

***“I’m just going to give up and let them do what they’ve got to do... My goal at the end of the day, is to get free and get back to life”*: Exploring the experiences of ethnic minority adults who have been compulsorily detained in secure settings.**

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THESIS PORTFOLIO: CANDIDATE DECLARATION

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Declaration and signature of candidate
<p>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.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>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.</p> <p>Signed:  Date: 30 April 2025</p>

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I would like to start by saying thank you to all the participants who so bravely shared their personal, and oftentimes, difficult stories with me. Your honesty, openness, and willingness to trust me with such sensitive parts of your lives has been inspiring. I feel truly honoured to have heard your experiences, and I hope this research reflects the care and respect that you deserve.

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Table of Contents

Thesis Abstract	6
Paper 1: Do ethnic differences in compulsory detention still exist? A global systematic literature review	8
Abstract	9
Introduction.....	10
Method	13
Search Strategy	13
Inclusion and Exclusion Criteria	14
Data Extraction	16
Quality appraisal of studies.....	16
Synthesis of findings	16
Figure 2: PRISMA 2020 Flow Diagram of Screening and Selection	17
Results	18
Study Characteristics.....	18
Quality Appraisal.....	35
Synthesis of findings	36
Discussion	40
Strengths and limitations	45
Clinical recommendations.....	46
Conclusion.....	46
References.....	48
Appendix A- Author guidelines.....	56
Appendix B: Table of search terms: Synonym for search terms in relation to question	58
Appendix C: Quality Appraisal adapted from Kmet et al. (2004)	59
Paper 2: Empirical Paper	60
Abstract	61
Introduction.....	62
Method	65
Ethics.....	65
Design	66
Epistemological position	66
Reflexivity.....	67

Recruitment and Procedure.....	68
Participants	69
Data Analysis.....	72
Results	72
1. Our voices don't matter	73
2. Disproportionate use of force and power.....	76
3. Racialised and culturally invalidated.....	77
4. Feeling held back.....	79
5. A bittersweet experience.....	81
Discussion	83
Implications and recommendations	86
Strengths and Limitations	87
Future research.....	88
Conclusion.....	88
References.....	89
Appendix D- Author guidelines.....	97
Appendix E- University Ethical Approval	98
Appendix F- HRA Approval	99
Appendix G- Trust Ethical Approvals	101
Appendix H- Research posters.....	105
Appendix I- Participant Information Sheets	107
Appendix J- Consent forms.....	119
Appendix K- Interview Schedule.....	123
Appendix L- Debrief sheets.....	125
Appendix M- Example of exploratory noting (right) and experiential statements (left).....	129
Appendix N- Example of organising experiential statements into PETS.....	130
Appendix O- Audit trail example of PETs and transcript lines.....	136
Appendix P- Example of organising PETs into GETs.....	137
Appendix Q- Themes and participants contributing to themes	140
Appendix R - Example of GETS and excerpts organised into table	141
Appendix S: Changes to theme titles post-viva	149
Appendix T- Example of excerpts from reflexive diary.....	150
Paper 3a: Executive Summary	153
Paper 3b: Executive Summary (Service-user shortened summary).....	165

Thesis Abstract

Paper 1 is a systematic literature review which aimed to explore whether ethnic disparities in compulsory detention continue to exist internationally for ethnic minority and migrant groups when compared to majority groups, whilst also aiming to synthesise possible explanations for this. This review aimed to expand upon a previous review conducted by Barnett et al. (2019). 10 quantitative studies were critically appraised, and the results were synthesised using narrative synthesis. The findings showed that ethnic minority and migrant groups continue to be at increased risk of compulsory detention on an international scale when compared to majority groups. Reasons for detention included: ethnic density; access and engagement with services; impact of diagnosis; risk/aggressive behaviours; sociodemographic factors; communication and cultural barriers. Due to methodological limitations impacting interpretation of the findings, this review highlighted that further longitudinal and qualitative research is needed to explore the lived experiences of ethnic minority and migrant groups in relation to compulsory detention.

Paper 2 is an empirical research study which explored the lived experiences of ethnic minority adults who have been compulsorily detained in secure settings in the United Kingdom (UK). Disproportionate rates of compulsory detention for ethnic minority groups compared to White-British groups has been a longstanding issue in the UK despite a number of initiatives being proposed to tackle these inequalities. Due to limited qualitative research in this area, the current study explored the experiences of six participants from diverse ethnic minority backgrounds using semi-structured interviews. Data were analysed using Interpretative Phenomenological Analysis (IPA). Five group experiential themes were identified: 1) *Our voices don't matter*, 2) *'Disproportionate use of force and power'*; 3) *'Racialised and culturally invalidated'*; 4) *'Feeling held back'*; 5) *'A bittersweet experience'*. The findings showed that lack of early help from professionals, insufficient support from prison systems, and lack of social support contributed to compulsory detention. Participants described feeling powerless, experienced a lack of choice and autonomy during their detention, and were subject to coercive treatment. Participants reported unequal and racialised treatment which was also related to intra-ethnic and inter-ethnic

differences in staff-patient relationships. Anti-racist practices should be embedded into services and services should involve meaningful service-user co-production.

Paper 3 (3a) is an executive summary of the empirical paper which has been written in a way that is accessible to participants who took part in the study, service-users, and for distribution to services and Trusts. The executive summary was reviewed with a participant from the study to review design, content, and readability. An additional executive summary (paper 3b) has been created to provide a shorter summary for service-users should they prefer this.

Paper 1: Do ethnic differences in compulsory detention still exist? A global systematic literature review

Target journal: BJPsych Open Journal

This systematic literature review has been formatted using APA style guide (7th Edition). It will be formatted and edited for BJPsych Open Journal following submission. Author guidelines can be found in Appendix A.

Abstract

Ethnic minority and migrant groups have been shown to be at increased risk of compulsory detention compared to majority groups across international studies. This systematic literature review aims to expand upon a previous review conducted by Barnett et al. (2019) to identify whether these inequalities still exist on a global scale, and to synthesise evidence that aims to provide explanations for these differences. A systematic search was completed between May and July 2024 using six databases and additional hand searching to identify 10 peer-reviewed quantitative studies. Results indicated that ethnic minority and migrant groups continue to be at elevated risk of compulsory detention on a global scale when compared to majority groups. A narrative synthesis was used to identify explanations for this, which included: ethnic density; access and engagement with services; impact of diagnosis; risk/aggressive behaviours; sociodemographic factors; communication and cultural barriers. Whilst these themes offer some explanation for disproportionate rates of detention, there are methodological limitations which limit the interpretation of results. Further longitudinal and qualitative research is needed to explore reasons for increased risk of compulsory detention in ethnic minority and migrant groups in more depth.

Keywords: ethnic minority, migrant, compulsory detention, reasons, explanations

Introduction

Adults from ethnic minority backgrounds have consistently been overrepresented in regard to psychiatric detention since the introduction of the Mental Health Act (1959) (Department of Health and Social Care (DHSC), 2018), and continue to be at increased risk of compulsory detention for mental health reasons in the United Kingdom (UK) (Bhui et al., 2003; Singh et al., 2014). The NHS reported that Black people were 3.5 times more likely to be compulsorily detained than White people (NHS digital, 2024). Despite initiatives aiming to tackle these inequalities figures continue to rise with latest figures concluding that Black people were more likely to be detained compared to White people (NHS digital, 2024; NHS England, 2019; Smith et al., 2020; The Parliamentary Office of Science and Technology, 2022). The significant inequalities faced by ethnic minorities has been addressed by The Independent Review of the Mental Health Act (DHSC, 2018) and due to the consistently elevated risk of Black people in particular being subject to higher rates of compulsory detention, it has been suggested that this may be related to systemic issues including unequal access to care, socioeconomic inequalities, and institutional racism (McKenzie & Bhui 2007).

