.

**Results**

Narrative synthesis was used to generate nine themes; effect of ethnicity on rates of compulsory admission, restricted pathways to care, degree of GP involvement, help-seeking barriers, overdiagnosis, criminal justice involvement, ethnic density, socio-economic factors and risk, from self-harm to risk of violence.

**Conclusion**

Some explanations for the ethnic inequalities with regards to compulsory admission provided, however, the reasons for compulsory admissions to mental health hospital amongst Black and Minority Ethnic (BME) groups continues to be limited.

# **Introduction**

A recent report published by the NHS Race and Health Observatory outlined the complexity between and within ethnic groups in England, reporting that individuals from Black and Minority Ethnic (BME) groups experience inequalities in health outcomes and access to/ experience of health services compared to those from white backgrounds. It also highlights the absence of valuable research that contains good quality data and analysis1,2 of health inequalities experienced by minoritised groups.

A high proportion of research literature has suggested and continues to highlight that those who experience the largest inequalities and disadvantages within mental health services/systems are those from non-White ethnic backgrounds.3 It is felt that these inequalities are reinforced by structural racism amongst the ethnic groups and considerations need to be made with regards to the wider social context in relation to socio-economic deprivation including: (a) housing, (b) employment and (c) the criminal justice system for which those from BME groups are disproportionately affected. This can ~~then~~ have a negative impact on individuals’ physical and mental health.4,5

It has been reported that the use of The Mental Health Act (1983) within England during 2019-2020, to compulsorily detain Black or Black British individuals in hospital is four times higher (321.7 detentions per 100,000 population) than individuals from the White Group (73.4 per 100,000 population). Rates of Community Treatment Orders for Black and Black British individuals were also ten times higher (61.3 per 100,000 population) than White individuals (6 uses per 100,000). Individuals classed as Black Caribbean were also reported to have the highest rates of detention to hospital for one’s mental health amongst all ethnic groups in the UK.6 Lowest detentions were seen in Chinese individuals (54.1 per 100,000), White Irish Individuals (69.9 per 100,000), White British individuals (70.5 per 100,000) and Indian individuals (71.9 per 100,000). It is estimated that overall detentions rose by 0.8% in the year 2019 up to March 2020.6,7 The increased detention rates highlight the importance of increasing accessibility to services to support individuals before they reach crisis and need to be detained, therefore decreasing the need for detention.

It has been highlighted that the prevalence of psychiatric disorders, particularly for psychotic disorders is significantly higher amongst ethnic minorities living in the UK compared with White British individuals.8,9,10 However, despite the overwhelming evidence provided from administrative data, rates of compulsory admission within the UK amongst ethnic minorities continues to rise.11 Individuals from Black, Asian and minority ethnic groups continue to experience higher rates of compulsory hospital admissions compared to White individuals and continue to be affected disproportionately.12 Studies are still yet to provide concise and adequate explanations for the high admission rates, particularly for individuals classed as Black African, Black Caribbean and Black Other.13

Deprivation of liberty under the Mental Health Act (1983) is a decision that can sometimes rest uneasily with clinicians, policy makers and service planners and can also have a negative impact and be a difficult process for service users and their families.14 The process around detaining an individual under the Mental Health Act can be complex and multifaceted and service users are usually identified by their clinical team as necessitating compulsory admission, usually after all alternatives have been exhausted. Service users are then referred to an Approved Social Worker (ASW) or Approved Mental Health Professional (AMHP) based on the medical recommendations that have been put forward for admission. The ASW or AMHP will then make the decision about whether a service user should be admitted and whether it is considered to be appropriate. It is then the duty of the AMHP based on two medical recommendations to decide whether an application should be made to a named hospital for the detention of the service user who has been assessed.15 However, it can be argued that this can introduce clinician bias with regards to issues around ethnic variability and how service users meet the threshold for risk of admission and whether this may have an influence on decision-making15, this process of decision-making will be addressed later in the review. It could be inferred that compulsory admission to hospital is viewed by healthcare professionals as a necessary action rather than an optimal treatment whilst on the mental health care pathway when other options are unavailable when individuals are in crisis. Whilst the decision to compulsorily admit an individual is often classed as a necessity to reduce risk of serious and/or immediate physical harm to the service user or others, it should be highlighted that this is a serious clinical intervention.

A number of initiatives have been established over the years to expand the range of service options available to those in crisis which include sanctuaries, safe havens, crisis houses and crisis cafes.16 NHS England 17 developed a Long-Term Plan committed to increasing the availability of these options and ensuring individuals are able to gain access to 24-hour crisis care. The UK Government have also made it their priority to address the inequalities in compulsory admission following the 2018 Independent Review of the Mental Health Act.18

In 2005 the Government developed the Delivering Race Equality in Mental Health Care *(DRE)* strategy.19 The strategy listed a number of outcomes that they aimed to have achieved by 2010 including: (a) reduced fear of mental health services amongst Black Minority and Ethnic (BME) communities, (b) enhance satisfaction with services, (c) reducing rates of admission for BME individuals to psychiatric inpatient units, (d) reducing the disproportionate rates of compulsory admission for BME individuals, (e) reduced use of seclusion amongst BME individuals, (f) increasing self-reported rates of recovery amongst BME individuals, (g) increased range of effective therapies such as peer support, psychotherapy, and counselling, alongside pharmacological treatment, and (g) creating opportunities for BME individuals to be involved in staff training, policy development and service development.

Additional organisations including The Zito Trust, the Sainsbury Centre for Mental Health, The Joseph Rowntree Foundation and Mind have highlighted the need for improved experiences of mental health services for Black African and Caribbean individuals.3 However, despite the numerous initiatives put forward, those from BME groups continue to express negative experiences of mental health services and higher rates of psychiatric admissions.20 Research continues to put forward questions about why these rates have not yet been reduced and how mental health services can better reflect the communities they serve.3

As highlighted earlier in the review, some research has set out to explain some of the high rates of admission amongst this group. Fernando 21 stated that mental health services continue to utilise a model that is mainly based on tradition western European psychiatry. It can be inferred that utilising this model neglects other cultural world views.22 However, the 2006 ‘Count Me In’ Census reflected that a lot of patients are referred through the criminal justice system, emphasising high police and court involvement.23

Keown et al24explored ethnic density at area-level and found this to be strongly associated with rates of compulsory admission/ treatment, however this was only demonstrated in urban areas where there was reported to be increased pressure on services, whilst having a higher concentration of risk factors for psychosis. Others have suggested focusing on environmental pathways such as: discrimination, social support and networks, poor income and living in more deprived areas. However they have acknowledged the complexity of such research.25

Other research have emphasised the power of the psychiatrists and professionals making the decisions to compulsorily admit an individual. Spector 26 stated that psychiatrists are limited by criteria that is documented in the Mental Health Act (1983) when the individual is experiencing difficulties with a treatable mental disorder, believed to be a risk to themselves or others, or is not willing to accept voluntary treatment. However, it can be inferred that these admissions are also based on stereotypes that exist within the wider society, such as Black males being perceived as more dangerous by mental health professionals.27,28 This is reiterated by McNeil and Binder 29 who compared clinician’s predictions of the risk of violence of psychiatric patients during the point of admission to hospital. They reported evidence of racial bias regarding the rates of false positive predictions of violence and that psychiatrists routinely over-estimated the potential of violence in non-white male psychiatric patients under their care. Keating et al30noted that this racial discrimination generates a circle of fear of mental health services within Black communities which may lead to a mistrust of services which is then perpetuated by prejudice, misconceptions, misunderstanding and sometimes racism. This is further reiterated by Keating and Robertson 31who stated that some mental health services can sometimes replicate similar experiences that those from Black communities experience in wider society, such as racism and discrimination. It can be inferred that negative experiences with such services re-triggers previous experiences of control and oppression such as exclusion from school, contacts with the police and the criminal justice system. 31(p442)

**Aims of the current review**

The aim of the current review is to collect and synthesise evidence that aims to explain ethnic inequalities in compulsory admissions within the UK. The review aimed to address the reasons for compulsory admission amongst Black Minority and Ethnic groups whilst also exploring the risk of admission and pathways to services.

# **Method**

A comprehensive scoping search was completed, prior to formally searching for research literature to establish an appropriate review topic and gain an understanding of appropriate search terms.

Both quantitative and qualitative studies were reviewed to explore risk of/and compulsory admissions and detentions to hospital under The Mental Health Act (1983) of anyone from Black Minority and Ethnic groups within the UK. The Preferred Reporting Items for Systemic Reviews and Meta-Analyses (PRISMA) guidelines 32 were used to guide and structure this review.

**Eligibility Criteria**

The review aimed to explore the risk of/and compulsory admissions and detentions to hospital under The Mental Health Act (1983). Specific inclusion and exclusion criteria were established to assess the eligibility of studies to be included in the review. The reviewer was aware of the potential of bias including publication bias within this sensitive subject area and so chose to include grey literature. Inclusion criteria included:

1. Articles that made reference to or contained an adult sample of participants from Black, Minority, and Ethnic groups.
2. Articles written in English due to lack of resources for translation services
3. Studies based in the UK.
4. Articles that referred specifically to risk of/and compulsory detention under the Mental Health Act, including various sections under the Mental Health Act.
5. Articles containing information regarding service users’ experiences and journey through the mental health system alongside some explanations/ hypotheses for the ethnic inequalities with regards to compulsory detention.

Due to the differences in client groups, children and adolescent samples were excluded. Studies were excluded if they:

1. Exclusively focused on the statistical differences of compulsory admission amongst the ethnic groups and did not include any hypotheses/ explanations for the statistical differences.
2. Did not make reference to detention under the Mental Health Act and focused on other forms of detention such as criminal detentions or community treatment orders.
3. Did not report or make reference to ethnicity.

**Sources**

Searches were conducted in April 2021 to June 2021 using EBSCOHost, including; PsychINFO, MEDLINE, PsycARTICLES, CINAHL Complete and Science Direct. Additional hand searches were also conducted via Google Scholar, Research Gate and EThOS e-theses online service to obtain additional articles and grey literature.

**Search Terms**

Search terms were guided using the SPIDER search tool 33 by considering the following where possible; the sample, phenomenon of interest, design, evaluation and research (see Table 1). To ensure all literature was considered that related to the research question, search terms were grouped using “OR” “\*” and “AND.” Limiters were then applied for classification and language to further consolidate more specific research. Limiters used for classification were “inpatient & hospital services” “health & mental health services” and “health & mental health treatment & prevention.” With regards to language, only English articles were selected which further reduced the search results.

As the review question did not target specific study methodology, it was decided that the ‘Design’ (D) and ‘Research Type’ (R) elements of the SPIDER Tool would not be included in the search terms. This was completed to capture articles that may not contain reference to these and to be as inclusive as possible.

## Table 1

*Search Terms used in systematic literature search*

|  |  |
| --- | --- |
| Domain | Search Terms |
| (S) Sample | Minority group\* OR ethnic minorit\* OR BME or Black Minority ethnic group\* OR minority ethnic\* |
| (PI) Phenomenon of interest | Section\* AND compulsory detention AND mental health act AND compulsory treatment AND mental health |
| (D) Design | Not used or included |
| (E) Evaluation | Ethnic disparit\* |
| (R) Research | Not used or included |

**Selection of Studies**

Studies were selected using a stepped process according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.32 Studies were firstly screened by title and abstract according to the inclusion criteria. Full text versions of the selected articles were then obtained and assessed for eligibility based on both the inclusion and exclusion criteria. Data was then extracted from the full text articles that addressed the aims of the review (see Figure 1).

## Figure 1

PRISMA 2020 Flow Diagram of Screening and Selection

Included

Eligibility

Screening

Full text articles excluded with reasons

(n = 24)

3 articles were from the period 1991 – 1994 and were deemed too old to be included

10 Articles were systematic or literature reviews which was not clear from the title and abstract

2 Articles were based outside of the UK

9 Articles mainly focused on statistics and did not make any reference to risk of admission, reason for admission or the patients journey through the system.

Studies included in synthesis

(n = 11)

Full text articles screened using inclusion and exclusion criteria

(n = 35)

Records screened

(n = 730)

Records excluded

(n = 695)

95 not in English

345 excluded by Title

255 excluded by Abstract

Records identified after limiters applied and duplicates removed

(n = 730)

Additional records identified through Google Scholar and EThOS

(n = 16)

Records identified through database searching

(n = 3,152)

Identification

**Publication Bias**

Due to the limited amount of qualitative data available and the sensitivity regarding this topic, where publications and journals may choose not to publish research that highlights significant ethnic inequalities within mental health services, grey literature was searched and included within this review. Hand searching of other data sources were conducted to examine and identify additional relevant studies that may be relevant but not peer reviewed. The author also consulted with an Expert by Experience around the topic and obtained their views and expertise to ensure that thorough searches were being conducted on, for example risk of and compulsory detentions to hospital and ensuring the correct language was being used. The reviewer also considered their own bias as a Black woman and someone belonging to a Black Minority and Ethnic group and the potential influence this may have had on the selection of articles. This was addressed through utilising a reflective diary and having open discussions with the researcher’s academic and clinical supervisor.

**Quality**

The quality of the quantitative studies included in the review were critically appraised using the Downs and Black Quality Assessment Checklist.34 The checklist is comprised of 27 questions, with a total possible score of 28 for randomised studies and 25 for non-randomised studies (see Appendix A). The checklist was given score ranges (see Appendix B) that corresponded with the quality levels previously reported by Hooper et al 35 excellent (26-28), good (20-25), fair (15-19) and poor (<14). The Critical Appraisal Skills Program 36 for qualitative studies was used to assess the quality of the one qualitative study included in the review (see Appendix C). The CASP tool is a ten-point questionnaire for the appraisal of qualitative research that appraise the methodology, results, and study usefulness in a local context. The CASP tool is a popular instrument for the appraisal of research. A limitation of the tool is that it can be quite medicalised with regards to the language it uses, for example using the term recruitment rather than involvement.36 The review contained one mixed methods study and so the Mixed Methods Appraisal Tool (MMAT) was used to appraise this study (see Appendix D). The tool is reliably used and designed to appraise studies that use mixed methods.37

**Synthesis of Results**

For this review, narrative synthesis was used. Popay and colleagues’ 38 guidance for conducting narrative synthesis in systematic review recommends four main elements for narrative synthesis including:

1. Developing a theory of how an intervention works and the reasons why and for whom
2. Developing a preliminary synthesis of the findings that are included in the studies
3. Exploring relationships within the data
4. Assessing the robustness of the synthesis

# **Results**

**Study Characteristics**

Eleven papers met the inclusion criteria for the review and the study characteristics are presented in Table 2. The date the articles were published ranged from 1995 to 2021, with two studies being published in 1995 and 1998.