Whilst there is overwhelming research evidencing the disproportionate rates of detention for Black people in the UK (Barnett et al., 2019; Care and Quality Commission, 2020), less is known about other ethnic minority populations. This includes South Asian (Singh et al., 2007) and migrant populations (Algeria et al., 2002). However, an international systematic review and meta-analysis conducted by Barnett et al. (2019) found that all ethnic minority and migrant populations are at increased risk of compulsory detention when compared to majority groups, indicating that this is a global issue in countries including the USA, Canada, and Netherlands.

Several reasons have been proposed for disproportionate rates of detention in minority groups. This includes adverse pathways to care and barriers in access to services (Singh et al., 2014). For example, Black Caribbean people are more likely to be referred to specialist mental health services by GPs rather than being supported in primary care (Bhui et al., 2003), and minority groups are more likely to experience more coercive pathways to care including police contact and emergency service use (Bhui et al., 2018). Ethnic differences in attitudes and beliefs around mental illness

and cultural stigma have also been hypothesised as preventing help-seeking in minority groups, and obtaining support in a timely-manner (Bhui et al., 2018; Clement et al., 2015). There has been debate around the effectiveness of psychological treatment which is based on Westernised and/or Eurocentric conceptual frameworks and there are questions about whether it meets the psychological and clinical needs of people from ethnic minority groups (Beresford & Rose, 2023; Fernando, 2014). This can lead to worsening outcomes, mistrust in professionals, and increased risk of compulsory detention (Prajapati & Liebling, 2021). Diagnosis of psychosis has been found to be elevated in ethnic minorities on a global scale, particularly for Black and migrant groups, which is often cited as a reason for compulsory detention (Barnett et al., 2019; Bhui et al., 2018; Knight et al., 2023; Lawrence et al., 2021; Solanki et al., 2023). However, psychosis alone does not meet criteria for detention, as detention requires a mental disorder that is of a nature and degree warranting hospitalisation; necessary, where an individual must pose significant risk to self or others; and appropriate treatment must be available. Therefore, psychosis alone points to insufficient explanation. Such trends reflect broader issues of disempowerment, social exclusion and lack of trust which appears evident mostly in ethnic minority groups (Bhui et al., 2018).

Additional explanations are linked to increased perceived risk of violence in ethnic minority groups (McNeil & Binder, 1995), clinician bias and influence of wider societal stereotypes such as Black males being viewed as more dangerous (Fernando, 2014), and racial discrimination which has also been cited as patients' own experiences of compulsory detention (Solanki et al., 2023). Furthermore, ethnic minorities are at greater risk of social disadvantage which impacts compulsory detention (Smith et al., 2020). Social isolation, housing difficulties, and greater ethnic density and neighbourhood deprivation increase levels of psychosis and compulsory detention in both Canada and the UK (Keown et al., 2016; Rotenberg et al. 2017; Welch et al., 2017). There are mixed findings in relation to sociodemographic factors such as age, gender, and employment having a significant impact upon compulsory detention (Gajwani et al., 2016; Singh et al., 2014), or having no significant impact upon compulsory detention (Singh et al., 1997).

In the comprehensive review by Barnett et al. (2019) findings showed that risk of compulsory detention is elevated in all minority groups, including migrants, when compared to majority groups globally. Figures appear elevated in the UK (in comparison to White-British groups: Black groups were 3-4 times more likely to be detained, South Asian 1.5-2 times more likely, and mixed and other minority ethnic groups were around 2 times more likely to be detained). However, the majority of studies were UK-based, and fewer studies have been conducted on a global scale (Halvorsrud et al., 2018). Explanations for increased rates of compulsory detention in minority and migrant groups found by Barnett et al. (2019) included increased comorbid drug use, higher levels of stigma, difficulty in detecting and diagnosis of mental health difficulties, cultural incompetence of professionals and services, and increased rates of psychosis. Whilst research has aimed to offer explanations for ethnic variations in compulsory detention, this is often reliant on correlational data. Barnett et al. (2019) found that 48% of studies in their review offered no explanations for ethnic disparities in compulsory admission and were not supported by primary evidence; instead, they were based on assumptions rather than causation which is problematic. This highlights that there is limited understanding of reasons for compulsory detention and healthcare inequalities, therefore making it difficult to embed legislation and practice to reduce this. Despite attempts to reduce disproportionate rates of ethnic minorities being compulsorily detained, particularly in the UK (NHS England, 2019), figures remain elevated. Therefore, it is imperative that research is continued in this area to help identify contributing factors and inform practices to promote health equality.

Aims of the current review: This review has two aims: 1) to synthesise quantitative research over the past five years to update and extend on the previous review by Barnett et al. (2019), and 2) to identify whether ethnic differences and increased risk of compulsory detention continue to exist globally and identify possible explanations for this.

Research Question: Do ethnic differences in compulsory detention still exist and what are the reasons for this?

Method

A scoping search was initially completed to ascertain feasibility of the current review, explore the breadth of research available on this topic, determine appropriate search terms, and refine the research question to ensure that the systematic review was comprehensive and well-targeted (Arksey & O'Malley, 2005).

This systematic literature review aimed to explore ethnic minority and compulsory admission to inpatient psychiatric hospital both within the UK and internationally. Quantitative studies were included which explored and/or compared the risk of compulsory admission to inpatient psychiatric hospital in ethnic minority groups. Studies were included if minority and majority groups were compared within the sample. Studies which compared rates and reasons for compulsory admission for migrants and native populations were also included.

Search Strategy

A systematic search was completed between May and July 2024. Databases searched included APA PsychArticles, PsychINFO, MEDLINE, Embase, Cochrane, Web of Science. Hand searches of articles screened at full-text stage were conducted via searching citations and reference lists to identify any further relevant papers; no further papers were found.

Search terms were identified by specifically reviewing Barnett et al.'s (2019) search terms. However, as the current review is a significantly smaller-scale project and only looked to explore risk of compulsory admission for ethnic minority and migrant groups, the researcher was selective in extracting relevant search terms. The researcher aimed to explore whether differences still exist in rates and risk of compulsory admission for ethnic minority and migrant groups on a global scale, whilst searching for papers which included comparison to majority groups. Synonyms of each key construct of the research question was listed (Appendix A). The review aimed to provide an update on Barnett et al.'s (2019) review looking at ethnic disparities in compulsory detention and therefore only looked at published papers since 2019.

The following search terms were used, including use of limiters and Boolean operators:

“disparit*” OR “variation” OR “inequalit*” OR “diff*” AND “compulsory detention” OR “compulsory treatment” OR “compulsory admission” OR “compulsory hosp*” OR “involun* detention” OR “involunt* treatment” OR “involunt* admission” OR “involun* detain*” OR “inpatient detention” OR “inpatient treatment” OR “inpatient admission” OR “inpatient hosp*” OR “psychiatric hosp*” OR “forensic psychiatry” OR “forensic patient” AND “mental health” AND “migrant*” OR “minorit* group” OR “ethnic minorit*” OR “ethnic group*” OR “BME” OR “BAME” OR “minorit* ethnic group*” OR “minorit* ethnic*” OR “racial* minorit*” OR “racial* background*” OR “racial* minorit*” OR “racial* group*”

Inclusion and Exclusion Criteria

Eligibility criteria for papers are detailed in Table 1 below.

Table 1:

Eligibility criteria for paper inclusion

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none">• Quantitative, peer-reviewed papers• Published in English due to lack of translation resources• Included adults from ethnically minoritised or migrant backgrounds and compared risk of compulsory admission in psychiatric settings to majority groups, and included possible explanations for differences• Studies that were UK or international• Papers published since 2019	<ul style="list-style-type: none">• Papers that included children or adolescents• Papers not explicitly referencing compulsory admission to psychiatric hospital (e.g., discussed only inequalities in mental health hospitalisation/ inequalities regarding length of stay in hospital/referred to inequalities in other areas of mental health e.g., increased risk of psychosis)• Did not refer to ethnicity

Publication Bias

The current systematic literature review only included peer-reviewed articles to obtain high-quality papers (Kelley et al., 2014; Rochon et al., 2002). Whilst there is risk of publication bias, where papers include findings that are statistically significant, are often more likely to be published (Haffer et al., 2019), the risk of bias in publication is debated (Nair, 2019). Nevertheless, research findings should be interpreted with caution.

Study selection and Data Extraction

Electronic database searches and hand searching yielded 1401 results. Of these, 130 duplicates were removed. 1271 articles were screened via title and abstract by one reviewer. If the reviewer was uncertain about whether a paper met inclusion

criteria, the full-text article was screened. After screening for title and abstract a total of 33 articles were identified for full-text screening. Of these, 10 met inclusion criteria. Figure 2 depicts the stepped process followed in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA guidelines) (Page et al., 2021).

Data Extraction

Data was extracted from the full-text articles of studies that were eligible. Study characteristics are presented in Table 3 in results.

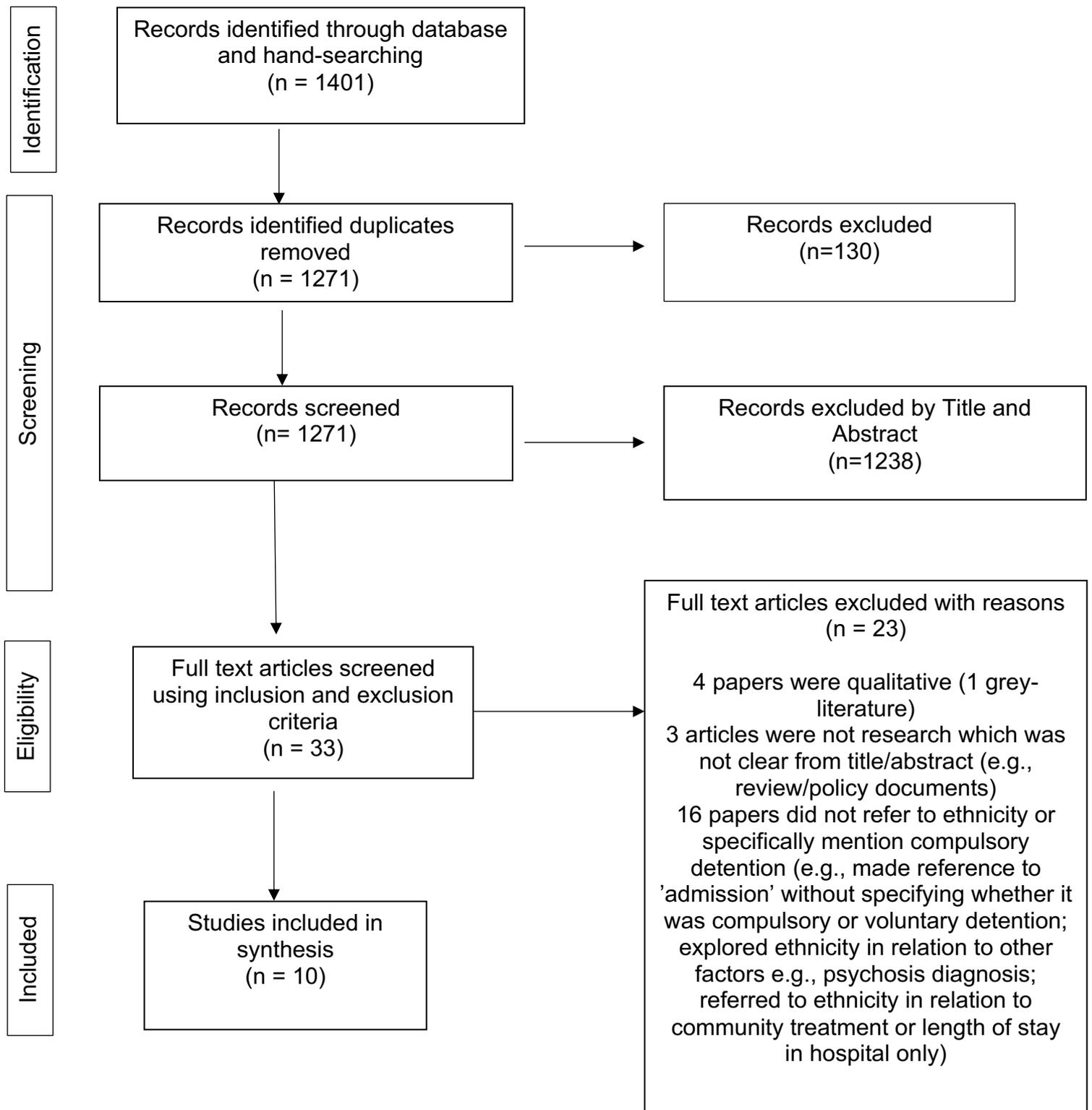
Quality appraisal of studies

The quality of all studies were critically appraised using the Quality Assessment Tool for Quantitative and Qualitative Studies (Kmet et al., 2004), a tool developed for use in public health settings. It allows the researcher to evaluate the quality of qualitative and quantitative papers through separate checklists (similar to the Critical Appraisal Skills Program, 2018), and allows the researcher to provide a percentage rating score out of a total score for review papers based on 14 criteria, offering a more thorough appraisal for the quality of studies. Researchers are instructed to respond 'Yes' (score 2), 'Partial (score 1), 'No' (score 0) or N/A (if items are not applicable to the study). Items not applicable are excluded from the summary score calculation. A summary score is obtained by summing the total score across each relevant item and dividing by total possible score. A score of 80% or higher suggests a high-quality study; 50-79% suggests moderate quality; below 50% suggests a low-quality study. All 10 quantitative studies were critically appraised using the quantitative section of the appraisal tool (Appendix B).

Synthesis of findings

To synthesise findings from quantitative data using varied methodological approaches, a narrative synthesis based on Popay et al.'s (2006) guidance was completed to provide a textual summary of statistical findings. This was based on comparing similarities and differences across studies, and consequently identifying broader concepts relating to rates and reasons for detention across different ethnic minority groups (Campbell et al., 2020).

Figure 2: PRISMA 2020 Flow Diagram of Screening and Selection



Results

Study Characteristics

10 papers met inclusion criteria for the review. Data was extracted from these studies. Study characteristics are presented in Table 3; a key for acronyms is added as a footnote.