## Table 2

*Table of study characteristics (All studies were conducted in the United Kingdom)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Author & Year | No. of service users | Demographics | Design | Key findings | Strengths | Limitations | Further Research |
| McBride et al39  2021 | 1,238,188 | -White British  -White Other (white Irish or any other white background)  -Black or Black British (Caribbean, African, any other Black background),  -Asian or Asian British (Indian, Pakistani, Bangladeshi, Chinese or any other Asian background  -Mixed (White and Black Caribbean, White and Black African, white and Asian or any other mixed background)  -Any other ethnic group  Mean age of 48 | Quantitative -multilevel logistic regression models | Reduced risk of compulsory admission when living amongst high own-group ethnic density for Asian and White patients (OR) 0.97, 95% CI 0.95–0.99 and 0.94, 95% CI 0.93–0.95  For White British patients a 10% increase in own-group ethnic density was associated with a protective effect against the risk of compulsory admission.  10% increase for risk of compulsory admission amongst White other and mixed groups (OR 1.18, 95% CI 1.11–1.26) | Explored ethnic density and risk of compulsory admission.  Used a nationally representative sample | Effect and power not reported  Incomplete data sets (MHMDS) used | Consideration of patient’s catchment area characteristics  Future research to be co-produced by service users, carers and communities |
| Audini  and  Lelliott40  2002 | Not recorded | -White (including white people of European, North American or Australasian origin)  -Black (including those described as Black-African, African-Caribbean, Black British or Black Other)  -Asian (including those of Indian, Bangladeshi, Pakistani, Chinese and Japanese origin)  -Other (including people of South American, Middle Eastern and North African origin)  48.3% male, 51.7% female | Quantitative – descriptive statistics looking at age, gender and ethnicity | Highest rates of detention for people Aged 25-34  Detentions 6 times more likely for Black people than White People | Explored number of detentions | Incomplete data sets  No. of service users included was not listed  Limited categories used to categorise ethnicity  Most affluent areas under-represented  Effect and power not reported | Considerations regarding data collection and sample population |
| Mann et al41  2014 | 674 | -White British  -White Other (White service users with no parents born in the UK, including White Irish)  -Mixed Black/White (one parent Black Caribbean or Black African, other parent White)  -South Asian (Bangladeshi, Indian, Pakistani, Sri Lankan origin)  -Other Asian (includes Chinese, Vietnamese, Philippines, Japanese)  -Black British (Black service users born in the UK)  -Black Caribbean (Black and born in the Caribbean)  -Black African (Black and born in Africa)  65% male, 35% female  Mean age at referral = 24 years, range of 18–35 | Quantitative - Descriptive statistics, univariate tests: Chi-squared, Fisher’s exact and ANOVA | Black African patients significantly more likely to be detained compared with White British patients, post-hoc analysis revealed limited GP involvement, reduced self-referrals, and increased criminal justice referrals accounted for the differences. | Accounted for differences within the data  Broad range of ethnicity categories used  Clear differentiation between and within ethnic and cultural groups | Incomplete datasets used  No adjustments made for multiple testing -Effect and power not reported  Lacked generalisability –ethnic minority mix not typical of UK | Need for more focused research (including qualitative work) into the different experiences of better-defined ethnic groups, differentiated by gender |
| Lawlor et al42  2012 | 287 | -White British  -White Other (including white Irish)  -Black Caribbean  -Black African  -Black Other  Mean age of 40.1 years, range (18-69) | Quantitative – descriptive statistics and univariate tests, Chi-squared, logistic regression | Identified inequalities amongst White British and Black Women and White British and White Other women., with ethnic group significantly associated with whether patients were admitted to hospital or crisis house.  Analyses revealed differences with regards to help-seeking behaviours during crisis which may contribute to the inequalities. | Included pathways to care, risk of admission and reasons for admission | Used clinician rated reasons for admission  Missing data  Small ethnic samples were excluded from analysis  Ethnic group based on clinical recordings  Sample not representative of UK  Effect and power not reported |  |
| Gajwani et al43  2016 | 863 | -White (including White British/Irish and White Other)  -Asian Pakistani (including Asian/Asian British Pakistani)  -African Caribbean (including African/British African Caribbean)  -Black African (including Black/Black British African and African-Other)  -Asian Indian (including Asian. Asian British Indian)  -Asian Bangladeshi (including Asian/Asian British Bangladeshi)  Mean age of 40.1, 60.3% male, 39.7% female | Quantitative – descriptive statistics, Chi-squared, Fisher’s exact, univariate analyses, logistic and multiple regression | BME patients more likely to be assessed and detained under MHA due to diagnosis of mental illness, presence of risk and poorer level of social support.  When age, diagnosis, risk and level of social support were accounted for, ethnicity did not change the odds of MHA detention | Explored socio-demographic and clinical factors  Looked at the influence of diagnosis | Missing data  Effect and power not reported | Further research into factors that contribute to the increased risk of detention |
| Singh et al44  2014 | Not recorded | -White (including Irish and other Europeans)  -Black Caribbean and Black African  -Asian (including Indian, Pakistani, Bangladeshi and Sri Lankan)  -Other (including Chinese and Vietnamese) | Quantitative- descriptive statistics, Chi-squared and logistic regression, odds ratios and confidence intervals | Ethnicity was not associated with the odds of detention. Significant predictors of detention under the MHA were (a) a diagnosis of psychosis, (b) risk being present, (c) living in supported accommodation, (d) being female, (e) aged over 30 and (f) being assessed in London. | Explored different sites and made comparisons of each site and rates of detention | Limited ethnic categories  Missing data  Effect and power not reported | None suggested |
| Bebbington  et al45  1995 | Not recorded | -White  -Black Caribbean | Quantitative – descriptive statistics, log-linear analysis | Ethnicity did not appear to be associated in decisions to use the Mental Health Act. There was a strong association between compulsory admission and diagnosis and challenging behaviour. | Explored differences between districts and rates of compulsory admission | Small sample sizes and differences in methods between studies  Effect and power not reported | Consider ethnic and cultural factors when developing mental health services |
| Singh et al46  1998 | 417 | -Black-Caribbean (including those of Afro-Caribbean or Black African ethnicity)  -White  -Asian  46.5% patients <35 years old  63.9% unemployed  43.9% living in rented accommodation | Quantitative – Descriptive statistics, Odds ratios and confidence intervals | Greater proportion of Black-Caribbean patients were single, had poor social support, had a psychotic episode longer than 30 days and were considered at risk of violent acting out but not deliberate self-harm  Being compulsorily detained was significantly related to having a diagnosis of psychosis, being unemployed and being considered to be at risk of violence | Explored differences in patients admitted to psychiatric wards  Explored socio-demographic factors | Ethnicity was defined by the service user’s key worker  Excluded data from Asian patients  Effect and power not reported | Be aware of racism and stereotyping |
| Oluwatayo and Gater47  2004 | 100 voluntarily admitted  100 compulsory patients | -Black African/Caribbean  -White | Quantitative – Cross-tabulation, chi-squared and t-test | Compulsorily admitted African/Caribbean patients had more factors indicative of poor engagement with services. Prior to admission, they were less likely to keep their appointments (56 % vs. 25%, x=28.8,  df=3, p<0.01), comply with their medication (57% vs. 33%, x=28,  df=5, p<0.001), contact their GPs and were more likely to present late | Reported on engagement with services  Explored circumstances leading to patient’s first admission | Relies on self-report | Need increased culturally sensitive services |
| Solanki48  2020 | 12 | -Black British/ African Origin  -Black Other  -Black African  -African Jamaican Mexican and American German  -British African  -Black British  -Caribbean and African | Qualitative – Thematic Analysis (TA) | 4 main themes identified  -Help is decided by others, not tailored to me  -I am not a person: I am a Black patient  -Mistreated or neglected instead of cared for  -Sectioning can be a space for sanctuary and support  -Highlighted police involvement, racism and engagement with services as key factors | -Ethnicity was self-reported using a pre-interview questionnaire  -Used a qualitative approach – more in-depth data obtained | -Sample was not inclusive of all BME groups | Embedding BME people who have experienced detention into clinical systems of leadership and delivery  -Understanding experiences in more specific samples |
| Brown49  2015 | Quant – 122  Qual - 17 | -White British  -Black-Caribbean  -Asian-Pakistani  -Asian Bangladeshi  -Mixed White and Black Caribbean  -Black African  -Asian Indian  -White Irish  -Mixed Black African  -Mixed Other  -Other | Mixed methods  Qualitative - Thematic Analysis  Quantitative – descriptive statistics, chi-squared and t-tests | -White British and Asian Pakistani had similar level of GP contact in pathway to care  -Black Caribbean patients less likely to experience GP involvement in their pathway to care. Also had greatest emergency medical contact. Living in isolation  Qual - 5 themes  -The appraisal of early signs of psychosis  -Psychosis as a crisis event  -Variety of help seeking behaviours  -The role of statutory services | -Explored carer’s narrative accounts leading to compulsory hospital admission  -Focused on obtaining, comparing and contrasting ethnic differences in actual experiences  -Service users described their own ethnicity  -Used mixed methods approach | -Lacked external validity  -Differences in Carer relationships may have influenced theme generation | -Improved access to psychiatric care |

## Synthesis of results

The data were analysed according to Popay et al38 to identify patterns across the data and consider the factors that might explain the ethnic inequalities with regards to compulsory detention and the risk of compulsory admission. This was identified through exploring the results and discussion in the research literature to identify the key findings, strengths, limitations, and suggestions made for further research. Robustness of the synthesis was tested using critical appraisal tools. Specific attention was paid to the ethnicities within the samples and how they were categorised as this differed across the studies and contributed to the external validity. Samples were also examined to determine whether they were representative of the UK population.

As the review included both qualitative and quantitative data, the data were translated into several thematic concepts that were addressed across the studies and used to explore the ethnic inequalities with regards to the risk of and reasons for compulsory admissions to mental health hospitals for a mental health episode. This included: effect of ethnicity on rates of compulsory admission, restricted pathways to care, level of/limited GP involvement, help-seeking barriers, overdiagnosis, criminal justice involvement, ethnic density, socio-economic factors and risk, including: (a) self-harm (b) self-neglect (c) harm to self and others (d) harm to property and (e) risk of violence.

**Effect of ethnicity on rates of compulsory admission**

All papers referred to the rates of compulsory detention amongst Black minority and ethnic groups compared to White British or White Other ethnic categories. However, it should be noted that four studies chose to solely make comparisons between Black African Caribbean participants including Black British, Black African, Black Caribbean and Black Other compared with White British and White Other.42,45,47,48

Six of the quantitative studies reported individuals from Black ethnicities including Black African, Black British, Black Caribbean and Black Other to have the highest rates of compulsory detention and were more likely to be detained under the Mental Health Act (1983) compared to other ethnic groups.39-43 However, three studies found that ethnicity was not a significant predictor of compulsory admission.42,45,44

Solanki48(p72) further highlighted the correlation between ethnicity and compulsory detention with participants stating, “I was detained because I was Black.”Participants expressed that they felt their ethnicity influenced clinicians’ decisions to compulsorily detain them and felt that particularly Black men were detained for socio-political reasons with a participant explaining that they were treated differently because of their ethnicity.

**Restricted pathways to care**

Some studies highlighted some notable differences amongst the BME groups with regards to their pathways into services and compulsory admission compared with White British and White other individuals. Lawlor et al42 found ethnic group to be significantly associated with whether service users were admitted to a hospital or crisis house. The authors reported that White Other and Black women were more likely to be admitted due to an assault on an unrelated person or destruction of property. Oluwatayo and Gater47 found that compulsory detention amongst African/Caribbean patients was linked to increased factors suggestive of poor engagement with services, including: (a) poor adherence with appointments, (b) non-compliance with medication, (c) presenting late in hospital, (d) not contacting their GP and (e) being admitted from home. It can be inferred that more focus and support is needed with early intervention services and youth offending teams to reduce adverse pathways to care and increase engagement with services.

**Level of GP Involvement**

Several studies have made reference to GP involvement being a significant predictor of compulsory admission across all ethnicities in their pathways to care, with reduced or absent GP involvement increasing the risk of compulsory detention with those from BME groups being less likely to seek support from their GP, although the reasons for this were not explicitly explored or explained. Mann et al41 reported participants who had limited involvement with their GP experienced increased rates of detention. This is reiterated by Brown49 who reported Black Caribbean patients were less likely to experience GP involvement in their care pathway and had reduced visits to their GP.

**Help-seeking barriers**

Help seeking and engagement with services (including self-referrals) were highlighted as important factors with regards to the risk of compulsory admission and detention under The Mental Health Act (1983). Mann et al41 found Black African patients to have significantly reduced self-referrals for help. This is reiterated by Oluwatayo and Gater47 who reported that African/Caribbean patients who were compulsorily detained had increased factors indicative of poor engagement with services prior to admission. They were less likely to keep their appointments, comply with medication, contact their GP’s and were more likely to be late to appointments. Lawlor et al42 found that White British women were more likely than others to actively seek help.

Barriers to help-seeking were explored in more depth within the qualitative and mixed method studies that were included within this review.48,49 Solanki48 found contradicting conclusions to Lawlor et al42 and Oluwatayo and Gater47 as participants in Solanki’s study described seeking support a number of times and receiving conflicting responses or little to no help or support. This then led to participants going into crisis and the response was detention. Brown49 highlighted the importance of families within the help-seeking process. They also found that help-seeking was influenced by religion and external sources such as prayer and obtaining counsel from religious figures. They also highlighted several barriers to help seeking such as having a lack of knowledge and understanding on where to source support, not being knowledgeable regarding the resources/services that are available and being denied support when they have approached services. However, both studies did not highlight additional explanations such as fear of the system, stigma around seeking/asking for help and cultural rules, norms, or expectations.

**Overdiagnosis and incidence of compulsory detention**

A number of studies made reference to diagnosis being a significant predictor of compulsory detention amongst BME groups. Lawlor et al42 found that rates of diagnosis for schizophrenia were the highest amongst Asian Bangladeshi, African Caribbean and Black African groups and found diagnosis to be a significant predictor of compulsory detention. This is further reiterated by Singh et al44 who found that serious mental illness and psychopathic disorders increased the odds of detention. Bebbington et al45 highlighted a strong interaction between ethnicity and diagnosis, in particular a diagnosis of schizophrenia. Singh et al46 found a diagnosis of psychosis amongst Black Caribbean patients increased their odds of compulsory admission. Additional research may be needed to focus solely on diagnosis amongst BME groups and the potential influence on compulsory admission.

**Criminal justice involvement**

Some studies have made reference to criminal justice services such as the courts, police, prison and probation having a significant influence in compulsory detention for individuals from BME groups, with these services making a higher number of referrals and the police being involved in detentions to hospital. Solanki48 reported that some individuals from BME groups encountered negative experiences with the police such as being restrained and, in some cases, arrested which further increased their confusion and distress. However, Brown49 reported that in some cases police involvement was required to reduce risk and aid emergency services. Police and criminal justice involvement were found to be the highest amongst Black African and Black Caribbean service users.41-43It can be inferred that due to the reduced help-seeking behaviours and limited support from services that those from BME groups are going into crisis and requiring intervention from the criminal justice services to reduce the risk of harm to themselves and others, with the police often being called by concerned family members.

**Ethnic density**

Mcbride et al39 specifically explored the effects of high own-group ethnic density on compulsory admission i.e. that living within areas of high own-group ethnic density reduces the risk of compulsory admission. Although the authors found limited evidence to support their ethnic density hypothesis, however, some effects were noted. For those from White Other or mixed ethnicity backgrounds, own group ethnic density was associated with an increased risk of compulsory detention. When exploring own group ethnic density amongst White British patients, the risk of compulsory detention decreased. No significant differences were found in relation to own group ethnic density amongst Black participants and risk of compulsory admission (OR 1.01, 95% CI 0.98–1.05).

**Socio-economic factors**

A number of studies have highlighted various socio-economic differences amongst the various ethnicities and their association with the risk of and influence of compulsory detention, these include age, marital status, social support, accommodation and employment status. Brown49 highlighted living in isolation as an important factor which negatively influenced help seeking. This is further reiterated by Singh et al44 who found living status to have a significant effect on compulsory detention.

Studies have also highlighted that individuals from Black ethnicities over the age of 30 are at increased risk of compulsory detention.43,44 However, this data was contradicted by Singh et al46 who reported that age, gender, employment status and level had no significant effect on risk of compulsory detention for Black-Caribbean service users, however they did find that a greater number of Black-Caribbean service users were single and had poor social support. They further highlighted that Asian service users had good social support and male service users were more likely to be unemployed.

**Risk: self-harm, self-neglect, harm to self and other, harm to property and risk of violence as a predictor of compulsory detention**

Some papers have made reference to levels of risk and this being a positive predictor of compulsory detention. This is reiterated by Lawlor et al42 who reported White British women to be more likely than Black women to be admitted due to risk of suicide and perceived as being at a higher risk of self-harm compared service users from Black ethnicities. Those from Black ethnicities demonstrated an elevated clinician perceived risk to others compared to those from White ethnicities. Clinicians reported White Other and Black women as having an increased risk of admission due to an assault on an unrelated person or destruction of property. This is supported by Singh et al46 who reported Black-Caribbean service users to be perceived as having a greater risk of violent acting out. However, this is contradicted by Bebbington et al45 who found significantly higher scores associated with challenging (aggressive, violent or destructive) behaviour amongst White compulsorily detained service users compared to Black-Caribbean service users.

# **Discussion**

This synthesis aimed to examine the research literature and findings for ethnic inequalities in compulsory admissions within the UK and aimed to address the reasons for increased compulsory admission amongst BME groups, whilst also exploring the risk of compulsory admission to hospital and pathways to mental health services.

Whilst the themes included within this synthesis highlight some explanations for ethnic inequalities, the reasons for compulsory admission to mental health hospitals amongst BME groups continues to be limited. The themes highlight that a majority of individuals from BME groups are referred through the criminal justice system, emphasising high police and court involvement. It can be queried whether there is a level of racial bias and stereotyping within the wider system that continues to influence the majority of individuals going through the criminal justice system. Previous research has highlighted the racial bias that already exists within mental health services and the criminal justice system with Black males often being perceived as more dangerous.27,28 Whilst research and reports continue to state the statistics and figures around this, there is limited to no research exploring the reasons why. It could be implied that those individuals are entering the criminal justice system during crisis and are being misplaced within services as their symptoms and presentation are being overlooked or misinterpreted. Furthermore, it could be argued that the criminal justice system continues to have its own issues with regards to institutional racism and that those from BME groups are being exposed to situations within the system that continue to have a negative impact on their mental health, further exacerbating their difficulties.