Table 3:

Study Characteristics

Author, Year, Country	Aims	Sample	Demographics	Design	Key Findings	KMET Score	Strengths	Limitations
McBride et al., 2023, United Kingdom	Ethnic density on risk of compulsory admission	1,238,188	White British, White other (White-Irish or any other white) Black or Black British (Caribbean, African, any other Black group) Asian or Asian British (Indian, Pakistani, Bangladeshi, Chinese or any other Asian background) Mixed (white and Black Caribbean, white and Black	Multilevel logistic regression	Rates of compulsory admission: Black patients (12.4%), mixed-ethnicity (7.3%), Asian (5.9%), White-Other (4.5%), White-British (3.0%) Ethnic density operates differently for different ethnicities For White-British patients, 10% increased own-group ethnic density	21	Nationally representative sample	Incomplete dataset (MHMDS)-high levels data missing (e.g., marital status/employment) Effect size and power not reported

African, White, and Asian or any other mixed background) and any other ethnic group.

Median age 48

was protective against increased risk of compulsory admission; remained when including area-level deprivation

Reduced risk in compulsory admission when living amongst high own-group ethnic density Asian patients only when accounting for area level deprivation

White-Other or mixed patients: 10% increased risk in compulsory admission; remained when including area-level

deprivation

Del-Favero et al., 2023, Italy	Evaluate compulsory admission rates in migrant and native population; investigate sociodemographic, clinical and care-related variables	1118 (2018-2020)	933 Native Italians 185 Migrants	ANOVA/ Pearson's bivariate correlation/ Hierarchical logistic regression model Retrospective single-centre study	Compulsory admissions more than double for migrants (23.2%) versus natives (9.11%) Migrants with Schizophrenia 11x more likely to be compulsorily detained than other diagnoses; natives detention for schizophrenia was 4x increased Male gender, lower education, homelessness, lack of	19	Large sample; almost all patients enrolled Representative of catchment area	Variables not accounted e.g., medication/symptom severity/migrant length of stay/migrant region of origin Data for admissions only >48 hours
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psychiatric care common in migrants and associated with increased risk

Variables mostly associated with compulsory admission in migrants was communication problems, psychosis, and aggressive behaviours

Freitas et al., 2022, UK	Impact of ethnicity and mediation effects of clinical care on involuntary admission (SLaM Trust)	18569/UK Inpatient (first time) between 2008-2021	White-British (44%) Black African (11%) Black British (10%) Other White (10%)	Logistic regression analyses Retrospective study- one Trust	Inequalities in 10/14 ethnic groups Highest rates of compulsory detention in Asian Chinese (52%), Black African (52%), Black	21	Diverse catchment area Generalisable to other urban areas	12 months prior only- unknown impact of previous care received Some variables not included e.g., social support, marital status, illness severity
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Black Caribbean
(6%)

Asian British (4%)

Median age
admission- 39

56% male

British/Other
Black (49%)

Lowest rates
for White-
British (23%)

No significant
inequalities in
White-Irish or
mixed

Higher number
of SLaM
appointments
for Black
patients,
higher home
treatment
appointments
in Asian
people-
associated
with increased
risk

Black patients
less likely to
have care plan
or
psychological
therapy

(increased risk)

Degree of ethnic differences not significantly explained by differences in clinical care in 12 months prior to admission- indicative that cultural differences and disadvantages may impact care outcomes

Collazos et al., 2021, Spain	Explore relationship between migrant characteristics and clinician evaluation upon encounter, compared with native Spanish population	40 clinicians	Latin-America, North Africa, Sub-Saharan Africa, Asia, Eastern Europe, Western Europe, native-Spanish patients	Multivariate regression/ descriptive cross-sectional study at two hospitals	No significant differences in compulsory admission between migrants and native populations	17	First study to acknowledge clinician perspectives Representative of Barcelona	Ad-hoc questionnaires not validated Confounding variables e.g., severity of symptoms, subjectivity on measures
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Clinician
comfort in
assessment is
influenced by
patient race,
ethnicity and
culture which
impacts
perceived risk,
diagnosis, and
pathway to
treatment

Migrants with
lower local
language
proficiency
more likely to
be diagnosed
with psychosis;
communication
barriers
associated
with perceived
aggression
and increased
risk of
involuntary
detention

Males more
likely to be

detained

Oduola et al., 2019, UK	Comparison of whether ethnic disparities have changed over 15-year period in same area of London: comparison of two studies	AESOP study: 266 versus CRIS-FEP study 446 with FEP First contact for psychosis More females in Black groups	Age 18-64: AESOP mean age: 31.9 years; CRIS-FEP mean age 33.6 years White British White-Other Black African Black Caribbean	Chi-square/logistical regression analyses	Risk of compulsory admission largely unchanged over time in relation to ethnicity Black African admissions remain 3x higher compared with White-British. Black Caribbean admissions reduced over time compared to White-British but finding not statistically significant Lower education rates in Black	21	Longitudinal study Large sample: robust datasets Good control of confounding variables	Some missing data
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					Caribbean across time; Unemployment and insecure living arrangements associated with increased risk in Black African patients			
Terhune et al., 2022, Sweden	Explore risk of compulsory admission at first diagnosis in migrants compared to host-nation	12,000	Sub-Saharan Africa, Middle East and North Africa, Non-Nordic European, Nordic countries (excluding Sweden), East Asia, South Asia, Latin America Swedish natives	Multilevel logistic regression	1298 compulsory admissions: migrants (13.5%) and migrants children (12%) versus Swedish-born (9.6%) Migrants (and children of) more likely to be admitted for psychotic disorder versus natives	22	Longitudinal data/national data Confounders well controlled	Some missing data

Increased risk
of compulsory
admission
associated
with region of
origin: Sub-
Saharan
African, North
African, Middle
Eastern and
non-Nordic
regions at
increased risk

Visible
migrancy
status
approximately
correlated with
increased risk
of detention

Higher
neighbourhood
own-region
migrant
density
associated
with increased
risk of
compulsory

					admission even after adjusting for socioeconomic factors			
					Possible reasons: lack of health literacy, lack of access to support			
Penney et al., 2020, Canada	Comparing voluntary and forced migrants with host-nation patients in FMHS	Forced migrants (60) Voluntary migrants (226) Canadian-born (234)	Forced (Mexico, Central America, Middle East, South Asia, Eastern Africa) Voluntary (Caribbean, Southern Europe) 84.2% men; mean age 37.28 (time of admission)	Chi-square/ z-test/ANOVA	Migrants at elevated risk for psychosis and overrepresented in FMHS and CJS- higher for Caribbean, Central American and Eastern/Western African; fewer from East/South Asia Migrants more likely to have	18	Large sample, populous area	Developmental/historical information lacking in migrant group May not generalise to non-forensic settings

					later onset psychotic disorder and higher age at admission			
					No differences in type of offences			
					Migrants had more familial support before illness onset; similar deterioration in relationships as natives at time of admission			
Tarsitani et al., 2022, Italy	Clinical and migratory factors associated with migrant and native compulsory detention	234 (PICU): 117 immigrants, 117 Italians	First generation migrants (Europe, Africa, Asia, South America) Italian natives	Cross-sectional study McNemar Test/Binary logistical regression	Migrants more likely to be compulsorily (32%) detained than Italian-natives (24%)	20	Matched samples study	Single-centre study- Sample size smaller than required for reliable regression analysis