The effect of the criminal justice system may have further negative repercussions, creating a cycle of fear within BME groups and leading to a mistrust of services, which in turn creates barriers to help-seeking, with those from BME groups being reluctant to seek support from other services and their GP as highlighted within the results. However, the results highlight some evidence of institutional racism within the wider system as being a contributory factor, as reported by Solanki48 who reported that those from BME groups stated that they sought support from services and were not taken seriously and not adequately supported, further exacerbating their fear and mistrust of services. This is evidenced by McNeil and Binder29 who found evidence of racial bias within the reporting of predictions of violence with psychiatrists over-estimating the potential for violence. An example of this is found within the theme of risk, with reports of those from Black ethnicities having an elevated clinician perceived risk of violence to others and violent acting out compared to those from White ethnicities.42,46 This may have further implications with regards to overdiagnosis amongst BME groups, with research highlighting a strong interaction between ethnicity and diagnosis and the influence this then has on compulsory admission.42,45,46

Ethnicity was defined and categorised differently across the papers (see Table 2). Some studies chose to categorise those from Black ethnicities into categories of Black British born patients/ service users, yet the same categories were not employed for other ethnicities such as those within the Asian categories who are British born. Several papers, Mann et al,41 for example used ethnic categories taken from the 2001 UK census to record ethnicity (based on categories available at the time) whilst other articles, Solanki,48 for example included self-reported ethnicity categories therefore demonstrating the inconsistencies. Whilst other ethnicities were defined by clinicians or taken from clinical notes.42,46

Despite articles making reference to a number of ethnic minorities’ categories and variations being contained within the sample, a majority of ethnic minority categories were actually excluded from the analyses due to small sample sizes. Therefore, the majority of ethnic minorities included and compared within the analyses of several papers were Black British, Black Caribbean and Black African. In some cases, service users who identified of being of mixed ethnicities (Mixed – White and Black/Caribbean) were included within the Black grouping categories further overrepresenting this ethnic group. Differences were also highlighted between the White British and White Other group with the White Other group demonstrating increased risk of compulsory detention compared to the White British group, yet in some studies those belonging to the White Other ethnic category were included within the White British group. The same can also be said for those belonging to Black ethnic categories with several papers highlighting differences between Black Caribbean, Black African, Black Other and Black British groups yet some studies chose to categorise all these categories under ‘Black’ and ignore the ethnic differences amongst the groups.42 Some study titles, Solanki,48 made reference to BME service users, yet contained a sample of majority Black ethnicities and neglected other ethnic groups.

Another methodological issue is that some quantitative papers included within the synthesis were missing data. Some studies compensated for missing data by assigning an assumed value and repeating the analysis for opposite assumptions42 whilst other studies made comparisons for those with and without missing data and re-ran the analysis.41 Additional studies used listwise deletion of missing data before the sample was analysed or simply excluded those with missing data from the analysis.39,43 In some instances where pre-existing data sets were used, other electronic databases and records were used to retrieve missing data.44 This resulted in limited information being provided regarding status, gender, and ethnicity in some samples, further impacting the ability to explore particular relationships within the data during analysis, reducing the internal validity.

All studies relied on pre-existing data sets which contain information recorded by clinicians only. Because accounts of risk of violence to others, barriers to help-seeking, level of GP involvement and overdiagnosis are taken from pre-existing data sets, there is little opportunity to explore the potential of clinician bias and stereotyping. This is emphasised by Sashidharan et al15 who highlighted issues with clinician bias around ethnic variability and how service users met the threshold for risk. It can be implied that additional qualitative data is needed from BME service users in order to reduce clinician reported bias and obtain first-hand detailed accounts of their journey through the system.

Six out of the 11 studies lacked external validity as they often took samples from areas with high ethnic diversity and own-group ethnic density, meaning that the sample was not representative of the UK population. This may also have an influence on socio-economic factors such as the social support available within those communities, level of deprivation, accommodation and employment status, which may affect mental health with regards to overdiagnosis and risk of compulsory admission.39 This is emphasised by Keown et al24 who found own-group ethnic density to be strongly associated with rates of compulsory admission/treatment, however there was reported to be an increased pressure on services due to having a higher concentration of service users at risk of psychosis. Considerations need to be made with regards to where and how data is being collected as areas with a higher proportion of certain ethnicities may produce higher levels of detention due to the sample population.

**Strengths and limitations**

The strength of the current synthesis is that it highlighted that there are poorer outcomes for individuals from BME groups, emphasising a number of wider issues within the system such as racial inequalities in provision and access to services and the role of overdiagnosis amongst BME groups that need to be addressed. Inclusion of grey literature, qualitative and mixed methods studies, highlight the need for more in-depth qualitative detail, providing first-hand lived experiences of BME service users, often missing or excluded from research on involuntary detention for Serious Mental Illness (SMI). A limitation of the synthesis is that the research literature under review contained several methodological issues including using pre-existing data sets, missing data, lack of qualitative lived experiences of compulsory admission, and varying differences within and between the categories used to describe ethnicity in the UK. Only one study by Oluwatayo and Gater47 conducted a power calculation and listed confounding variables with the exception of the qualitative study which was evident during the quality appraisal.

**Clinical recommendations for practice**

Additional research may be needed to focus solely on diagnosis amongst BME groups and increased risk of compulsory admission, and explore clinician’s views of diagnosis amongst BME groups. This may help to further explore the criteria that is being used within diagnostic assessments and how this can be culturally appropriate and not based mainly on western European psychiatry.

More focus and support may be needed within early intervention services and youth offending teams as there were higher rates of adverse pathways to care amongst Black ethnicities with criminal justice involvement significantly influencing compulsory detention. In addition, research needs to focus on exploring the reasons for those from BME groups entering the criminal justice system and then having subsequent referrals into mental health services. Further research is needed to capture BME groups’ journey through the system, including their experiences of mental health provisions pre-admission and clinician decision-making and how individuals experience this decision-making and the effect it has on their experiences.

# **Conclusion**

The review highlighted some explanations in select studies for ethnic inequalities in compulsory admission. However, the reasons for compulsory admissions to mental health hospital amongst BME groups continues to be limited. Emphasising the need for in-depth qualitative research providing first-hand lived experiences of BME service users that are missed or excluded from research surrounding compulsory detention for Serious Mental Illness.

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# **Appendix A**

**Downs & Black Checklist for measuring study quality (Downs & Black, 1998)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Perceived ethnicity and the risk of compulsory admission | | | | |
| Author & Year | Singh et al. 1998 | | | Notes/Justification |
| Reporting | **No = 0** | **Yes = 1** | **2** |  |
| 1. *Is the hypothesis/aim/ objective of the study clearly described?* |  | Yes |  | Clear hypothesis and aim cited |
| 2. *Are the main outcomes to be measured clearly described in the Introduction of Methods section?*  If the main outcomes are first mentioned in the Results section, the question should be answered no. |  | Yes |  | Described sampling method, period of sampling and data collection |
| 3. *Are the characteristics of the patients included in the study clearly described?*  In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given. |  | Yes |  | Characteristics including ethnicity clearly define within the article |
| 4. *Are the interventions of interest clearly described?*  Treatments and placebo (where relevant) that are to be compared should be clearly described. |  | Yes |  |  |
| 5. *Are the distributions of principal confounders in each group of subjects to be compared clearly described?*  A list of principal confounders is provided | **No = 0**  No | **Partially = 1** | **Yes = 2** |  |
| *6. Are the main findings of the study clearly described?*  Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below). |  | Yes |  | Clearly outline in tables and described precisely in the body of text |
| 7. *Does the study provide estimates of the random variability in the data for the main outcomes?*  In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimate used were appropriate and the question should be answered yes. |  | Yes |  | Standard deviation and confidence interval figures are provided |
| 8. *Have all important adverse events that may be a consequence of the intervention been reported?*  This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A List of possible adverse events provided). |  | Yes |  |  |
| 9. *Have the characteristics of patients lost to follow-up been described?*  This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered no where a study does not report the number of patients lost to follow-up. |  | Yes |  | Described reason for excluding Asian service users in further analysis |
| 10. H*ave actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?* |  | Yes |  |  |
| External Validity  All of the following criteria attempt to address the representativeness of the findings of the study and whether they may be generalised to the population from which the study subjects were derived. | **No = 0** | **Unable to determine = 0** | **Yes = 1** |  |
| 11. *Were the subjects asked to participate in the study representative of the entire population from which they were recruited?*  The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine. | No |  |  | Only three categories of ethnicity were used |
| 12. *Were those subjects who were prepared to participate representative of the entire population from which they were recruited?*  The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population. | No |  |  | Only three categories of ethnicity were used |
| 13. *Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?*  For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialised centre unrepresentative of the hospitals most of the source population would attend. |  |  | Yes |  |
| Internal validity – bias | **No = 0** | **Unable to determine = 0** | **Yes = 1** |  |
| 14. *Was an attempt made to blind study subjects to the intervention they have received?*  For studies where the patients would have no way of knowing which intervention they received, this should be answered yes  . |  |  | Yes |  |
| 15. *Was an attempt made to blind those measuring the main outcomes of the intervention?* |  |  | Yes |  |
| 16. *If any of the results of the study were based on “data dredging,” was this made clear?*  Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes. |  |  | Yes |  |
| 17. *In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?*  Where follow-up was the same for all study patients the answer should be yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no. |  |  | Yes |  |
| 18. *Were the statistical tests used to assess the main outcomes appropriate?*  The statistical techniques used must be appropriate to the data. For example non-parametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes. |  |  | Yes |  |
| 19. *Was compliance with the intervention/s reliable?*  Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes. |  |  | Yes |  |
| 20. *Were the main outcome measures used accurate (valid and reliable)?*  For studies where the outcome measure are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes. |  |  | Yes |  |
| Internal validity – confounding (selection bias) | **No = 0** | **Unable to determine = 0** | **Yes = 1** |  |
| 21. *Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?*  For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case control studies where there is no information concerning the source of patients included in the study. |  |  | Yes |  |
| 22. *Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time?*  For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine |  |  | Yes | Details of the period of time the sample was collected has been clearly stated |
| 23. *Were study subject randomised to intervention groups?*  Studies which state that subjects were randomized should be answered yes except where method of randomisation would not ensure random allocation. For example alternate allocation would score no because it is predictable. | No |  |  | This is a non-randomised study |
| 24. *Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?*  All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no. | No |  |  | This is a non-randomised study |
| 25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?  This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In non-randomized studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no. |  | Unable to determine |  |  |
| 26. *Were losses of patients to follow-up taken into account?*  If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes. |  |  | Yes |  |
| Power | **No = 0** | **Yes = 1** |  |  |
| *Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%*  *Sample sizes have been calculated to detect a difference of x% and y%*  0 = <n1  1 = n1 – n2  2 = n3 – n4  3 = n5 – n6  4 = n7 – n8  5 = n8 + | No |  |  | Power or effect size was not mentioned within the method, results or discussion |
| Total = 20  26 – 28 (Excellent)  20 – 25 (Good)  15 – 19 (Fair)  14 or less (Poor)  Categories taken from (Hooper, Jutai, Strong, & Russell-Minda, 2008) Age-related macular degeneration and low-vision rehabilitation: a systematic review |  |  |  |  |

# **Appendix B**

**Downs and Black Checklist (Downs & Black, 1998) including score ranges developed by Hooper et al. (2008)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Author | | | | | | | | |
| Questions | McBride O et al. 2021 | Audini & Elliot, 2002 | Mann et al. 2014 | Lawlor et al. 2010 | Gajwani et al. 2016 | Singh et al.2014 | Bebbington et al. 1995 | Singh et al. 1998 | Oluwatayo & Gater, 2004 |
| Q 1 | Y | N | Y | Y | Y | Y | Y | Y | Y |
| Q 2 | Y | N | Y | Y | Y | Y | Y | Y | Y |
| Q 3 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 4 | Y | N | Y | Y | Y | Y | Y | Y | Y |
| Q 5 | N | N | N | P (1) | N | P (1) | N | N | N |
| Q 6 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 7 | Y | N | Y | Y | Y | Y | N | Y | N |
| Q 8 | Y | N | Y | N | N | Y | N | Y | N |
| Q 9 | Y | N | Y | Y | Y | Y | N | Y | Y |
| Q 10 | Y | N | Y | Y | N | N | N | Y | N |
| Q 11 | Y | U | N | N | N | N | N | N | N |
| Q 12 | Y | N | N | N | N | N | N | N | N |
| Q 13 | Y | Y | Y | Y | Y | N | Y | Y | Y |
| Q 14 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 15 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 16 | Y | U | Y | Y | Y | Y | Y | Y | Y |
| Q 17 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 18 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 19 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 20 | Y | U | Y | Y | Y | Y | Y | Y | Y |
| Q 21 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 22 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 23 | N | N | U | N | N | N | N | N | Y |
| Q 24 | N | N | N | N | N | N | N | N | N |
| Q 25 | N | N | Y | Y | Y | Y | N | U | U |
| Q 26 | U | Y | Y | Y | Y | Y | Y | Y | Y |
| Q 27 | N | N | N | N | N | N | N | N | Y |
| Total | 21 | 11 | 21 | 21 | 19 | 20 | 16 | 20 | 19 |
| Downs and Black appraisal checklist responses: Yes (Y) No (N) Unable to determine (U) Partially (P) | | | | | | | | | |

# **Appendix C**

**CASP Qualitative Checklist (Critical Appraisal Skills Programme, 2018)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Experiences of adults from a Black Minority Ethnic (BME) background who have been detained as inpatients under the Mental Health Act (1983) | | | | |
| Author and Year | Solanki, 2020 (Grey Literature) | | | |
| Section A: Are the results valid? | Yes | Can’t Tell | No | Comments |
| 1. Was there a clear statement of the aims of the research?  Consider  -What was the goal of the research?  -Why it was thought important  -Its relevance | Yes |  |  |  |
| 2.Is a qualitative methodology appropriate?  Consider  -If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants  -Is qualitative research the right methodology for addressing the research goal | Yes |  |  |  |
| Is it worth continuing? | | | | |
| 3. Was the research design appropriate to address the aims of the research?  Consider  -If the researcher has justified the research design (e.g. have they discussed how they decided which method to use) | Yes |  |  |  |
| 4. Was the recruitment strategy appropriate to the aims of the research?  Consider  -If the researcher has explained how the participants were selected  -If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study  -If there are any discussions around recruitment (e.g. why some people chose not to take part) | Yes |  |  | Recruited participants through the NHS |
| 5. Was the data collected in a way that addressed the research issue?  Consider  -If the setting for the data collection was justified  -If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)  -If the researcher has justified the methods chosen  -If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)  -If methods were modified during the study. If so, has the researcher explained how and why  -If the form of data is clear (e.g. tape recordings, video material, notes etc.)  -If the researcher has discussed saturation of data | Yes |  |  | Research procedure and data collection are thoroughly described.  Described how the interviews were conducted, topic guide was used and explained how this was developed |
| 6. Has the relationship between researcher and participants been adequately considered?  Consider  -If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location  -How the researcher responded to events during the study and whether they considered the implications of any changes in the research design | **Yes** |  |  | Researcher commented on reflexivity and reflected on being a BAME individual and recognised that her experiences may not be the same as other BAME individuals |
| Section B: What are the results? | | | | |
| 7. Have ethical issues been taken into consideration?  Consider  -If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained  -If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)  -If approval has been sought from the ethics committee | Yes |  |  | Very detailed description around confidentiality and ethical considerations |
| 8. Was the data analysis sufficiently rigorous?  Consider  -If there is an in-depth description of the analysis process  -If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data  -Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process  -If sufficient data are presented to support the findings  -To what extent contradictory data are taken into account  -Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation | Yes |  |  | Thematic analysis was used and the theme’s and sub-themes described in detail. An extensive reflective account is provided at the end of the Thesis |
| 9. Is there a clear statement of findings?  Consider  -If the findings are explicit  -If there is adequate discussion of the evidence both for and against the researcher’s arguments  -If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)  -If the findings are discussed in relation to the original research question | Yes |  |  |  |
| Section C: Will the results help locally? | | | | |
| 10. How valuable is the research?  Consider  -If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature  -If they identify new areas where research is necessary  -If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used | Yes |  |  |  |

# **Appendix D**

**Mixed Methods Appraisal Tool – Version 2018 (Hong et al., 2018)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Understanding Excessive Rates of Compulsory Hospital Admission amongst Black-Caribbean Patients, During First Episode Psychosis (FEP) | | | | |
| Author and Year | Brown, 2015 | | | |
| Questions | Yes | No | Can’t Tell | Comments |
| Screening Questions | | | | |
| S1. Are there clear research questions? | Yes |  |  |  |
| S2. Do the collected data allow to address the research questions?  *Further appraisal may not be feasible or appropriate when the answer is ‘No’ or ‘Can’t tell’ to one or both screening questions* | Yes |  |  |  |
| Qualitative | | | | |
| 1.1. Is the qualitative approach appropriate to answer the research question? | Yes |  |  |  |
| 1.2. Are the qualitative data collection methods adequate to address the research question? | Yes |  |  |  |
| 1.3. Are the findings adequately derived from the data? | Yes |  |  |  |
| 1.4. Is the interpretation of results sufficiently substantiated by data? | Yes |  |  |  |
| 1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation? | Yes |  |  |  |
| Quantitative randomized controlled trials | | | | |
| 2.1. Is randomization appropriately performed? | n/a |  |  |  |
| 2.2. Are the groups comparable at baseline? | n/a |  |  |  |
| 2.3. Are there complete outcome data? | n/a |  |  |  |
| 2.4. Are outcome assessors blinded to the intervention provided? | n/a |  |  |  |
| 2.5 Did the participants adhere to the assigned intervention? | n/a |  |  |  |
| Quantitative non-randomized | | | | |
| 3.1. Are the participants representative of the target population? |  | No |  |  |
| 3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)? | Yes |  |  |  |
| 3.3. Are there complete outcome data? | Yes |  |  |  |
| 3.4. Are the confounders accounted for in the design and analysis? | Yes |  |  |  |
| 3.5. During the study period, is the intervention administered (or exposure occurred) as intended? | Yes |  |  |  |
| Quantitative descriptive | | | | |
| 4.1. Is the sampling strategy relevant to address the research question? | Yes |  |  |  |
| 4.2. Is the sample representative of the target population? | Yes |  |  |  |
| 4.3. Are the measurements appropriate? | Yes |  |  |  |
| 4.4. Is the risk of nonresponse bias low? |  |  | Can’t tell |  |
| 4.5. Is the statistical analysis appropriate to answer the research question? | Yes |  |  |  |
| Mixed methods | | | | |
| 5.1. Is there an adequate rationale for using a mixed methods design to address the research question? | Yes |  |  |  |
| 5.2. Are the different components of the study effectively integrated to answer the research question? | Yes |  |  |  |
| 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? | Yes |  |  |  |
| 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? | Yes |  |  |  |
| 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? | Yes |  |  |  |

# **Appendix E**

***BJPsych Open* Author guidelines**

Please refer to the following website for a full list of author guidelines:

<https://www.cambridge.org/core/journals/bjpsych-open/information/instructions-contributors#_Review>

**Paper**

* The word count should be between 3000 and 5000 words in length (excluding references, tables and figure legends) and may include up to 40 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study.
* Structured abstract of up to 250 words with the headings: Background; Aims; Method; Results; Conclusions (Trial Registration Number and Data Set Information where appropriate). Please find further guidance on writing an effective abstract here.
* Quantitative studies: abstracts should provide effect sizes with confidence intervals (not P-values alone).
* Conclusions, in isolation, are likely to be used by others citing or promoting the work and must therefore be an accurate reflection of the study's main findings.
* Tables and Figures - there is no limit for tables and figures unless the number becomes cumbersome and detracts from the paper. We recommend that large tables and figures (exceeding one journal page) should be included as supplementary material.
* Main Text - The main text should include the following sections: Introduction, Method, Results and Discussion.
* Introductions should normally be no more than one paragraph. Longer introductions may be permissible but should be split with subheadings if they exceed two paragraphs.
* Discussion should always include limitations of the paper to ensure balance, use of subheadings is encouraged in this section.
* A Conclusions section is not required in the main text.

**Review**

* There is no word limit or maximum number of references, tables or figures.
* The abstract and main text should be structured in the same way as Papers.
* We require authors to register the protocol for systematic reviews before data extraction on an accessible, searchable site such as PROSPERO. Please include the registration number in the abstract. If the review has not been registered, we are unable to consider your submission.
* Systematic reviews are preferred, narrative reviews will be published only under exceptional circumstances.
* Previously published Reviews for groups such as the Cochrane Collaboration and the National Institute for Health and Care Excellence should be submitted with the latest version of the parent review and its status, so an informed decision can be made about the added value of the submitted paper.

# **Paper 2: Exploring the experiences of Black Men through the decision-making process in secure settings: A qualitative study**

This empirical paper has been prepared for The Journal of Black Psychology and the author guidelines are in Appendix P

# **Abstract**

**Background**

Research has highlighted those of Black ethnicity not being involved in key aspects of decision-making and having more negative experiences of inpatient provisions

**Aims**

To explore Black men’s experiences of decision-making processes within forensic inpatient settings and their perceptions of these services

**Method**

The study used Interpretative Phenomenological Analysis (IPA) and semi-structured interviews were conducted with 5 Black men aged 33-40 who had experiences of forensic inpatient provisions within the last 10 years and now been discharged.

**Results**

Eight Group Experiential Themes (GETs) and 9 sub-themes were identified, including: the role of/ significance of medication, family involvement in decision-making and compliance with treatment and concordance around treatment.

**Conclusion**

Participants highlighted a lack of involvement in decisions around their care. Forensic services and inpatient provisions need to support Black men to be involved in shared decision-making and encourage collaborative involvement in decisions.

*Keywords:* Black men, forensic inpatient settings, decision-making, IPA

# **Introduction**

Literature within the United Kingdom (UK) has highlighted the disparities that exist and continue to exist between African and African Caribbean individuals compared to other ethnic groups with regards to compulsory admission, mental health experiences and treatment (Raleigh & Goldblatt, 2021; Robertson et al., 2021). Statistics from 2021 highlighted compulsory admission amongst Black and Black British individuals being four times higher than White individuals (NHS Digital, 2021).

Postcolonial theory suggests that diagnostic categories used within psychiatry are informed by racism, which originates from slavery. Influencing an oppressive, colonial mindset rooted in stereotyping, racial bias and dysconscious racism which has been maintained within the UK (Walker, 2020). Researchers have suggested decolonising psychology through discussing colonial history associated with race and racism, exploring the issues surrounding White privilege and Whiteness (Wood & Patel, 2017).

Majors et al. (2020) focused on the mental health needs of Black men within the UK, highlighting several negative experiences within mental health services and the impact these experiences have had on their engagement with mental healthcare professionals. Experiences include: the overuse/misuse of medication, coercive pathways to care, increased barriers to accessing psychological therapy and the mistrust of mental health and psychiatric services (Majors et al., 2020). It can be inferred that individuals of Black ethnicity are seeking appropriate support from mental health services to assist with processes of change and development. However, healthcare professionals may not always consider the social constructs of race and the influence of discrimination and oppression, alongside the interplay that occurs between the power employed in clinical systems of psychology and psychiatry when liaising with individuals from Black ethnicities, which can impact their sense of self, wellbeing and position in society (Fernando, 2017; Majors et al., 2020).

There is an increasing need for research to support Black men to be able to discuss their concerns and difficulties surrounding their mental health and mental health services. Keating (2021) explored Black men’s thoughts and experiences of mental health through photographs. Participants further highlighted the difficult and coercive pathways to care, speaking of a fear and mistrust of engaging with mental health services, with professionals mishandling distress, being influenced by stereotypical views, and demonstrating a reluctance to engage with Black service users. A key finding of the research was how Black men believed they were perceived by those in their community, needing to be strong as Black men and being perceived as dangerous, violent and aggressive by professionals and those outside of their community (Keating, 2021). Black men being perceived as dangerous has been a common feature within research. Walker (2020) highlighted the common ideology and stereotype of Black men being perceived as more dangerous within mental health services and how this narrative has further supported the dehumanisation of the Black man, increasing the risk of overuse of force and sedative medication as they are perceived as a threat. This is supported by Salla and Danso (2018) where service users reported several discriminatory practices including unnecessary use of force, unjustified suspicion; lack of effort to communicate; overuse of sectioning; more restrictive care; over-reliance on psychotropic medication and lack of access to evidence based psychological care. It was also felt that some of these discriminatory practices were extensions of institutional racism experienced by Black service users and their families in their daily life.

## Decision-making and the Universal Personalised Care Model

The NHS Long Term Plan reported patient-centred care as being at the forefront of services providing care that is respectful of and responsive to service users preferences, needs and values, highlighting the importance of these values guiding all clinical decisions (NHS England, 2019). Shared decision-making (SDM) was referenced as part of The Universal Personalised Care Model. Elwyn et al. (2012) defined SDM as a process where patients and clinicians are able to make decisions together, based upon the best available outcomes. Taking into consideration the advantages and disadvantages of each other and ensuring patients are supported to make clinically informed decisions. However, it has been queried how SDM can be implemented within secure and forensic services due to potential concerns around service user’s capacity, insight and risk. Research has reflected on compliance, adherence and concordance within psychiatry and the clinician-service user relationship emphasising the importance of obtaining the service users’ perspectives and ensuring the appropriate treatment is decided following a discussion with the service user. Concordance ensures that there is an agreement between the clinician and service user which enables them to have open discussions around treatment. It is important that these processes are considered when reflecting on decision-making (Chakrabarti, 2014).

## Decision-making

Research has highlighted concerns around those from Black communities appearing to not be involved in key aspects of decision-making such as decisions around medication that do not require the force of the law, with compulsory treatment and medication often being used to manage risk and mental health for these communities (Clarke, 2020). This is reiterated by Urquía and Salla (2019) who explored Black men’s experiences of the secure care pathway. Black men reported that they were not consulted with regarding decisions made around their medication. They also stated that they felt they were being given stronger medications compared to their White counterparts, and they questioned whether this was due to them being perceived as more dangerous. It can be inferred that this lack of involvement within decision-making leads to disempowerment further highlighting the power imbalances that are reflected within the mental health system (King, 2019). However, this has not been explored further within the literature. This highlights the need to involve Black men in decision-making to thoroughly define their needs and how these needs can be met.

Research has evidenced structural disadvantages amongst ethnic minorities and how these disadvantages contribute to and are sustained by their experiences within mental health services (Lawrence et al., 2021). Lawrence et al. (2021) reported that White British family members and White service users with psychosis experienced greater success at being able to negotiate their treatment and challenge psychiatric decisions compared with their Black Caribbean counterparts. The researchers highlighted that Black Caribbean service users did not feel listened to by professionals and their concerns were unheard. This is reflected in the research of Salla and Danso (2018) where Black service users in secure settings highlighted unequal and unfair treatment at several decision-making points. They also reflected that their difficult social experiences such as the effects of racial trauma were not taken into consideration when professionals were making decisions.

## Aims of Study

The study aims to explore Black men’s experiences of decision-making processes within forensic inpatient settings and their experiences and perceptions of these services. This study aims to expand upon the research of Salla and Danso (2018) and Urquía and Salla (2019) as biased decision-making was a theme that came out of their research but not fully explored.

# **Method**

## Ethics

The study was reviewed and approved by Staffordshire University Ethics Committee (see Appendix A). Participants were informed about the potentially distressing nature of the research via the Participant Information Sheet (see Appendix B) and steps were taken to manage sensitive issues appropriately and respectfully through checking in with participants during the interview to check on their wellbeing when distressing topics arose, alongside providing an opportunity for reflection and debrief after the interview.

Participants were debriefed and they were provided with a list of support services offering additional support via the Debrief Sheet (see Appendix C) and given additional time following debrief to reflect on the interview process. Informed consent was gained using a consent form (see Appendix D) which was presented online via Qualtrics (Qualtrics, 2022) or through electronic signature on the PDF document in both prior to taking part in the research and participants were given the option to choose their own pseudonyms to maintain anonymity and confidentiality.

## Design and approach

The research aims to capture the experiences of men of African and/or Caribbean heritage using a qualitative idiographic approach, focused on understanding, and exploring those experiences phenomenologically. It was therefore felt that Interpretative Phenomenological Analysis (IPA) would be an appropriate methodology over Thematic Analysis as IPA focuses on examining personal lived experience, understanding individual experiences and how participants make sense of their experiences (Smith et al., 2009; Smith, 2011). Whereas, Thematic Analysis focuses on common and shared meanings, more suited to constructivism (Kiger & Varpio, 2020). IPA requires intensive qualitative analysis and detailed accounts of participants’ experiences, and it is recommended that the method of data collection is in-depth, semi-structured interviews (Smith et al., 2011) as they allow more flexibility than a more conventional structured interview (Wengraf, 2001).

An interview schedule (see Appendix E) was used to ensure that the information gathered coincided with the research question.

## Epistemology and IPA

Epistemology is the theory of knowledge, which explores how knowledge is gained and what sources are used to gain this knowledge. It is important for the researcher using IPA to be aware of their epistemological position with regards to their view of the world and how their knowledge may influence the interpretation of the data (Smith et al., 2021). The epistemological position of the researcher was interpretivism due to believing that knowledge is generated as individuals interpret their experiences of the world. The researcher approached the research with an awareness that individuals can experience the same objective reality in different ways (Schwandt, 1994). Given the social constructs that exist around race as a social construct (Bryant et al., 2022), racism as a discriminatory practice, and the lived experience of Black males in mental health settings, the researcher was aware of their own cultural heritage and experiences of injustice as a Black woman when assigning meaning to the experiences of Black males.

## Reflexivity

As a Black woman and mental health professional with my own personal experiences of racism, prejudice, discrimination, and racial injustices, it was important for me to engage in several reflective processes throughout the research journey. Engward and Goldspink (2020) suggest the use of a reflective diary, which I used to facilitate self-awareness and record discussions around my own frustrations and difficulties encountered during the research journey (see Appendix F for an excerpt). A bracketing interview was used to protect against emotionally challenging material and explore my own beliefs and identify biases within the research process that may potentially influence the analytical process. This ensured a valid and reliable interpretation of participants’ lived experience (Tufford & Newman, 2012).

### ***Co-production and service user involvement***

It has been highlighted that co-production helps to promote a culture of shared learning and innovation (Applied Research Collaboration - Kent, Surrey and Sussex, 2021). As a Black professional within mental health and being aware of the stigma that still exists within the Black community around talking about mental health difficulties, it was important to the researcher to involve Black male service users and Experts by Experience (EBE) from the start of the study to obtain their views, experiences, skills, and knowledge to help shape the research (NIHR, 2021).

Two Black male EBE with prior experiences of secure settings were approached via a charitable organisation to obtain their perspectives of being a Black male within these settings alongside their thoughts about the project and the key issues they felt needed to be addressed within the research.

The researcher consulted their research and clinical supervisors, alongside EBE and experienced clinicians within the field to develop the interview schedule to identify appropriate questions.

## Recruitment

Participants were recruited using online posters (see Appendix G) from August 2021 until March 2022 that were distributed to community organisations specialising in Black mental health as well as social media platforms such as Twitter, Facebook, and Instagram. The researcher’s university email was provided in recruitment materials to provide participants with the opportunity to express interest in the research and discuss the study in more detail with the researcher. Letters of invitation (Appendix H) were also sent to community groups alongside the poster to aid recruitment. The researcher also benefited from speaking with individuals within the Black community about Black mental health and discussing the importance of the research, which gained interest through word-of-mouth.

To establish relationships with mental health groups within the community, permission was obtained to speak with the heads of service of the community organisations who acted as gatekeepers to discuss the research further. From these discussions the researcher was invited to team meetings to discuss the research with the wider team to then circulate amongst service users they were working with.

Following expressions of interest in the research, participants were provided with a participant information sheet (see Appendix B) informing them about the research and providing support networks for participants to access before and after interviews to help manage potential distress. For those wishing to have more detailed discussions regarding the research, the researcher spoke with participants via telephone and answered any additional questions. Informed consent was obtained using a consent form (see Appendix D). The consent form and participant information sheet were also uploaded and sent via Qualtrics to increase accessibility. Pseudonyms were used to maintain the anonymity and confidentiality of the participant and all identifying information was removed, such as locations and names of facilities. As the participants were required to disclose quite personal experiences, some participants requested the interview schedule prior to the interview so they were able to make supplementary notes in preparation for the interview.

The research was conducted during the Covid-19 pandemic and followed BPS guidance for conducting research during the pandemic and subsequent restrictions around face-to-face research (BPS, 2021). Semi-structured interviews were recorded using Microsoft Teams and BPS guidance around internet mediated research (BPS, 2021a) was followed around obtaining valid consent for video recording, data security and respecting the privacy and dignity of participants. Interviews lasted between 45 to 90 minutes and recordings were saved to Staffordshire University Microsoft server (One Drive) account for additional security so they could be transcribed following the interview. Participants were encouraged to inform the researcher if they were experiencing fatigue or concentration difficulties and wished to take a break from the interview and were invited to take short breaks throughout the interview. Following the interview, participants were provided with a debrief sheet (see Appendix C) and time to reflect on the interview.

## Participants and sampling

Purposive sampling using the Criterion-I sampling strategy, which involves identifying important criterion, was used to identify participants who possessed the knowledge and experience of the phenomenon of interest (Palinkas et al., 2015). Participants were Black men of African and/or Caribbean heritage over the age of 18 who have been discharged from forensic inpatient services and had an admission to or experiences of a forensic inpatient setting within the last ten years to capture retrospective accounts of their experiences. Taking into consideration the time frame and to be inclusive of everyone’s experiences and minimise barriers to participating, the researcher allowed participants up to the age of 65. Due to a lack of funding, there was no access to an interpreter, therefore participants needed to be proficient in speaking and understanding the English language (see Table 1).

In keeping with qualitative methodology and IPA and sample size sufficiency (Kerr et al., 2010), the study recruited 5 participants. Clarke (2020) and Smith et al. (2021) recommends 4-10 participants for professional doctorate research due to the level of detail needed to account for individual experience.