Age/gender/
diagnosis match

regardless of
symptom
severity;
higher for
refugees and
asylum
seekers

Increased risk
for migrants in
Italy for <2
years

Language,
culture, and
communication
barriers
associated
with increased
risk

Migrants less
educated,
more
frequently
married. Age,
sex, country of
origin, forced
migration,
diagnosis not
associated
with increased

risk

Jankovic et al., 2020, England	Exploring access rates to secondary mental health services including compulsory admissions	22,073 women who had first contact with MHS during perinatal period: 282 involuntary admissions (NCDR data)	18+ All ethnic groups included	Descriptive/multivariate logistical regression	Black, Asian, and White-Other background more likely to be involuntarily admitted than White-British women and receive diagnosis of psychosis Lower access to CMHS for these ethnic groups: increased risk of compulsory detention; lack of early intervention may lead to more severe presentations Language, cultural stigma	20	Diverse sample representative of population Near complete dataset	Relatively small sample size of involuntary admissions- not possible to standardise rates; but ethnic difference remains fairly large
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and deprivation associated with lack of access to community services

Higher density of ethnic minorities associated with lower demand/need for mental health care

Rotenberg et al., 2019, Canada	Ethnicity and impact on involuntary detention	166 involuntarily admitted (psychosis)	East Asian (20.5%) South Asian (10.2%) Black African (16.9%) Black Caribbean (16.9%)	Logistical Regression	Ethnicity did not significantly predict involuntary admission; instead, predictors were symptom severity, age,	17	Multiple ethnic groups	Sample size not sufficiently powered Single-centre study
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White North
American
(16.3%)

White European
(19.3%)

being brought
to ED
involuntarily,
and access to
psychiatrist in
community

Key¹

¹ **MHMDS**- Mental Health Minimum Dataset

CRIS-FEP- Clinical Record Interactive Search-First Episode Psychosis

CJS- Criminal Justice System

ED- Emergency Department

SLaM- South London and Maudsley

FEP- First Episode Psychosis

NCDR- National Community Data Repository

CMHS- Community Mental Health Service

AESOP- Aetiology and Ethnicity in Schizophrenia and Other Psychosis

FHMS- Forensic Mental Health Services

MHS- Mental Health Service

Quality Appraisal

Eight studies were rated as 'high quality' and two studies were rated as 'moderate quality'. Two papers reported possible insufficient sample sizes for reliable regression analysis (Rotenberg et al., 2019; Tarsitani et al., 2022). Jankovic et al. (2022) highlighted a small percentage of women involuntarily detained which resulted in a small sample size, meaning the researchers were unable to adjust for age and deprivation which may have impacted reliability of findings may have been influenced by demographic and socioeconomic differences rather than being reflective of true differences in use of mental health services. Whilst some studies had large samples representative of population diversity (including factors such as ethnicity and socioeconomic status) (Freitas et al., 2023; Jankovic et al., 2020; Oduola et al., 2019), one did not (Tarsitani et al., 2022) and therefore may limit generalisability of findings in this review.

Studies varied in methodological rigour. Whilst all studies attempted to control for confounding variables, only four papers evidenced good control over confounding variables (McBride et al., 2023; Oduola et al., 2019; Tarsitani et al., 2022; Terhune et al., 2022) therefore increasing validity of their findings and reducing possible bias. Several studies had missing data (Freitas et al., 2022; McBride et al., 2023; Oduola et al., 2019), or sociodemographic data not accounted for, such as marital status, employment, illness severity, previous clinical care, migrant history, or length of stay, (Collozas et al., 2021; Del-Favero et al., 2023; Freitas et al., 2022; McBride et al., 2023; Penney et al., 2020). This may have impacted the validity of findings across all papers and resulted in mixed conclusions being cited as reasons for increased risk of compulsory detention. Additionally, the papers referred to ethnicity or region of origin for migrants to varying degrees, for example Freitas et al. (2023) compared 14 ethnicities, whereas Oduola et al. (2019) compared only four ethnicities. All international papers except Rotenberg et al. (2019) referred to migrants' region of origin rather than ethnicity, and one paper only referred to 'migrants' as an overall comparison group (Del-Favero et al., 2023). This disparity in defining ethnicities may result in difficulty drawing comparisons when exploring which minority groups appear to be at elevated risk of compulsory admission across studies and possible reasons

for this. Nevertheless, the findings from these studies still provide valuable information on whether disparities in minority groups exist in relation to compulsory detention when compared to majority groups.

Five out of 10 papers analysed data from single-centre or single-Trust sites (Del-Favero et al., 2023; Freitas et al., 2022; Penney et al., 2020; Rotenberg et al., 2019; Tarsitani et al., 2022) which, whilst representative of the area population, are limited in broader generalisability. Penney et al. (2020) only explored a forensic mental health service; whilst providing important findings, they are difficult to generalise to other settings. Three studies looked at longitudinal data (Freitas et al., 2022; Oduola et al., 2019; Terhune et al., 2022), and the remainder were cross-sectional. Whilst cross-sectional studies enable findings around prevalence of compulsory admission and ethnic disparity, and enable comparison of numerous variables, there is higher risk of confounding variables impacting findings, potential of bias, and findings only provide a snapshot of a situation therefore making it difficult to infer causality.

All studies used forms of regression, correlation, or ANOVA. Whilst associations between variables can be concluded, they do not necessarily infer causation. Only one study looked at primary data exploring clinician perspectives; however, they used a non-standardised questionnaire containing subjectivity (Collozas et al., 2021) which may impact the reliability of these findings.

Synthesis of findings

10 quantitative studies exploring inequalities in risk of compulsory admission between one or more ethnic minority group and majority groups, or between migrant and native populations, and/or possible explanations for this were retrieved and reviewed.

Eight studies reported ethnic inequalities in compulsory detention for minority groups compared to majority groups, or migrant groups compared to native populations (Del-Favero et al., 2023; Freitas et al., 2022; Jankovic et al., 2020; McBride et al., 2023; Oduola et al., 2019; Penney et al., 2020; Tarsitani et al., 2022; Terhune et al., 2022). One study based in Canada found that ethnicity did not significantly predict

compulsory admission when adjusting for sociodemographic variables, symptom severity, and community care (Rotenberg et al., 2019). Whilst Collozas et al. (2021) also found no significant differences between Spanish natives and migrant populations in relation to compulsory admission, they did find lower rates of admission for Latin-American patients compared to native-Spaniards. All studies were from high-income countries (UK, Canada, Italy, Sweden, Spain). Four studies were based in the UK, two studies were based in Canada, two in Italy, one in Sweden, and one in Spain.

Ethnic inequalities in rates of detention

Six studies reported specific variations in ethnicity on rates of detention. Black patients were found to be at highest risk of compulsory detention in three UK-based studies (McBride et al., 2019; Freitas et al., 2023; Oduola et al., 2019); of these patients, Black African patients were at highest risk (Freitas et al., 2023; Oduola et al., 2019) and East Asian patients were also found to be at elevated risk in one study (Freitas et al., 2023). Oduola et al (2019) found that Black African and Black Caribbean patients had persistently higher rates of compulsory admission over a 15-year period (when comparing groups between 1997-1999, and 2010-2012), during first-episode psychosis. Although overall rates of compulsory detention had reduced over this time in the UK, Black African patient admissions remained three times higher compared to White-British groups (Oduola et al., 2019). Jankovic et al. (2020) found ethnic inequalities in compulsory admission for all minority groups when compared to White-British women. In studies conducted in other countries, patients from the Caribbean, North and West African origin, and Sub-Saharan Africa were also noted to be overrepresented compared to figures for native populations in, for example, Canada (Penney et al., 2020) and Sweden (Terhune et al., 2022). Higher rates of detention were also found in Asian populations (McBride et al., 2019; Penney et al., 2020) and Middle Eastern and non-Nordic migrants (Terhune et al., 2022) when compared to majority groups. Whilst country of origin was not associated with risk of compulsory admission in Tarsitani et al.'s study (2022), migrants were at increased risk of compulsory detention when compared to the native population. Similarly, whilst Del-Favero et al. (2023) did not specify country of origin for migrants, they also found increased risk of compulsory detention for migrants compared to native populations. By contrast, one study found increased

odds of compulsory admission for native-Spaniards when compared to Latin-Americans (Collazos et al., 2021).

Ethnic Density

Findings from Jankovic et al. (2020) suggest higher density of ethnic minorities is associated with lower need for mental health care, however McBride et al. (2023) found limited evidence that living within areas of high own-group ethnicity acts as a protective factor against compulsory admission. McBride et al. (2023) found mixed results: no significant difference was found between Black participants and own-group ethnic density in relation to compulsory admission; for White-Other and mixed-ethnic backgrounds, own-group density was associated with increased risk of compulsory admission. In Asian patients, a very small reduction in compulsory admission was noted, only when accounting for area-level deprivation and density of population, and for White-British participants, own-group ethnic density reduced risk of compulsory admission. In migrant populations, higher own-region migrant density (migrants who have been born in the same region living in the same area) was associated with increased risk of compulsory admission (Terhune et al., 2022).

Access and engagement with services

Two UK studies found that ethnic minority groups had lack of access to community mental health services (Jankovic et al., 2020), and Black patients were less likely to receive psychological therapies or have a care plan in the twelve months prior to admission (Freitas et al., 2023). However, Black patients were found to have a higher number of clinical appointments and Pakistani patients had higher number of home treatment appointments in the twelve months prior to compulsory admission which was associated with increased risk (Freitas et al., 2023). Further studies suggested that lack of psychiatric care was more common in migrants who may be disadvantaged in access to support in the lead up to compulsory admission (DeL-Favero et al., 2023; Terhune et al., 2022). Rotenberg et al. (2019) also noted that lack of psychiatric care in the community resulted in higher risk of compulsory admission.

Impact of diagnosis

Migrants were found to more commonly be diagnosed with psychosis or Schizophrenia disorders compared to native populations which was associated with increased risk of compulsory admission (Collozas et al., 2021; Del-Favero et al., 2023; Penney et al., 2020; Tarsitani et al., 2022). Black perinatal women were also more likely than their White counterparts to be diagnosed with psychosis (Jankovic et al., 2022). Three studies looked specifically at psychosis presentations and compulsory admission, and within these, elevated rates of compulsory admissions were found in ethnic minority groups suggesting a link with diagnosis and compulsory detention (Freitas et al., 2023; Oduola et al., 2019; Terhune et al., 2022).

Risk/aggressive behaviours

Risk/aggressive behaviours were only considered in four studies. Penney et al. (2020) found ethnic minorities were overrepresented in the criminal justice system and forensic mental health system (FHMS). Perceived risk and aggressive behaviours were hypothesised to be associated with increased risk of compulsory admission in minority groups in other studies (Collozas et al., 2021; Del-Favero et al., 2022; Tarsitani et al., 2022).

Sociodemographic factors

Studies found various sociodemographic factors associated with increased risk of compulsory detention. Lower education levels were noted in both migrants and Black patients (Oduola et al., 2019; Tarsitani et al., 2022). Unemployment, homelessness, and insecure living arrangements were more prevalent in Black African patients (Oduola et al., 2019). Migrants were found to have later onset of symptoms and later admission to services (Penney et al., 2020). Male gender was associated with increased risk of compulsory detention in two studies (Collozas et al., 2021; Del-Favero et al., 2023), whilst Oduola et al. (2019) found more Black females were compulsorily detained compared to White British groups. Penney et al. (2020) found that migrants had more familial resources prior to illness onset and were more likely to be married and have children versus native groups; however, both groups had similar levels of social support deterioration by time of admission. Tarsitani et al. (2022) found that migrants were more frequently married. Visible migrancy status was approximately associated with increased risk of detention (Terhune et al., 2022),

and migrants' length of stay in Italy for less than 2 years was associated with increased risk of compulsory admission (Tarsitani et al., 2022).

Communication and cultural barriers

Language and communication barriers were associated with increased risk of compulsory detention for minority groups (Collazos et al., 2021; Jankovic et al., 2020; Tarsitani et al., 2022). Collozas et al. (2021) found that clinician comfort was influenced by patient race, ethnicity, and culture, whereby increased discomfort, including around cultural competency and language comprehension, was associated with increased risk of compulsory admission. Communication and cultural barriers were associated with misinterpretation of symptoms in minority groups which was associated with increased risk of misdiagnosis (Collozas et al., 2021), often being psychosis. Clinician misinterpretation of symptoms was also associated with increased perceived levels of violence (Collozas et al., 2021; Tarsitani et al., 2022; Terhne et al., 2022) as miscommunication was related to migrants appearing as non-consenting to voluntary treatment, and becoming agitated by processes (Collozas et al., 2021). Studies also found that rather than variables such as prior clinical care or socioeconomic factors (e.g., homelessness) being good predictors of compulsory admission in minority groups, it was cultural differences and structural barriers that better explained ethnic disadvantages in compulsory detention (Freitas et al., 2022; Oduola et al., 2019; Penney et al., 2020; Tarsitani et al., 2022; Terhune et al., 2022). Additionally, factors including migration trauma, poor healthcare literacy, and stigma were hypothesised to be associated with increased risk of compulsory detention in minority groups (Jankovic et al., 2020; Tarsitani et al., 2022; Terhune et al., 2022).

Discussion

This review of global literature aimed to explore whether disproportionate rates of compulsory detention still exist in ethnic minority and migrant groups, and possible reasons for this. It aimed to update and collate research since the comprehensive review by Barnett et al. (2019). Findings from 10 studies were synthesised into seven thematic concepts: 1) Ethnic inequalities in rates of detention; 2) Ethnic density; 3) Access and engagement with services; 4) Impact of diagnosis; 5)

Risk/Aggressive behaviours; 6) Sociodemographic factors; 7) Communication and cultural barriers.

Findings in this systematic literature review show that ethnic inequalities in compulsory detention continue to persist for ethnic minority and migrant groups on a global scale, mirroring findings by Barnett et al. (2019). Black people were at highest risk of compulsory detention compared to White people (Jankovic et al., 2020; McBride et al., 2023; Oduola et al., 2019). South Asian and East Asian minority groups were at increased risk compared to White groups (Freitas et al., 2022; McBride et al., 2023). Region of origin was associated with increased risk of detention in migrants when compared to native populations, with migrants from African and Caribbean regions at highest risk followed by Middle Eastern, Central America, South and East Asia (Penney et al., 2020; Terhune et al., 2022). Refugees and asylum seekers, and migrants with shorter length of stay in countries were also at increased risk of compulsory detention (Tarsitani et al., 2022). One study found no significant difference between ethnic minority and native groups and compulsory detention, but found that native-Spaniards were at higher odds of detention compared to Latin-Americans (Collozas et al., 2021); however the majority of Latin-Americans in the sample were female and less likely to be diagnosed with psychosis which is supported by findings showing that males are more likely to be diagnosed with psychosis (Morgan & Fisher, 2007), and psychosis is associated with increased risk of compulsory detention (Barnett et al., 2019). This may provide some explanation for the differences in these findings. Additionally, Rotenberg et al. (2019) found that ethnicity did not predict risk of compulsory detention which is contradictory to previous findings by the same research team (Rotenberg et al., 2017), however this could be attributed to the small sample which was not sufficiently powered for reliable analysis.