## Table 1

*Participant eligibility criteria*

|  |  |
| --- | --- |
| Inclusion Criteria | Exclusion Criteria |
| Male | Those who have not had experience of forensic inpatient settings |
| African and/or Caribbean or identify as being Black | Females |
| Must have had an admission to a forensic inpatient provision within the last 10 years and now discharged | Over 65 years old |
| Proficient in English | Lack of capacity to give informed consent, if capacity to consent is in doubt, the participant will not be included in the study |
| 18 – 65 years old | Not proficient in English or unable to understand and communicate in English |
| Be willing to and able to provide informed consent |  |

## Analysis

All interviews were transcribed verbatim, and the researcher followed the steps for analysis outlined in Smith, Flowers, and Larkin (2021) using the updated terminology. What was previously referred to as emergent themes is now called experiential statements and experiential statements now form Personal Experiential Themes (PETs) which are then developed into Group Experiential Themes (GETs). The initial step to IPA analysis involves immersing oneself in the data. Therefore, the researcher read and re-read the transcripts several times and watched the video recordings of the interviews. During this process, the researcher made notes reflecting on their initial thoughts, feelings, and observations regarding each transcript (see Appendix I for transcript excerpt). Given some of the distressing content contained within the transcripts, this helped the researcher to reflect on the parallel processes surrounding their feelings of anger that occurred alongside the reading of the data.

The researcher read the transcripts and highlighted text and phrases that appeared important, reflecting on what the phrases told the researcher about the participant’s experience/world. This strategy helped to form exploratory notes, which were written alongside each transcript, which had a phenomenological focus reflecting on the participants concerns, thoughts, emotions and experiences of compulsory detention and decision-making. Notes consisted of linguistic, descriptive and contextual commentary, including repeated phrases and reflections on how participants felt (see Appendix J). Exploratory notes were examined and used to construct experiential statements relating to each participant’s experience (see Appendix K). Connections were sought across experiential statements, clustering statements that the researcher felt fit together (see Appendix L). Clusters of experiential statements were given a title to describe its characteristics which became the participants’ Personal Experiential Themes (PETs) which were divided into sub-themes (see Appendix M). These steps were completed for each transcript and once this was completed the researcher worked with the PETs established from each transcript to develop Group Experiential Themes (GETs) across transcripts along with sub-themes, considering convergences and divergences at group level between the participants (see Appendix N). This was placed into written format into a table highlighting the GET and sub-theme, including the relevant experiential statements and quotes from the contributing participants (see Appendix O). Quotes that best reflected the GET and research study were selected from the GET table in Appendix O to include in this report.

# **Results**

The researcher experienced numerous barriers to recruitment and found recruitment extremely challenging. Additionally Black male service users were approached to enhance reflexivity regarding the researcher’s own frustrations around recruitment and the effect these may be having on the research. The researcher discussed potential barriers to recruitment which included Black male’s being reluctant and/or uncomfortable around providing retrospective accounts of their experiences due to being in a more positive time of their life. Suggestions were made as to how potential participants could be approached to build rapport and trust and aid recruitment; including getting involved in Black male support groups and offering incentives to taking part in the research. The researcher attended two staff meetings at a community organisation and attended an event focused on Black men having open discussions around mental health. Eight Black men expressed interest in the study and three declined to take part in the study. When the researcher queried why, one reflected that they were in a more positive place in their lives and therefore did not wish to reflect back on previous negative experiences. Another potential participant felt that they were not in a stable enough mental state to discuss their previous experiences and the other potential participant declined to comment.

The study utilised an IPA approach and it is important to note participants’ pathways into services. Three out of the five participants spoke of experiencing psychosis which was perceived to be triggered by cannabis (see Table 2). Analysis of each participant’s Personal Experiential Themes (PETs) led to the development of eight Group Experiential Themes (GETs) and nine sub-themes taking into consideration the convergences and divergences at group level between participants (see Table 3). Not all GETs had a sub-theme and not all participants’ experiences will be detailed in the results.

## Table 2

*Participant characteristics*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pseudonym | Age Range | Ethnicity (self-reported) | Year of admission | Reason for admission (self-reported) |
| AL | 35 - 39 | Mixed heritage – Caribbean and Caucasian | 2012 | Drug induced psychosis |
| David | 30 - 34 | Nigerian | 2012 | Psychosis (Bipolar) |
| John | 35 - 39 | Black Caribbean – Jamaican | 2016-2017 | Drug induced psychosis |
| Nana | 40 - 44 | Ghanaian | 2017 | Psychosis (Schizophrenia) |
| Leon | 35 - 39 | Mixed heritage – Caribbean and Irish | 2000-2015 | Psychosis (Schizoaffective disorder) |

## Table 3:

*List of Group Experiential Themes (GETs) and sub-themes*

|  |  |
| --- | --- |
| GETs | Sub-themes |
| 1. The role of/significance of medication | 1.1 Medication adherence – no choice |
| 1.2 Medication used as behaviour management |
| 1.3 Level of involvement in decisions about medication |
| 1. Family involvement in decision-making | 2.1 Family advocating on their behalf |
| 1. Interactions with healthcare professionals | 3.1 Influence of staff interaction on decisions |
| 3.2 Experience of decisions made by professionals |
| 1. Compliance with treatment and concordance around treatment | 4.1 Needing to comply to avoid consequences |
| 4.2 Need to act on own volition |
| 1. Coercion and use of power to control and dehumanise |  |
| 1. Interactions with service users | 6.1 Influence on decisions |
|  |
| 1. Wanting provisions that meet service user needs |  |
| 1. Significance of ethnicity |  |

# **The role of /significance of medication**

This group experiential theme provides interpretations of participants’ experiences of decisions made around medication and their level of involvement in these decisions.

## *1.1 Medication adherence – no choice*

Four out of five participants spoke about having a lack of choice around their role in decision-making concerning medication and having to accept the medication regardless of their thoughts and perceptions of the medication: "That's not even an option. You [leans forward] *have to* take medication on the ward”(David, p.4)

There is a sense of participants feeling like professionals did not consider their level of maturity when considering medication and having control over them, explaining that it “infantilizes you.” "I felt like, I felt like I had no choice…[pauses] it kind of…infantilizes you and makes you feel like a child" (John, p.7)

## *1.2 Medication used as behaviour management*

Several participants spoke of medication being used as a strategy to manage what may be considered as undesirable behaviour by staff on the ward. This could include medication being used to make an individual calmer when presenting in a highly anxious and distressed state "they’ll be like telling you to calm down and if not then they’ll restrain you or give you like an injection…to make you like calm down or they’ll tell you to take a tablet to calm down" (Nana, p.4)

It was felt that some participants viewed the use of medication in a negative way which was used as a form of control to elicit more desirable behaviours on the ward. Leon described medication being used forcibly during restraint and this being often being used as a way to manage his behaviour when he was “kicking off” and not complying with his medication: “I was always getting restrained…getting pinned down and [looked solemn] getting injected” (Leon, p.8)

## *1.3 Involvement in decisions about medication*

Some participants reflected on having minimal influence and involvement with professionals regarding their decision to medicate and being unaware of the processes around medication: "I had no idea [shakes head] of the process at all" (John, p.7) “They was like “ahh you have to take it, you have to take it, because…that’s the drug the psychiatrist gave you.” (Nana, p.7)

However, some participants referred to being involved in some aspects of the decision-making process around decisions to medicate through medication reviews which were used to establish their thoughts and feelings around the medication: "Yeah, I was there, of course, of course. Yeah, I was there, I was there. You can't just pop up and say “here, this is what you are gonna be taking” [laughs]" (David, p.10)

Leon reflected on the benefits of speaking with a different clinician, where he felt valued and heard which enabled him to have the confidence to express wanting a change of medication: "then I started talking to the doctor and you know, saying“look maybe these aren’t working, the medications are doing this to me.” Then they started giving me different medications to see if they would work" (Leon, p.11)

# **Family involvement in decision-making**

Family featured heavily throughout participants accounts of their time on the ward, with family often advocating for participants at times when they were unable to advocate for themselves and professionals providing information to family members regarding the care of participants and communicating decisions that were made.

## *2.1 Family advocating on their behalf*

Four out of five participants described their family members being involved throughout their time on the ward and being informed by professionals at key points in their care and decisions that were being made regarding their care. They spoke of benefiting from having family members, mainly their mothers advocating for their care on their behalf which they felt influenced decisions that were made regarding their care: "Yeah every step of the way [nodding] they were involved, my family. If they weren’t involved [shakes head and looks up] then I don’t know where I woulda been by now." (Nana, p.8). With some expressing that they believed they experienced more positive treatment due to family involvement and believe they would have encountered more negative experiences had it not been for their family: "I think that erm because I had a supportive family, they might have treated me a lot better than they treat some other people." (John, p.14)

Leon reflected on the impact of not having family members involved in his care, meaning that all decisions were made by the mental health team. He highlighted that in the absence of family members, other sources of support, such as friends were not contacted and involved in decisions around his care: "I haven’t spoken to family for years so [sad expression] So it's all been made like by the team, not, not me, and not any of my friends and stuff so." (Leon, p.8)

# **Interactions with healthcare professionals**

## *3.1 Influence of staff interaction on decisions*

Some participants felt that their interactions with staff on the ward contributed to how they were perceived by other clinicians which they felt coincided with decisions made regarding their care. David recalled positive interactions with staff members on the ward helping them to feel at ease: “I don't know if it influenced decisions that was made about my care, but I know it definitely made my stay much easier” (David, p.8)

David went on to state that he felt interactions with staff can have a negative influence on service users mental state as staff have access to participants when they are at their most vulnerable: “I think staff can trigger patients even more than anything [leans forward] because like they've got access to you at your most vulnerable state” (David, p.8)

He also highlighted the limited interactions that occurred between himself and staff on the ward, implying that staff on the ward only converse with service users at specific times (during meal and visiting times, for example) which may have contributed to feeling lonely and isolated: “So I think the only time you really get spoken to is erm, food time, medication time and visitation time.” (David, p.5)

All participants described feeling confused regarding their admission and why they had been placed due to limited interactions with staff on the ward. There was a sense of participants feeling like they did not belong on ward and feeling somewhat detached from the ward environment, with reality not coinciding with their own perceptions of reality:

"I didn’t really know where I was…they wouldn't let me leave. So I couldn't recognise that I was in the hospital, really…You feel like what's happening, is what's happening and everyone else is mad…I didn't really think at the time that I was suffering from anything.” (John, p.5)

## *3.2 Experience of decisions made by professionals*

Some participants described a lack of involvement regarding the decisions made around their care, highlighting those decisions were often not explained by clinicians which left participants feeling dismissed, overlooked and viewing clinicians as officious and lacking sympathy:

“Erm, I felt that they were a bit officious and not very sympathetic…None of them would tell me what was going on really. And so I felt a bit ignored…Doctors at the end of the bed would like, natter to themselves and discuss something and then walk away…I felt like I wasn't involved in any decision-making process apart from what to eat for dinner” (John, p.7)

Participants reflected on not feeling listened to by professionals which left them feeling alone and neglected, particularly when some participants made complaints which they felt were ignored and not upheld: “I put in a PALS complaint [about a racist remark] and then nothing, nothing happened.” (Leon, p. 13)

However, some spoke of feeling supported by staff through being guided by staff regarding how they should behave on the ward to help them work towards discharge:“if you get some nice staff they will tell you, you know they’ll be nice to you and stuff like that….tell you ”you should just, you know behave yourself, do what you have to do and just leave.” (Nana, p.5). Whilst others reflected on the benefits on being involved in professional’s meetings. With professional’s meetings being used to establish and review participants’ wellbeing and mental state “Yeah we went to a few like…meetings and stuff…talking about mental health problems and what those problems were and how we could cope, cope with them and manage them” (AL, p.2)

In hindsight some participants acknowledged the role of clinicians and clinicians needing to lead on their care due to their mental state, even though this may have conflicted with how they felt at the time:

“half of me feels like it's an outrage, because we should be [involved in care]. But I can see why, when you're not in your right mind, other people do have to kind of take over because your mind is not telling you the right things.” (John, p.8)

# **Compliance with treatment and concordance around treatment**

Compliance featured heavily in all participants’ experiences of their time on ward with participants stating that they felt they had no choice but to comply with treatment, whilst feeling like they needed to act on their own volition. This also overlaps with the sub-theme medication adherence and behaviour management.

## *4.1 Needing to comply to avoid consequences*

There was a sense of participants feeling like they had to comply with the rules of the ward and having very limited control over their environment. Participants spoke of feeling like they had to comply with their treatment to avoid additional time being added to their admission which would have had a detrimental effect on their mental health, with many participants developing a fear and anxiety regarding a lengthier admission:

“If you’re not taking your medication, you’re not complying or you’re not doing the things you have to do to, to get out of there, then basically…its like torture basically…you’re just gonna be in there for a, a long time…You’ll be in there for life basically, if you don’t comply.” (Nana, p.3)

When discussing what compliance looked like for Nana he quoted: “Complying…you just have to abide by the rules basically because if you don’t you’ll just be in there for a long time” (Nana, p.3)

Different interpretations could be derived from Nana’s narrative. It can also be assumed that the participant’s fear of additional time being added to their admission and delayed discharge influenced their own decision to comply with treatment.

## *4.2 Needing to act on own volition*

In order to take some control back regarding their experiences and to avoid potential additional negative experiences, participants spoke of needing to act on their own volition, surrounding how they behaved on the ward and also being able to advocate for themselves in relation to decisions around their care:

“I was like “Yo my birthdays coming up, I need to get out of here” And then…a meeting got set up, and then they did obviously a review and then I ended up getting discharged. But if I didn't push for it, I don't know if that would have happened.” (David, p.6)

# **Coercion and use of power to control and dehumanise**

Several participants spoke of feeling powerless and helpless when interacting with clinicians and feeling like clinicians had authority over them and decisions that were made regarding their care. This was especially prevalent when discussing the use of physical restraint and feeling like they were unable to provide informed consent to treatment and decisions around their treatment due to their mental state and also due to feeling powerless: “So I had to sign it and I was actually signing my consent to being sectioned and I had absolutely no idea that I was, erm, consenting to be submitted in” (John, p.6). Some participants also referenced privilege revocation, where a demonstration of behaviours on the ward or outside the ward which were deemed undesirable resulted in a loss of privileges such as being granted leave from the ward: “You’ll get like, in trouble for that [not complying] and you could lose your like, your privileges, privilege like to go out or something.” (Nana, p.6)

Leon spoke of feeling like he had no control over what was happening to him and spoke of sectioning being used to manage his behaviour, following engaging in violent behaviour in prison:

“And then like when I got, on a, you know a criminal section. They, they talked to me about it, but I didn't, you know, there was nothing [pause] I could do about where I was going or what I was doing really.” (Leon, p.5)

Leon also reflected on being strip searched on the ward and how this left him feeling humiliated and shamed but not having the power to do anything about what was happening:

“And then when I got made to stand there in the room with like four or five people just being strip searched, it was a bit, you know, the only other time I’ve had that done that was in prison.” (Leon, p.13)

# **Interactions with service users**

Participants spoke of interactions with other service users on the ward being a key part of their experiences on the ward and how they were perceived by clinicians.

## *6.1 Influence on decisions*

Some participants felt that who they associated with on the ward regarding service users contributed to how they were perceived on the ward by clinicians, which influenced decisions made regarding their care:

“If you had like people like who like get themselves in trouble…if you’re involved with them, they will tell you like, keep away from that person, because you will get yourself, like, in trouble, so just like keep away from them and if you don’t then you actually get yourself involved with that person, then you will get yourself in trouble, so that’s a no no basically…You learn from your mistakes basically” (Nana, p.6).

# **Wanting provisions that meet service user needs**

# 

All participants were asked to reflect on anything they would have liked to have happened differently throughout their care to establish how provisions can meet their needs. Some participants highlighted where provisions were inadequate, which raised a number of considerations and recommendations for clinical practice:

“I mean, I could say I’d have liked someone to talk to me on a proper level…someone just talking to me a bit more.” (Leon, p.14)

“Yeah, I would have liked to have been explained the decision-making processes, what I was given and why I was there…so you are not sitting there in utter confusion and not knowing where you are and what is happening to you.” (John, p.13)

# **Significance of ethnicity**

Some participants felt there was a racial element within the system, believing that admissions were racially motivated with those governing the system segregating secluding ethnic minorities in particular hospitals:

“Yeah…I read that black people are the majority in hospitals but uh the three that I’ve been to, there was one that was predominantly black when I was in [location removed]. There was a lot of guys like Asian guys in there and a couple of white guys in there. And then, when I was in the first one, it was all white people. I think there was one other black guy or two other black guys but I can remember it just being me. The last hospital I was in, all white guys again, so you know, yeah, its, its not a mixture. Its secluding, you know, different races and for the people that govern it, I feel like you know they want certain races together.” (Leon, p.15)

Others also spoke of the wards having a lack of culturally appropriate food and their cultural needs often not being met despite requests being made. Some participants also reflected that having a lack of ethnic staff on the wards made them feel like they had “no one to relate to” (Leon, p.4). Additionally, participants provided an example of having to fit into the system rather than the system providing culturally appropriate individual care tailored to their ethnic identity:

“Well, there's options [laughs] I mean you can't ask for like, you can't say, “Oh, I want, I dunno, rice and peas” and they will go get it for you. They’ve got their option and you just got to deal with that option.” (David, p.5)

# **Discussion**

The research highlights the importance of reflecting on Black males’ experiences of decision-making and reflecting on the operation of power in relation to their individual experiences. The Power Threat Meaning Framework (Johnstone & Boyle, 2018) can be used to help make sense of how power operates through psychiatry which may have heightened the participants threat responses and the way they experience decisions. The research has highlighted how power manifests within forensic inpatient settings and how this is experienced by Black males and influences how they experience decisions.