This review highlighted a number of possible reasons for increased risk of compulsory detention in ethnic minority groups. Interestingly a number of themes appeared to be interlinked. Firstly, in line with previous research minority groups are more likely to be diagnosed with psychosis (Barnett et al., 2019), which is related to increased risk of compulsory detention (Freitas et al., 2022; Oduola et al., 2019; Terhune et al., 2022). However, it has often been critiqued that psychosis alone does

not meet criteria for detention and therefore does not alone offer sufficient explanation for increased rates of compulsory detention amongst ethnic minority groups (Barnett et al., 2019). This current review may serve to offer some explanation around this as language and cultural barriers were found to contribute to this disparity (Collazos et al., 2021; Jankovic et al., 2020; Tarsitani et al., 2022). One study found that clinicians often felt more discomfort when assessing patients from different cultural, racial, and ethnic backgrounds to their own (Collozas et al., 2021), particularly when there were language barriers. When clinicians felt less comfortable and culturally incompetent, they were more likely to misdiagnose patients, often with psychosis, due to misinterpretation of symptoms (Collozas et al., 2021; Tarsitani et al., 2022). This supports previous research where poor understanding of symptoms can lead clinicians to view patients as 'strange' or 'crazy' and result in greater likelihood of viewing such behaviours as aggressive or violent (Marie & Miles, 2008), which increases the likelihood of compulsory detention. Terhune et al. (2022) found similar conclusions, where they hypothesised that language and communication barriers were linked to minority groups being perceived by professionals as more aggressive or non-consenting to voluntary treatment, therefore leading to increased risk of compulsory admission. These findings are also consistent with previous research suggesting that clinician bias impacts shared decision-making due to wider societal stereotype influences, where professionals can perceive Black males to be more 'dangerous' leading to compulsory detention (Fernando, 2014). Additionally, previous research has also shown racial bias in clinician's prediction in risk of violence where risk has been over-estimated for non-White groups (McNeil & Binder, 1995), demonstrating the power that professionals hold (Spector, 2001). This is problematic as such discrimination can replicate experiences that ethnic minorities face in wider society where compulsory detention can be re-traumatising and retrigger previous experiences of oppression and control, and perpetuate feelings of fear and mistrust of services by service-users (Keating & Robinson, 2004).

Lack of community support and barriers to access was also found to be directly and indirectly associated with increased risk of compulsory detention amongst ethnic minority and migrant groups (Freitas et al., 2022; Jankovic et al., 2020; Oduola et al., 2019; Rotenberg et al., 2019; Terhune et al., 2022). Studies showed that minority groups had lack of access to community psychiatric support (Freitas et al., 2022;

Jankovic et al., 2020), and this was associated with an increase in severity of symptoms by the time support was received, which arguably requires more intensive support. However, as well as structural barriers to access, poorer health literacy and cultural stigma was also associated with increased risk of compulsory detention in minority groups. This is supported by findings which demonstrated that higher rates of admissions were found in neighbourhoods with high own-region migrant density (Terhune et al., 2022), and some ethnic groups in the UK being at elevated risk when living in high own-group density neighbourhoods (McBride et al., 2023). This suggests that community cultural stigma may also maintain barriers against seeking access to timely support. Whilst significant literature supports findings that ethnic minorities experience barriers to access due to structural barriers, cultural beliefs, and stigma (Bhui et al., 2018; Singh et al., 2014), stigma may not offer sufficient explanation alone as research has also shown that ethnic minorities, particularly Black Caribbean people, are less likely to be supported in primary care and do not feel heard when attempting to seek help (Solanki et al., 2023). This may suggest possible racial discrimination, or again, may link to cultural incompetence when working with minority groups.

In refugee and asylum seekers, migration trauma was also associated with increased risk of compulsory detention (Tarsitani et al., 2022). This may be linked to the fact that refugees and asylum seekers often experience post-traumatic symptoms (Nose et al., 2020) and therefore are already more vulnerable in mental state. This, coupled with experiencing difficulties with social integration and lack of mental health literacy, may exacerbate mental health deterioration (Martinovic et al., 2009). Barriers to accessing timely support has serious implications for involuntary migrants as such coercive interventions can retraumatise migrants and negatively impact their mental health leading to mistrust in services (Kiselev et al., 2020b; Schock et al., 2016), and perpetuate patterns of mental health deterioration since research has also found rates of compulsory readmission to services is also increased in minority groups (Barnett et al., 2019). Similarly, migrants with less time in the host country were at increased risk of compulsory admission (Tarsitani et al., 2022). This may also be linked to increased migration trauma and social integration difficulties alongside communication and cultural barriers, and barriers around access to mental health support (Kieslev et al., 2020b; Martinovic et al., 2009).

Sociodemographic factors such as lower education and housing issues were more prevalent in migrant and Black ethnic minorities which was associated with increased risk of compulsory admission (Del-Favero et al., 2023; Oduola et al., 2019; Tarsitani et al., 2022) and supports previous findings (Bhui et al., 2018). There were mixed findings around whether age, marital status and gender was associated with compulsory admission (e.g., Oduola et al., 2019; Penney et al., 2020; Tarsitani et al., 2022) which mirrors previous research (Gajwani et al., 2016; Singh et al., 2007; Singh et al., 2014). These mixed findings may be explained by the fact that only some studies included in this review measured sociodemographic variables and to differing degrees, or these variables were part of their missing data (e.g., McBride et al., 2023), therefore impacting the validity of overall findings. Similarly, where research has often cited adverse pathways to care for ethnic minorities such as increased police contact, these findings were not apparent in this review. This is likely due to studies not including referral information or severity of symptoms which could impact this (e.g., Freitas et al., 2022). Penney et al. (2020) found an overrepresentation of ethnic minority and migrant groups in FMHS, which is the only study which draws links with the criminal justice system.

Whilst possible explanations have been proposed from the papers reviewed, it is important to note that there were several methodological issues impacting validity and reliability of findings. Firstly, several studies had missing data (such as sociodemographic variables being sporadically measured), and did not account sufficiently for confounding variables. For example, Freitas et al. (2023) predicted that ethnic minority groups who had more clinical appointments and home treatment were at an increased risk of compulsory detention, however, the authors did not account for severity of symptoms or clinical contact prior to twelve months of collecting data. Whilst this finding may suggest that increased community care appointments increase the risk of compulsory admission for ethnic minorities, it may also suggest that patients who had more appointments were already more unwell and therefore had an increased need for more intensive support. Due to this, causal links are difficult to establish.

The majority of studies also relied on pre-existing data which can lead to issues with completeness of data and may lead to biases in analysis. Additionally, the majority of

papers were single-centre studies limiting generalisability, and many used cross-sectional data limiting causality to be inferred. Importantly, all studies used forms of regression or correlational analysis which means that most findings are based on associations rather than causation and therefore findings should be interpreted with caution. This may also explain why the reasons proposed for disparities in ethnic minority compulsory detention compared to majority groups, are interlinked, and there is no one 'true' reason reflected, and mirrors findings from Barnett et al.'s review (2019) where findings were mainly based on associations and assumptions. However, it may also reflect how ethnicity is a complex construct which encompasses multiple interacting variables and intersectional characteristics which adds to the level of complexity in finding 'causation'. Whilst research has suggested that experiences of institutional and structural racism contribute to the disproportionate rates of compulsory detention for ethnic minority and migrant groups (McKenzie & Bhui, 2007), this was not directly explored in any of the studies. Only one study noted an approximate association with visible migrancy and compulsory detention (Terhune et al., 2022) and therefore this also needs to be presented as a possible explanation for disproportionate rates of detention.