The research demonstrated the issue around compliance, adherence and concordance within participant’s accounts of decisions on the ward. With some participants describing no involvement in decision-making processes and decisions made regarding their care, with clinicians not gaining their perspectives. Participants spoke of having a lack of choice around their treatment and feeling as if they had no choice but to comply as this would positively influence their likelihood of discharge. This was also reflected in the participant’s communications with staff on the ward where staff had informed them that if they ‘stay out of trouble’ and ‘do as they are told’ then this will result in being discharged from the ward at an earlier date. Control theory (Carver & Scheier, 1982) can be used to explain participants responses to decisions and their need to comply. It can be implied that participants changed their behaviour and complied to treatment to cooperate with their attempts maintain control within an environment where they had no control.

The research highlighted the overuse/misuse of medication, with participants feeling like they had no choice but to adhere with medication. Whilst participants spoke of not having direct involvement in decision-making processes, many participants referenced their family being involved throughout their admission, often advocating on their behalf and being informed of decisions around their care by professionals, with some believing they would have been exposed to more negative experiences within inpatient provisions if not for the support of their family. This supports the modifications suggested by Salla & Danson (2018) regarding families being more involved in the care and discharge planning of service users.

The research supported the findings of Majors et al. (2020) concerning the overuse/misuse of medication. Participants spoke of having no involvement in the decisions made by clinicians to medicate. They spoke of often not being informed about what they were prescribed and the potential adverse side effects, with some referencing medication being forced upon them through being administered intramuscularly. This left some participants feeling infantilised and like they had no control over what was happening and no influence on decisions made regarding their care. Fernando (2017) highlighted the interplay between power employed in the clinical systems of psychiatry and participants heavily referenced the authority that staff and clinicians on the ward had over them and other service users. There was clear evidence of the overuse of force and sedative medication highlighted in participants’ accounts as referenced by Walker (2020). Participants perceived that medication was often used to manage behaviour which may have been perceived as undesirable, negative, or violent by clinicians.

Participants reported the mishandling of distress, which supports the findings of Keating (2021). Some participants shared that their concerns were not taken seriously with one making a complaint to PALS following hearing a racist comment being made by White staff on the ward and this not being upheld or taken seriously. Another participant spoke of an unwillingness to raise subsequent issues regarding his care as he believed that these would not be taken seriously or ignored by professionals. Whilst participants did not directly reflect on how they believed they were perceived by professionals it was implied that they did not want to draw attention to themselves. Participants remained silent so as not to draw attention to themselves out of fear that any negative perceptions adopted by clinicians or staff on the ward may result in additional time added to their admission, which they reflected would have had a detrimental impact on their mental health.

The findings indicated a lack of communication with clinicians (see Salla & Danso, 2018) with participants having no access to evidence-based psychological interventions. Whilst they had some involvement in professionals’ meetings, many participants were left with limited understanding surrounding their admission, diagnosis and rules associated with the ward. This coincides with the research of Keating (2021) as several participants spoke of medication being prescribed as part of their initial phase of treatment without a thorough explanation of their needs, which added to their feelings of powerlessness. Although some participants described some explanations being provided by clinicians, due to their mental state at the time, the explanations provided were not detailed enough for them to be able to make concrete decisions surrounding their care.

## Clinical recommendations for practice

Forensic inpatient provisions may need to implement current standards already in existence regarding collaborative decision-making and reflect on how they provide support to service users who do not have supportive family members or a person to advocate on their behalf. The findings highlight the need for families to be actively involved in service users’ care as participants spoke of being treated more positively due to their family’s involvement. This highlights the need for approaches to be co-produced with service users and their families. However, it is recognised that there may be implications around this regarding confidentiality and participants ability to provide informed consent around the sharing of information. Where service users do not have family members or a nominated person, services need to consider assigning service users a family support member who could be individuals who volunteer their time to support and advocate for service users in inpatient provisions. An example of this can be found in the Culturally Adapted Family Intervention (CaFI, 2022) where peer mentors and volunteers are nominated to support service users within the family intervention in the absence of family members.

Clinicians within forensic inpatient settings may need to employ trauma informed care principles to support collaborative decision-making and reflect on how they can provide trauma informed care to Black males when the system around them is traumatising. Forensic inpatient settings may need to reconsider the role of mental health advocates and allow them to have more involvement during key aspects of and decisions made regarding the treatment and care of service users of Black ethnicities within inpatient provisions with this coinciding with the inclusion of family members. This will support shared-decision making and a systemic model of working which encompasses all those in the service users’ support network (Elwyn et al., 2012).

Though there was no direct reference to the presence of institutional racism, within the interviews, one participant reflected on believing that racism featured within the system that governs where ethnic minorities are admitted believing that ethnic minorities were segregated on particular wards in specific locations. Clinical Psychology may benefit from decolonising the curriculum to engage current Trainees and ensure future clinicians are aware of issues around race, whiteness and white privilege and the impact this can have on ethnic minorities, particularly those of Black ethnicities, helping to address post-colonial theory (Wood & Patel, 2017; Walker, 2020).

## Strengths and limitations

A limitation of the current study is that it captured retrospective accounts of participant’s experiences in inpatient provisions spanning across from 2012 to 2017. Due to the impact of Covid-19, the researcher was unable to capture the current experiences of Black men in inpatient provisions. However, this is also a strength of the study as it offered remote involvement and gave the researcher access to a broader sample. The ease of access and ‘distance’ from being in forensic inpatient settings may have helped participants speak openly without fear of providing critical views as a current inpatient.

A strength of the research is that it is continuing to highlight the stagnant and malingering issues within mental health experiences of Black male (or wider racialised service user groups) in inpatient services, specifically for psychosis.

## Future Research

Further research could be undertaken to establish the difference between Black service users having significant family involvement in decisions surrounding their care and service users who have limited to no involvement of family members. Larger sample sizes should also be considered to reflect on why forensic services fail to involve/ meet the need of Black male inpatients in their care.

Participants highlighted the need to comply with treatment and decisions surrounding their care and feeling like they had no choice but to comply with medication. Future research is needed to obtain professional and service user perspectives around how compliance is viewed and whether their views of compliance differs across ethnicities, given the stereotypes surrounding Black men being more dangerous and aggressive (see Walker, 2020) and whether there are cultural biases around what is seen to be compliant within mental health services and inpatient provisions for this population. There is a sense of participants losing aspects of their identity and personality, forensic inpatient provisions should consider the use of power mapping to identify environmental factors that may be contributing to Black men’s experiences of decisions and the influence of different power systems. This will help Black men to identify their own level of power and consider how this influences their identity and ideology around Black masculinity alongside their willingness to engage with mental health services.

# **Conclusion**

Forensic services and inpatient provisions need to support Black men to be involved in shared decision-making and encourage collaborative involvement in decisions.

# **Dissemination**

This research may be disseminated amongst service user involvement networks within forensic services and at the Group of Trainers in Clinical Psychology Conference. An infographic may also be used to share details of the research across social media platforms.

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# **Appendix A**

**Full ethical approval by Staffordshire University Ethics Committee**

Graphical user interface, application

Description automatically generated

# **Appendix B**

**Participant Information Sheet**

**INFORMATION SHEET FOR PARTICIPANTS**

**Title of study**

Exploring the experiences of Black Men through the decision-making process in secure settings: A qualitative study

**Invitation Paragraph**

You are being invited to participate in this research project which forms part of a Doctorate level thesis research project in Clinical Psychology. Before you decide whether you wish to take part, it is important to understand why the research is being done and what your participation will involve. Please take the time to read the following information carefully and feel free to ask any questions and discuss it with others if you wish. Please keep this Participant Information Sheet and a copy of the signed Consent Form. Ask me if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**

The purpose of the study is to explore your previous experience of the decision-making process within secure settings. Research has illustrated that black men experience discrimination and prejudice within mental health services and this research seeks to explore participants experience of and perceptions of these services and the decisions that are made.

**Why have I been invited to take part?**

You identify as a black man of African and/or Caribbean heritage who has had an admission to a secure forensic inpatient provision within the last 10 years and have now been discharged from services. You are between 18 and 65 years old and live in the UK.

**What will happen if I take part?**

To protect your identity, a different name of your choice will be used within the study. You will be invited to take part in a recorded interview that will be 60 – 90 minutes long to discuss your experiences.

In line with Covid-19 government guidelines, interviews will take place using an online platform at a time that is convenient for you. In light of restrictions being lifted then the interview will take place face-to-face in a setting convenient for you with an adequate amount of privacy where you feel comfortable enough to speak about your experiences.

The interview will be recorded using the online platform, and this will only be done with your consent, and I will indicate when the recording of the interview will start. The data will then be collected and analysed. In light of restrictions being lifted and interviews taking place face-to-face, then the interview will be recorded using a Dictaphone that is encrypted for additional security. All names, locations and personal information will be removed or changed to protect your identity.

**Do I have to take part?**

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact me if you have any questions that will help you to decide about taking part. If you decide to take part, I will ask you to sign a consent form and you will be given a copy of this consent form to keep.

**What are the possible risks of taking part?**

You will be asked quite personal information about yourself and your experiences which you may potentially find distressing/upsetting which may cause emotional distress or anxiety. Steps will be taken to support you with any distress and make sure sensitive issues are managed appropriately and respectfully.

If at any point you feel distressed during the interview, please inform the researcher and it will be stopped immediately. There will be time for reflection and debrief after the interview has taken place. Please find a list of support services attached should you feel you require further support.

**What are the possible benefits of taking part?**

You will have the opportunity to share your experiences of being a black man within forensic inpatient provisions and share your story, both positive and negative.

**Data handling and confidentiality**

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR). In accordance with University regulations, data is required to be stored for 10 years after the completion of a research project, where the data is then destroyed. Interview recordings will be deleted after they have been analysed. Your details will be kept for as long as necessary for the purpose of the research.

A different name of your choice (pseudonym) will be used to protect your identity and maintain confidentiality. Quotes will be used and included as part of the research. Specific services will not be mentioned in the research and any identifying information such as names, locations to be used in the research or as part of training materials and publication will be removed.

Should you report that you or someone you know are at risk, then confidentiality will need to be broken. If you share that a serious crime has been committed then this will need to be reported. Additionally, if you share failings within a service, then this may need to be discussed with the Academic Supervisor.

The data will be stored electronically on a password protected computer and any other electronic devices used within the study will be encrypted. Any documents linked to the study will also be password protected. Any paper documents and research materials will be appropriately stored in a locked filling cabinet at Staffordshire University.

The research team which includes my academic supervisor may have access to some of the data to help with analysis. Staff members from the research team may also have access to the data for the purposes of audit and analysis.

**Data Protection Statement**

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a ‘task in the public interest’ You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments, and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner’s Office, please visit [www.ico.org.uk](http://www.ico.org.uk).

**What if I change my mind about taking part?**

You are free to withdraw from the study at any point, without having to give a reason. Withdrawing from the study will not affect you in any way. You can withdraw your data from the study up until **28 days after the interview has been completed** after which withdrawal of your data will no longer be possible due to the data being processed and anonymised where the researcher will no longer be able to identify the data as yours.

If you choose to withdraw from the study, we will not retain any information that have provided us as part of this study. You can notify the researcher by email if you wish to withdraw from the study.

**What will happen to the results of the study?**

The study results will form part of a doctoral thesis research project which may be publicly available. They may also be published in psychological peer reviewed journals depending upon acceptance by the journal’s editors.

**What if I have further questions, or if something goes wrong?**

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information: Dr Tim Horne, Research, Innovation and Impact Services, Cadman Building, Staffordshire University, College Road, Stoke-On-Trent, ST4 2DF, [Tim.Horne@staffs.ac.uk](mailto:Tim.Horne@staffs.ac.uk), 01782295722

**Who has reviewed the study?**

The study has been reviewed and approved by Staffordshire University Ethics Committee.

**Who should I contact for further information?**

If you have any questions or require more information about this study, please contact me or my supervisor Dr Kim Gordon using the following contact details:

Chanae Mayers, Trainee Clinical Psychologist, email: [m024465j@student.staffs.ac.uk](mailto:m024465j@student.staffs.ac.uk)

Dr Kim Gordon, Academic Supervisor, email: [Kim.Gordon@staffs.ac.uk](mailto:Kim.Gordon@staffs.ac.uk)

**Thank you for reading this information sheet and for considering taking part in this research.**

If in the event you feel psychologically distressed by participation in this study or wish to seek support regarding some of your experiences discussed today, please refer to the following services:

**African and Caribbean Community Initiative**

Website: <http://www.acci.org.uk/>

Telephone: +44 (0)1902 571 230

Fax: +44 (0)1902 571 233

Email: [support@acci.org.uk](mailto:support@acci.org.uk)

**Mind Infoline**

Website: [www.mind.org.uk/information-support/helplines](http://www.mind.org.uk/information-support/helplines)

Telephone: 0300 123 3393 (9am-6pm Monday to Friday) or text 86463

Email: [info@mind.org.uk](mailto:info@mind.org.uk)

**Samaritans**

Website: <https://www.samaritans.org>

Telephone: 116 123 (24 hours a day, free to call)

Email: [jo@samaritans.org](mailto:jo@samaritans.org)

# **Appendix C**

**Debrief Sheet**

Logo

Description automatically generated**Staffordshire University**

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

[www.staffs.ac.uk](http://www.staffs.ac.uk)

**School of Life Sciences and Education**

**Debriefing Sheet**

Thank you for taking part in my research study and completing the interview. Your involvement is very much appreciated. I would like to remind you that you have up until 28 days after taking part to withdraw your data from the study.

The aim of the study was to explore black men’s experiences of inpatient forensic services and the decisions that are made, following discharge within the last 10 years. The study aimed to highlight decisions on how conflict is managed, either through seclusion, restraint or de-escalation techniques and how this is experienced by black male service users. Conflict is defined as disagreements that may happen between service users and healthcare professionals as well as with other service users.

Studies have highlighted decisions made within secure settings involving black men are often biased. Some men have spoken about the unfair treatment at different points in their care and felt that the professionals involved in their care and making decisions did not think about some of the difficult experiences they may have had (Urquia & Salla, 2019).

The study wanted to explore the decisions that mental health professionals make and the positive/negative affect this can have on those who use their service. It also aimed to highlight whether decisions made within this setting influence/ affect whether you are sectioned under the Mental Health Act (1983) and how this plays a part in how medication is given.

Reference:

Urquia, N., & Salla, A. (2019) Black men's experiences of the secure care pathway. [PhD Research, University of Nottingham]. <http://nebula.wsimg.com/4c0f55760bd648c9620170d192d9f923?AccessKeyId=C7F3DFCDF0DD650378CA&disposition=0&alloworigin=1>

If you have any questions regarding this study, please feel free to ask the researcher at this time or email Chanae Mayers, Trainee Clinical Psychologist at [m024465j@student.staffs.ac.uk](mailto:m024465j@student.staffs.ac.uk).

If in the event you feel psychologically distressed by taking part in this study or wish to seek support regarding some of your experiences discussed today, please refer to the following services:

**African and Caribbean Community Initiative**

Website: <http://www.acci.org.uk/>

Telephone: +44 (0)1902 571 230

Fax: +44 (0)1902 571 233

Email: [support@acci.org.uk](mailto:support@acci.org.uk)

**Mind Infoline**

Website:[www.mind.org.uk/information-support/helplines](http://www.mind.org.uk/information-support/helplines)

Telephone: 0300 123 3393 (9am-6pm Monday to Friday) or text 86463

Email: [info@mind.org.uk](mailto:info@mind.org.uk)

**The Black, African and Asian Therapy network**

Website: <https://www.baatn.org.uk/>

Email: [eugene@baatn.org.uk](mailto:eugene@baatn.org.uk)

**Mind Equality Improvement Team and Young Black Men Programme**

Email: [quality@mind.org.uk](mailto:quality@mind.org.uk).

**Time to Change - 300 Voices**

Website: <https://www.time-to-change.org.uk/>

Email: [info@time-to-change.org.uk](mailto:info@time-to-change.org.uk)

**Sandwell African Caribbean Mental Health Foundation**

Website: <https://www.sacmhf.co.uk/>

Telephone: +44 (0)121 525 1629

Fax: 0121 525 5838

Email: [Info@sacmhf.co.uk](mailto:Info@sacmhf.co.uk)

**Samaritans**

Website: <https://www.samaritans.org>

Telephone: 116 123 (24 hours a day, free to call)

Email: [jo@samaritans.org](mailto:jo@samaritans.org)

**Living Well UK**

Website: <https://livingwellconsortium.com/>

Telephone: 0121 663 1217

# **Appendix D**

**Consent Form**

**RESEARCH PROJECT CONSENT FORM**

**Title of Project:** **Exploring the experiences of Black Men through the decision-making process in secure settings: A qualitative study**

**Researcher: Chanae Mayers**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I have read and understood the information sheet. | Yes |  | No |  |
| I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily. | Yes |  | No |  |
| I understand that my participation in this study is entirely voluntary and that I can withdraw at any time without having to give an explanation. | Yes |  | No |  |
| I understand that the interview will be audio-recorded/video recorded. | Yes |  | No |  |
| I consent that data collected could be used for publication in a scientific journal or could be presented in scientific forums (conferences, seminars, workshops) or can be used for teaching purposes and understand that all data will be presented anonymously. | Yes |  | No |  |
| I agree that data will only be used for this project, although the data may also be audited for quality control purposes. | Yes |  | No |  |
| All data will be sorted safely on a password protected computer (electronic data) or locked away securely (hard copies of data) for 10 years before being destroyed. | Yes |  | No |  |
| I understand that I can withdraw my data from the project up to 28 days after taking part in the study without having to give an explanation and will notify the researcher by email. | Yes |  | No |  |
| I hereby give consent to take part in this study. | Yes |  | No |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Participant (print) Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Researcher (print) Date Signature

# **Appendix E**

**Interview Schedule**

Logo

Description automatically generated**Staffordshire University**

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

[www.staffs.ac.uk](http://www.staffs.ac.uk)

**School of Life Sciences and Education**

**Interview Schedule**

**Introduction**

Thank you for agreeing to participate in this interview. I am interviewing to gain a better understanding of your experiences within a secure setting. Any mental health provisions or identifying information will not be included in the write-up.

Participation in this study is voluntary and you have the right to withdraw from the interview at any time. The interview may last approximately 1 hour or longer, depending on how much information you would like to share. With your permission, I would like to video record the interview because I do not want to miss any of your experiences. All responses will be kept confidential and pseudonyms will be used to protect your identity. You may decline to answer any question or stop the interview at any time for any reason. Are there any questions about what I have explained?

*Please note that this guide only represents the main themes to be discussed with the participants and as such does not include various prompts that may also be used. Non-leading and general prompts may be used, such as “can you tell me a little bit more about that?” and “What happened?*

**About you**

Before we begin, would you mind telling me a little bit about yourself. Question can be tailored to specific person/ situation.

**1.Introduction and journey into service**

* How old are you?
* Can you tell me how you first came into contact with services?
* What was your journey into services?
* What were the circumstances around you going into a secure forensic setting?
* How many times have you been admitted into services? How long were you there for?
* When was your most recent admission? And when were you discharged?
* What was your understanding of diagnosis after your admission?

If no

What do you think your diagnosis may have been?

If yes

How did you feel about the diagnosis?

**2.Ethnic Identity**

* What is your heritage/ ethnic group?
* What decisions were made to meet your cultural needs during your admission?
* How did you feel?

**2.Decision-making processes**

* What were your experiences of the decisions made about your care?
* Who informed you about these decisions?
* How were you informed about these decisions?
* How did you feel about these decisions?
* How did you feel about the way you were informed about these decisions?
* How did they impact you?
* What impact did they have on your care?
* Who else was included in those decisions?
* Who do you think should have been included in those decisions?
* How involved were you in the decisions made about your care?
* In what way were you involved in the decisions made about your care?

**3.Conflict**

* What were your experiences of decisions made around conflict?
* What happened? How was this managed? For example, were restrictive practices used e.g. seclusion, restraint, segregation, blanket restrictions.
* What were your experiences of restrictive practice?
* How did you feel about this decision?
* What did other people make of this decision?

**4.Interactions with healthcare professionals/ staff and service users**

* How did you feel your experiences/ interactions with staff influenced decisions made about your care?
* How did you feel your experiences/interactions with service users influenced decisions made about your care?

**6.Racism**

* Can you remember a time when you were not treated fairly?
* Why do you think you were treated that way?

If yes

* In what ways do you think this influenced decisions made about your care? Who knew about it? How was this managed?

**7.Medication**

* What was your experience of medication for your mental health?

If yes

* What were your views about this?
* How was the decision made around this?

**Is there anything that you would have liked to have happened that could have been done differently during your time within the secure setting?**

**Experience of interview**

How was your experience of doing this interview?

Is there anything else you would like to add?

# **Appendix F**

# **Excerpts from reflective diary**

|  |  |
| --- | --- |
| Monday 27th April 2020 – Discussion with Experts By Experience  I was very grateful for the input and both E and D gave me a lot to think about. E had personal experiences of secure settings and I really valued his reflections and advice provided, given his first hand experiences. It made me reflect on my purpose in both Clinical Psychology and the purpose of my research. I want to be an advocate for change and highlight the inequalities within the system. I recognise that this will be difficult, however this is something that I am passionate about with regards to helping those within my community and shaping services so they are best able to meet the needs of services users from my community. | Tuesday 11th August 2020 – Discussion with Clinical Psychologist  Really valuable and honest discussion and what it is genuinely like for service users of colour within secure settings. Role of Psychiatry appears to be dominant in decision making and issue of compliance and non-compliance and the contexts around this. AM felt that identity is sometimes compromised when wanting to appear compliant. Identity can get lost when in secure settings, cultural identity not taken into consideration. Demonstrated that there is still a lot of unconscious bias with professionals which does appear to influence decision making. |
| Wednesday 27th May 2021- Discussion with Research Supervisor  Kim helped me to really think about the research and what it is I want to achieve, where I would like my research to be published, potential barriers to research being published. Will be talking about sensitive issues and biased practices, will be exposing the system and lack of changes within the system, some may not be happy about me highlighting this. | Tuesday 27th July 2021- Discussion with Head of Service    I spoke with the Service Lead of an organisation in Birmingham, however before I even had an opportunity to talk about my research I was cut off and the person claimed that the men who use their service are “over researched” Whilst I understood what she was saying I explained that the area I wish to research is an area that is under-researched. I felt angry at this point because as a black woman and professional, I felt the response I received was not professional and I felt like they could have listened to me first before making their judgement |
| Friday 14th January 2022- Frustrations around recruitment  I am becoming extremely frustrated with services that are supposed to be supporting those in the Black community with mental health issues. I have emailed various organisations and reached out via twitter and heard nothing back. I reached out to MIND who were running a Black men’s programme and heard back from MIND with the individual programme leads email addresses, however my emails remained unanswered.  This is really disheartening as this is research I am passionate about, it makes me reflect on why not much research is done with black people because it hard to gain access to this population and I have found that services that state they are passionate about helping this population have not been useful and are making it even hard to access this population | Saturday 2nd April 2022 – Reading and re-reading of transcripts  When reading some of the transcripts, I can feel myself becoming angry and feeling sad, especially for the men who had more negatives experiences during their admissions. It is interesting that those who had more positive experiences referred to themselves as “lucky” and I think to myself what is “lucky” about being treated the way you are supposed to be treated, why should that be viewed as lucky. |

# **Appendix G**

**Online poster used to recruit participants**

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# **Appendix H**

**Letter of invitation**

Logo

Description automatically generated**Staffordshire University**

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

[www.staffs.ac.uk](http://www.staffs.ac.uk)

**School of Life Sciences and Education**

**LETTER OF INVITATION**

**Exploring the experiences of Black Men through the decision-making process in secure settings: A qualitative study**

I am a second-year trainee on the Doctorate in Clinical Psychology course at Staffordshire University. To complete my doctoral programme, I am required to complete a Thesis. I am interested in black men’s experiences of the decision-making processes within secure settings. This research seeks to explore their experience of and perceptions of these services and the decisions that are made.

I am looking for black men of African and/or Caribbean heritage between the age of 18 and 65 who have had experience(s) of inpatient forensic settings within the last ten years and have now been discharged. You will be invited to participate in an interview with myself to discuss your experiences during your inpatient stay within a secure setting. Topics will cover experiences around how conflict was managed, experiences of decision making, power and authority with regards to healthcare professionals and how decisions were made in relation to the administration of medication and sectioning under the mental health act (if this applies).

The interview will take place online using Microsoft Teams at a time that is convenient for you. Should restrictions ease, then the interview may take place face to face at a time and place with adequate privacy that is convenient for you where you will feel comfortable enough to speak about your experiences.

If you would like to express interest in taking part, then please contact:

**Chanae Mayers, Trainee Clinical Psychologist**

**Email:** [m024465j@student.staffs.ac.uk](mailto:m024465j@student.staffs.ac.uk)

# **Appendix I**

**Excerpt of initial thoughts of transcript**

![Text, letter

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# **Appendix J**

**Exploratory notes made on transcript**

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# **Appendix K**

**Experiential statements made on transcript**

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# **Appendix L**

**Clustering of experiential statements**

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# **Appendix M**

**Example of organising Personal Experiential Themes (PETs) and sub-themes**

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# **Appendix N**

**Organisation of Group Experiential Themes**

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# **Appendix O**

**Table of Group Experiential Themes (GETs) taken from Smith et al. (2021)**

|  |
| --- |
| Table of Group Experiential Themes   1. **The role of/ significance of medication**   **1.1 Medication adherence – no choice**  Lack of choice around acceptance of medication  *"That's not even an option. You have to take medication on the ward, that's not even an option."* (David, line 123-124)  "Felt like I had no choice" "infantilizes you"  *"I felt like, I felt like I had no choice and then it kind of infant, infantilizes you and makes you feel like a child"* (John, line 187-188)  Reflection on rules of the ward - medication adherence and working towards discharge  *"Basically, take your medication, keep out of trouble you know, don’t, don’t do things you’re not supposed to do and just keep clean, get clean and just get out of there as soon as possible"* (Nana, line 94-95)  Felt he had to comply with medication  *"You just take the medication. Like I said it was, we didn't have a choice"* (Leon, line 243)  **1.2 Medication used as behaviour management**  Staff controlled behaviour through administering medication intravenously  *"I’d just basically get injected. I don't know what injection I had. Sometimes it would be, you know I get an injection and it would knock me out straight away"* (Leon, line 292-293)  Medication used as a way to manage behaviour  *"And then we like got into like a little scuffle, and then I think I got injected, that was the first time I had ever been injected before."* (David, line 54-55)  Medication used to calm behaviour  *"they’ll be like telling you to calm down and if not then they’ll restrain you or give you like an injection so like you know, to make you like calm down or they’ll tell you to take a tablet to calm down"* (Nana, line 104-105)  Medication used to manage mental health presentation  *"And that's when I was like sedated and everything and for when you're diagnosed with psychosis"* (AL, line 12-13)  **1.3 Level of involvement in decisions about medication**  An expectation of involvement "of course" "you can't just…"  *"Yeah, I was there, of course, of course. Yeah, I was there, I was there. You can't just pop up and say “here, this is what you are gonna be taking” [laughs]"* (David, line 284-285)  Collaborated with new Doctor to make a change medication - finally felt listened to  *"then I started talking to the doctor and you know, saying “look maybe these aren’t working, the medications are doing this to me.” Then they started giving me different medications to see if they would work"* (Leon, line 314-316)  Not involved in decision around being forced to take medication – helpless  *"I think it was just the fact that I was kicking off. So there was no one involved in the decision making about it"* (Leon, line 335-336)  Medication uses and side effects not explained  *"They don’t really explain the drugs what they give you basically, they don’t really explain it."* (Nana, 214-215)  No awareness of decision made to medicate  *"I had no idea of the process at all"* (John, line 197)   1. **Family involvement in decision-making**   Mother involved in meetings with professionals  *"And plus like you have someone with you. So my mom would be there"* (David, line 303)  Mother advocated for John not to be admitted to a psychiatric hospital due to fear of lengthier admission  *"And my mom would say no, because once they're in there, they don't like you know, never come out again."* (John, line 358-359)  **2.1 Family advocating on their behalf**  Family involvement in care and decisions  *"Yeah every step of the way, they were involved, my family. If they weren’t involved then I don’t know where I woulda been by now."* (Nana, line 222-223)  Reflection on having a supportive family and this being reflected in his treatment compared to others  *"I think that erm because I had a supportive family, they might have treated me a lot better than they treat some other people."* (John, line 409-411)  Did not have any family members to advocate on his behalf - all decisions made by the team  *"I haven’t spoken to family for years so. So it's all been made like by the team, not, not me, and not any of my friends and stuff so."* (Leon, line 231-232)   1. **Interactions with healthcare professionals**    1. **Influence of staff interaction on decisions**   Communication with staff on the ward occurs during specific times  *“So I think the only time you really get spoken to is erm, food time, medication time and visitation time. And that's about it.”* (David, line 148-149)  Interactions with staff made stay "easier"  *“I don't know if it influenced decisions that was made about my care, but I know it definitely made my stay much easier”* (David, Line 237-238)  Reflecting on power and authority of staff  *“I think staff can trigger patients even more than anything, because like they've got access to you at your most vulnerable state. Do you know what I mean? so any word, they say like, it's just mad that they've got so much power that they probably don't even know about.”* (David, Line 238-240)  Reality did not coincide with how he felt "everyone else is mad"  *“You feel like what's happening, is what's happening and everyone else is mad”* (John, Line 125)  Highlighted location of admission and confusion surrounding where he was placed  *“Erm, and they kept me in there for a few days, erm [pause] and yeah, I didn’t really know where I was, or, and they wouldn't let me leave. So I couldn't recognise that I was in the hospital, really.”* (John, Line 35-36)  **3.2 Experience of decisions made by professionals**  Found staff "officious and not very sympathetic" - felt ignored with limited communication with staff  *“Erm, I felt that they were a bit officious and not very sympathetic. Erm there were too many of them. None of them would tell me what was going on really. And so I felt a bit ignored.”* (John, line 333-334)  Felt professionals less sympathetic due to diagnosis not being organic  *“it was a bit dismissive. Erm there wasn't like very much sympathy. But I can see why. I*  *mean, if, sorry, if they're dealing with people who have got like organic conditions and stuff, and they didn't bring it on themselves. And then they've got to deal with people who, where it was drug induced, I can see what where maybe they'd be a bit less sympathetic privately”* (John, line 259-262)  Lack of collaborative decision making surprising "shockingly"  "Erm, not really, not really, you know, shockingly, like not really, I don't remember really having conversations with like, erm, nurses or in…about that anyway." (David, line 117-118)  No explanation of what was happening provided - left confused  *"I would have like to have been explained the decision-making processes, what I was given and why I was there, yeah that was the main thing, like just give people something to go on, so they don’t, so you are not sitting there in utter confusion and not knowing where you are"* (John, line 399-401)  Not listened to - complaints not upheld - not taken seriously  *“then I put in a PALS complaint and then nothing, nothing happened.”* (Leon, Line 397-398)  Influence of interactions with staff on decisions regarding care  *“Yeah, if you get some nice staff they will tell you, you know they’ll be nice to you and stuff like that, basically, tell you “look you’re not supposed to be in here” and “like you’re young, you’re talented you should just, you know behave yourself, do what you have to do and just leave.”* (Nana, Line, 132-134)  Changes meeting used to have open discussions around mental health difficulties  *“Yeah we went to a few like changes meetings and stuff like that, like talking about mental health problems and what those problems were and how we could cope, cope with them and manage them.”* (AL, Line 59-61)  Feels outraged about lack of involvement in decisions  *“Erm, half of me feels like it's an outrage, because we should be. But I can see why, when you're not in your right mind, other people do have to kind of take over because your mind is not telling you the right things.”* (John, Line 234-236)   1. **Compliance and concordance**    1. **Needing to comply to avoid consequences**   Non-compliance negatively influencing length of admission  *“If you’re not taking your medication, you’re not complying or you’re not doing the things you have to do to, to get out of there, then basically it’s just like, it’s like, its like torture basically. You won’t get out of there basically, you’re just gonna be in there for a, a long time, really really long time. You’ll be in there for life basically, if you don’t comply.”* (Nana, Line 80-84)  Compliance and the need to abide by the rules  *“Complying…you just have to abide by the rules basically because if you don’t you’ll just be in there for a long time”* (Nana, Line 89-90)   * 1. **Need to act on own volition**   Inability to advocate for self, may have delayed discharged  *“I remember, I said like, “Oh, my birthday is coming up in a couple of weeks, I need to get out of here” And then…erm… because they'll like tell you like, they'll be like “Ahh that’s the doctor you need to talk to or whatever” so when I saw him, I was like “Yo my birthdays coming up, I need to get out of here” And then…erm… a meeting got set up, and then they did obviously a review and then I ended up getting discharged. But if I didn't push for it, I don't know if that would have happened.”* (David, Line 154-159)   1. **Coercion and used of power to control and dehumanise**   *“I got made to stand there in the room with like four or five people just being strip searched, it was a bit, you know, the only other time I’ve had that done that was in prison.”* (Leon, line 384-385)  No recollection/awareness of what he was signing, therefore informed consent not gained when consenting to sectioning and admission  *“So I had to sign it and I was actually signing my consent to being sectioned and I had absolutely no idea that I was, erm, consenting to be submitted in.”* (John, Line 164-165)  Loss of privileges through negative interactions with other service users  *“You’ll get like, in trouble for that* [not complying] *and you could lose your like, your privileges, privilege like to go out or something.”* (Nana, Line 179-178)  Helpless - no control over their own circumstances  *“And then like when I got, on a, you know a criminal section. They, they talked to me about it, but I didn't, you know, there was nothing [pause] I could do about where I was going or what I was doing really.” (*Leon, Line 144-146)   1. **Interactions with service users**    1. **Influence on decisions**   Interactions with service users influenced decisions regarding care  *“Oh yeah, yeah, yeah, yeah, yeah. If you had like people like who like get themselves in trouble, you’re gonna get, if you’re involved with them, they will tell you like, keep away from that person, because you will get yourself, like, in trouble, so just like keep away from them and if you don’t then you actually get yourself involved with that person, then you will get yourself in trouble, so that’s a no no basically. That you should not, that you shouldn’t do that. You learn from your mistakes basically in there and so basically.”* (Nana, Line 163-168)   1. **Wanting provisions that meet service user needs**   Would have like to be involved in decisions made about care - prefer a collaborative process - better communication between him and professionals  *“I mean, I could say I’d have liked someone to talk to me on a proper level, but then I don't know what they would have seen at the time. So, if I think I’m being normal, the staff are gonna know that, they’re gonna see that it ain’t so. Like, yeah, someone just talking to me a bit more.”* (Leon, Line 421-423)  Would have like the decision-making processes explained to him - what medication he was given and why he was admitted onto the ward  *“Yeah, I would have like to have been explained the decision-making processes, what I was given and why I was there, yeah that was the main thing, like just give people something to go on, so they don’t, so you are not sitting there in utter confusion and not knowing where you are and what is happening to you.”* (John, Line 399-402)  Staff and professionals could have informed/involved him in decisions regarding care  *“They could have told me more about like my care, like, like, my medication. Like before they ever gave me a new drug, I’d rather them, let them tell me, like “Okay this is, this is this drug, this is what it does” and you know, “this is what will happen and how you’ll feel” and like your care, its like, theres certain things that they don’t really tell you, its like, they just, they rush it, basically. You know, they rush your, your, your…care like and before you know it, their like “ahh you’re about to leave.”* (Nana, Line 231-235)   1. **Significance of ethnicity**   Challenging own stereotypes of ethnicities on the ward  *“See that….that's what really, like, changed my whole thinking, when I saw different ethnicities because in my mind, I just thought it was like black people, do you know what I mean?”* (David, line 319-320)  Reflection of different ethnicities in hospitals  *“the three that I’ve been to, there was one that was predominantly black when I was in \*location\* There was a lot of guys like Asian guys in there and a couple of white guys in there. And then, when I was in the first one, it was all white people. I think there was one other black guy or two other black guys but I can remember it just being me. The last hospital I was in, all white guys again, so you know, yeah, its, its not a mixture.”* (Leon, line 444-448)  Limited food options and lack of culturally appropriate food  "Well, there's options [laughs] I mean you can't ask for like, you can't say, “Oh, I want, I dunno, rice and peas” and they will go get it for you. They’ve got their option and you just got to deal with that" (David, line 146-147)  Caribbean meal option did not feel optional  "Like it's not, It's not, you know, it’s not caribbean basically and then they were saying, well, that's what you're getting." (Leon, line 107-108) |

# **Appendix P**

**Author Guidelines for The Journal of Black Psychology**

**Manuscript Length**

***Full-Length Manuscripts***

Full-length manuscripts reporting results of a single quantitative study generally should not exceed 35 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double spaced.

Reports of qualitative studies generally should not exceed 45 pages. For papers that exceed these page limits, authors must provide a rationale to justify the extended length in their cover letter (e.g., multiple studies are reported). Papers that do not conform to these guidelines may be returned with instructions to revise before a peer review is invited.

Literature reviews generally should not exceed 40 pages, including references.

Papers that do not conform to these guidelines may be returned with instructions to revise before a peer review is invited.

Every effort should be made by the author to see that the manuscript file contains no clues as to the author's identity. Footnotes containing information pertaining to the identity of the author or institutional affiliation should be on separate pages. Manuscripts, including references, must be double spaced throughout and must conform to guidelines given in the Publication Manual of the American Psychological Association, 7th Edition (APA, 2019).

The manuscript file should begin with a title page, omitting the author's name and affiliation but including the title and the date submitted. Following the title page should be a 100-175 word abstract and 4-5 keywords. The introduction section should follow and precede, in order, the Method, Results, and Discussion sections for empirical reports. Following in order should be note pages, references (entries double spaced and alphabetically listed), appendixes, tables, and figures. Table and figure locations should be indicated in text by callouts (e.g., "[insert Table 1 here]") inserted after the respective paragraphs. Figures must be camera ready.

Please go to <https://journals.sagepub.com/author-instructions/jbp> for the full author guidelines

# **Paper 3: Executive Summary**

**Exploring Black men’s experiences of decisions made by healthcare professionals in mental health hospitals**

**By Chanae Mayers**

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**Aims of the research**

This research aimed to look at how Black men feel about decisions made by healthcare professionals including nurses, psychiatrists and healthcare assistants etc in mental health hospitals and wards. The research was inspired by the research of Dr Norman Urquia and Dr Anthony Salla (2019) who explored Black men’s experiences of mental health hospitals and found Black men had negative experiences of the decisions that were made in relation to their care.

*As a Black woman of Caribbean heritage and a Black professional, I am aware of the stigma that still exists within the Black community when talking about mental health difficulties. Therefore, it was important to me to involve Black men with previous experiences of mental health services in the development of this research to get their thoughts about the research and what key issues they felt needed to be addressed.*

*They were also involved in the development of the interview questions to make sure they were appropriate and worded in a sensitive way. I also approached a Black male Expert by Experience and John\* who took part in the research to help write this executive summary and highlight points from the research they felt needed to be included.*

*\*Name changed to maintain confidentiality*

**2020-2021 Statistics from NHS Digital (2021) highlighted the following:**

Black individuals receive poorer treatment and have more negative experiences of mental health services compared to other ethnicities

People who identify as Black Caribbean have higher rates of admission to mental health hospitals amongst all the ethnicities in the UK

Black and Black British people are 4 times more likely to be sectioned under the Mental Health Act compared with White people

**Please refer to the Glossary at the end of this summary which explains any terms used**

**Why look at Black men’s experiences of decisions?**

Statistics from the ‘Commission on Race and Ethnic Disparities: The Report’ highlighted ethnic inequalities within mental health services for individuals from Black Minority and Ethnic groups

There have been concerns raised within research around individuals from Black communities appearing to not be involved in key decisions around their care

Previous research has shown that Black men’s concerns are often not taken seriously by mental health professionals

Research has highlighted that Black Caribbean service users do not feel listened to by professionals

There is a lack of research exploring the experiences of Black men in mental health hospitals with a focus on the positive and negative impact of decisions that are made regarding their care

**Why is this research important?**

*"The mental health field doesn't serve the cultural interest or understand the nuances of black people in this country. We suffer more poor mental health, which indicates the services are failing us more, and there are too few Black mental health practitioners, who would likely make Black people suffering with mental health issues feel more comfortable and able enough to access and maintain treatment. Like in many other medical statistics from Black women’s mortality rates during pregnancy, to chronic pain being ignored, psychiatric services seem to be afflicted with institutional racism. That is why this research is vital. Better outcomes for Black people benefit society as a whole.*

*As a Black person who has had poor mental health and interaction with services, I for one am grateful to Chanae for focusing her research in this area."*

John

**Who approved the research?**

The research was approved by Staffordshire University Ethics Committee

**How was confidentiality maintained?**

All men involved in the study were given false names of their choosing to protect their identity and information such as locations and names of hospitals were removed

**Who was invited to take part?**

Men of African and/or Caribbean heritage or identify as Black

Men aged 18-65

Men who have been admitted to a mental health hospital within the last 10 years and now been discharged

**Who was involved in the research?**

Below is a table of the men who took part in the research

|  |  |  |
| --- | --- | --- |
| Name | Age | Ethnicity |
| AL | 35 | Mixed heritage – Caribbean and Caucasian |
| David | 33 | Nigerian |
| John | 35 | Black Caribbean (Jamaican) |
| Nana | 40 | Ghanian |
| Leon | 37 | Mixed heritage – Caribbean and Caucasian |

**How were the men approached to take part in the research?**

Online posters were used and sent to community organisations specialising in Black mental health as well as on social media such as Twitter, Facebook and Instagram. The researcher also benefited from speaking with individuals within the Black community about Black mental health and discussing the importance of the research which gained interest through word of mouth.

Men who showed interest in the research were given more information and had an opportunity to ask the researcher questions about the study. Men who provided their consent to take part in the study were interviewed online using Microsoft Teams and the interviews were recorded so they could be analysed.

The interviews were analysed using Interpretative Phenomenological Analysis (IPA)

**What is IPA?**

IPA is an approach that is used to help understand people’s experiences and their understanding of the world. It is interested in trying to make sense of and interpretating people’s experiences.

**What did the research show?**

There were 8 Group Experiential Themes and 9 sub-themes. Quotes from the men who took part in the study are presented under each theme and sub-theme to demonstrate what was said by the men relating to those themes.

It was important to the researcher to explore the men’s journey into services and 4 out of the 5 men spoke of experiencing psychosis which was caused by smoking cannabis.

1. **The role of/significance of medication**

Men spoke of their experiences of medication, how professionals influenced decisions around medication and whether the men were involved in decisions about their medication:

***Medication adherence – no choice***

4 out of 5 men spoke about having no choice around taking medication and having to accept medication despite their thoughts about it:

*"That's not even an option. You have to take medication on the ward” (David)*

***Medication used as a behaviour management***

Several men spoke about medication being used on the ward to as a way to make them “calmer” when anxious, in distress or being perceived as aggressive:

*"they’ll be like telling you to calm down and if not then they’ll restrain you or give you like an injection…to make you like calm down" (Nana)*

*“I was always getting restrained…getting pinned down and…getting injected” (Leon)*

***Level of involvement in decisions about medication***

Some men spoke of having limited involvement around the decisions made to give them medication and were not aware of the processes around medication:

*“They was like “ahh you have to take it, you have to take it, because…that’s the drug the psychiatrist gave you.” (Nana)*

However, some men shared that they were involved in decisions around their medication and that it helped to speak with a different Doctor:

*"then I started talking to the doctor and you know, saying “look maybe these aren’t working, the medications are doing this to me.” Then they started giving me different medications to see if they would work" (Leon)*

1. **Family involvement in decision-making**

***Family advocating on their behalf***

4 out of 5 men spoke of their family being involved throughout their time on the ward and having decisions explained to them by professionals at key points in their care and spoke of their family speaking up for them:

*"Yeah every step of the way, they were involved, my family. If they weren’t involved then I don’t know where I woulda been by now." (Nana)*

*"I think that erm because I had a supportive family, they might have treated me a lot better than they treat some other people." (John)*

1. **Interactions with healthcare professionals**

***Influence of staff interaction on decisions***

Some men felt that the way they interacted with staff on the ward added to how they were viewed by the clinicians

*“I don't know if it influenced decisions that was made about my care, but I know it definitely made my stay much easier” (David)*

***Experience of decisions made by professionals***

Some men spoke of having limited involvement in decisions made around their care and that decisions were often not explained to them by clinicians which left them feeling dismissed, overlooked and viewing the clinicians as having no sympathy:

*“Erm, I felt that they were a bit officious and not very sympathetic…None of them would tell me what was going on really. And so I felt a bit ignored…Doctors at the end of the bed would like, natter to themselves and discuss something and then walk away…I felt like I wasn't involved in any decision-making process apart from what to eat for dinner” (John)*

Some men spoke of not feeling like they were not listened to:

*“I put in a PALS complaint [about a racist remark] and then nothing, nothing happened.” (Leon)*

1. **Compliance with treatment and concordance around treatment**

Men spoke of feeling like they had no choice but to accept treatment

*“If you’re not taking your medication, you’re not complying or you’re not doing the things you have to do to, to get out of there, then basically…its like torture basically…you’re just gonna be in there for a, a long time…You’ll be in there for life basically, if you don’t comply.” (Nana)*

When asked what complying looked like Nana said

“Complying…you just have to abide by the rules basically because if you don’t you’ll just be in there for a long time”

1. **Coercion and use of power to control and dehumanise**

Several men spoke of feeling powerless and helpless when interacting with clinicians and spoke of having their privileges, such as leave taken away when they did not conform to the rules and not having any control over what was happening to them:

*“You’ll get like, in trouble for that [not complying] and you could lose your like, your privileges, privilege like to go out or something.” (Nana)*

1. **Interactions with service users**

Men spoke of their interactions with other men on the ward being a key part of their experiences on the ward and how they were viewed by clinicians.

***Influence on decisions***

Some men felt that who they chose to speak with on the ward, in terms of other men on the ward influenced how they were viewed by clinicians which influenced decisions about their care:

*“If you had like people like who like get themselves in trouble…if you’re involved with them, they will tell you like, keep away from that person, because you will get yourself, like, in trouble, so just like keep away from them and if you don’t then you actually get yourself involved with that person, then you will get yourself in trouble, so that’s a no no basically…You learn from your mistakes basically” (Nana)*

1. **Wanting provisions that meet service user needs**

All men were asked to think about what they would have liked to have happened differently throughout their care.

They raised that some hospitals were inadequate and made suggestions:

*“Yeah, I would have like to have been explained the decision-making processes, what I was given and why I was there…so you are not sitting there in utter confusion and not knowing where you are and what is happening to you.” (John)*

1. **Significance of ethnicity**

Some men felt that Black men being admitted to hospitals were racially motivated and that ethnic minorities are being segregated

*“Yeah…I read that black people are the majority in hospitals but uh the three that I’ve been to, there was one that was predominantly black when I was in [location removed]. There was a lot of guys like Asian guys in there and a couple of white guys in there. And then, when I was in the first one, it was all white people. I think there was one other black guy or two other black guys but I can remember it just being me. The last hospital I was in, all white guys again, so you know, yeah, its, its not a mixture. Its secluding, you know, different races and for the people that govern it, I feel like you know they want certain races together.” (Leon)*

**What did the research show?**

The research showed that Black men are not involved in decisions around their care because professionals often did not effectively communicate decisions that were made during key aspects of their care.

Men also spoke of having a lack of choice around their treatment and feeling like they had no choice but to comply with treatment as they felt this would help them to be discharged from the hospital. This also links with the increased use of medication and having no choice but to take the medication that was prescribed.

**What could have been done better?**

The researcher would have liked to capture Black men’s more recent experiences in mental health hospitals, which was not possible due to Covid-19. However, it was important to hear from Black men who may have felt unheard or silenced because of the stigma around mental health and give them the opportunity to share and reflect on their experiences.

**What does this mean for future research?**

It should be noted that trying to get Black men to take part in this research was extremely challenging. This was discussed with the Expert by Experience who contributed to this summary who stated the following:

*“Because of the adverse experiences that black men have, perhaps they are lacking in faith and belief that using their voice will lead to any meaningful change and improvement. It is important to address some of the structural issues that exist within services that lead to this type of disengagement”*

Future research is needed to explore professionals and Black men’s views around compliance and whether this is influenced by stereotypes held about Black men. Research also needs to explore the involvement of family members and whether this influences the way Black men are treated in mental health hospitals.

Mental health services and hospitals need to support shared decision making and encourage active involvement in decisions made around their care

**Glossary of terms**

|  |  |
| --- | --- |
| Coercion | Persuading someone to do something through using force or threats |
| Compliance | Changing your behaviour because you feel like you have to |
| Comply | To conform, submit or adapt |
| Concordance | An agreement reached between service user and healthcare professional |
| Disengagement | Withdrawing from involvement in a situation |
| Medication adherence | Whether service users are taking their medication as prescribed |
| PALS | Patient Advice and Liaison Service |
| Racially motivated | Motivated by someone’s race |
| Segregate | To set apart, isolate or divide |

**References**

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