Strengths and limitations

This review has updated on Barnett et al.'s (2019) quantitative research using a comprehensive database search. It highlights that ethnic minority and migrant groups continue to be at increased risk of compulsory admission compared to majority groups. Whilst literature has often focussed on socioeconomic explanations for disparities in compulsory admission, this review highlights the need to address systemic issues within healthcare systems. As well as socioeconomic factors, institutional factors including cultural barriers, cultural competence, clinician bias, and communication difficulties appear vital in explaining, at least in part, some of these differences. It reflects the need for more longitudinal studies to investigate variables which could provide more information around causality, a need for further research which explores clinician perspectives, and importantly, service-user's more nuanced and complex lived experiences of their journeys into mental health services to provide richer information for reasons relating to compulsory detention.

Limitations of this review are that it did not include grey literature and therefore may be vulnerable to publication bias. Many studies included were impacted by confounding variables and had missing data which impacts the validity and reliability of findings. Additionally, qualitative research papers were not included in this review which may have included service-user lived experiences of compulsory admission, and may have provided more in-depth insight around reasons for increased detention rates in minority groups through primary data collection.

Clinical recommendations

There is a need, not only for cultural competence, but improved cultural sensitivity training for clinicians with a greater need for cultural awareness of how symptoms are expressed across cultures to reduce perceived risk of violence and aggression, and misdiagnosis. Language barriers need to be addressed through use of interpreting services to support communication with minority groups and avoid miscommunication which may enable appropriate and timely support, and facilitate accurate assessment and appropriate care. Access to services needs to be improved for ethnic minority and migrant populations which could be through reducing global mental health stigma while increasing awareness in communities such as through spiritual leaders or through increased out-reach services. Further longitudinal research is needed which can explore interacting variables in more depth.

Conclusion

This review highlights that over the past five years, inequalities in rates of compulsory detention continue to exist for ethnic minority and migrant groups on a global level, compared to majority groups. Reasons for this are broadly similar to findings by Barnett et al. (2019) which include cultural incompetence, difficulty in detection and diagnosis, increased psychosis rates, and stigma. Research needs to consider nuanced exploration around communication and cultural barriers, access to support, environmental factors, and risk. Possible reasons for disproportionate rates continue to be based mainly on associations, limiting the ability to infer causality.

This emphasises the need for more longitudinal studies, and qualitative research involving service-user experiences and their journeys through the mental health system to identify contextual explanations for compulsory detention. This will help inform and embed legislations and clinical practice to reduce inequalities more effectively.

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Appendix A- Author guidelines

BJPsych Open Journal Author Guidelines

Full author guidelines can be found at

<https://www.cambridge.org/core/journals/bjpsych-open/information/author-instructions/preparing-your-materials#fndtn-new>

Preparing your Submission

Checklist: What to Include

Authors will be asked to confirm the following elements are included during submission. Any omissions may cause delays.

Word Document:

1. Title – The title should be brief and relevant. Titles should not announce the results of articles and (apart from editorials) they should not be phrased as questions.
2. Author Names – The full names of the authors should appear on the title page in the form that is wished for publication. When submitting a manuscript authored by a group, please specify the name of the group and identify the group members on the title page who can take credit and responsibility for the work as authors. Other group members (non-author contributors) should be listed under Acknowledgements or in Supplementary Material.
3. Main Text – See relevant [Article Type](#) for individual specification.
4. Clinical Trials Registration – In accordance with [ICMJE guidelines](#), *BJPsych Open* requires all clinical trials to be registered in a public trials registry at the beginning of the research process (prior to patient enrolment). Trial registration numbers should be included in the abstract, with full details of the trial in the Methods section.
5. Materials, equipment and software – The source of any compounds not yet available on general prescription should be indicated. The version number (or release date) and manufacturer of software used, and the platform on which it is operated (PC, Mac, UNIX etc.), should be stated. The manufacturer, manufacturer's location and product identification should be included when describing equipment central to a study (e.g. scanning equipment used in an imaging study).

6. Ethics Statement – All authors are required to follow the [ICMJE guidelines](#) on the protection of research participants.

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 section 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.

Appendix B: Table of search terms: Synonym for search terms in relation to question

Differences	Compulsory admission	Mental health	Ethnic or migrant
"disparit*" OR "variation" OR "inequalit*" OR "diff*"	"compulsory detention" OR "compulsory treatment" OR "compulsory admission" OR "compulsory hosp*" OR "involun* detention" OR "involunt* treatment" OR "involunt* admission" OR "involun* detain*" OR "inpatient detention" OR "inpatient treatment" OR "inpatient admission" OR "inpatient hosp*" OR "psychiatric hosp*" OR "forensic psychiatry" OR "forensic patient"	"mental health"	migrant*" OR "minorit* group" OR "ethnic minorit*" OR "ethnic group*" OR "BME" OR "BAME" OR "minorit* ethnic group*" OR "minorit* ethnic*" OR "racial* minorit*" OR "racial* background*" OR "racial* minorit*" OR "racial* group*"

Appendix C: Quality Appraisal adapted from Kmet et al. (2004)

Questions	Author											
	Dei-Favero et al., 2023	Frietas et al., 2022	Collazos et al., 2020	McBride et al., 202	Oduola et al., 201	Tehrune et al., 2020	Tarsitani et al., 2022	Jankovic et al., 202	Rottenberg et al., 2019	Penney et al., 2020		
Q1. Question / objective sufficiently described?	2	2	2	2	2	2	2	2	2	2	2	2
Q2. Study design evident and appropriate?	2	2	2	2	2	2	2	2	2	1	2	2
Q3. Method of subject/comparison group selection or source of information/input v	1	2	1	2	2	2	2	2	2	1	1	1
Q4. Subject (and comparison group, if applicable) characteristics sufficiently des	1	2	1	1	1	2	2	2	2	2	2	2
Q5. If interventional and random allocation was possible, was it described?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Q6. If interventional and blinding of investigators was possible, was it reported?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Q7. If interventional and blinding of subjects was possible, was it reported?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Q8. Outcome and (if applicable) exposure measure(s) well defined and robust to r	2	2	1	2	2	2	1	2	2	2	1	1
Q9. Sample size appropriate?	2	2	2	2	2	2	2	1	1	1	1	1
Q10. Analytic methods described/justified and appropriate?	2	2	2	2	2	2	2	2	2	2	2	2
Q11. Some estimate of variance is reported for the main results?	2	2	2	2	2	2	2	2	2	2	2	2
Q12. Controlled for confounding?	1	1	1	2	2	2	2	2	1	1	1	1
Q13. Results reported in sufficient detail?	2	2	1	2	2	2	2	2	2	1	2	2
Q14. Conclusions supported by the results?	2	2	2	2	2	2	2	2	2	2	2	2
Score	86%	95%	77%	95%	95%	95%	90%	90%	77%	82%		

Paper 2: Empirical Paper

***“I’m just going to give up and let them do what they’ve got to do... My goal at the end of the day, is to get free and get back to life”*: Exploring the experiences of ethnic minority adults who have been compulsorily detained in secure settings**

Target journal: Cultural Diversity Ethnic Minority Psychology

This paper has been formatted using APA style guide (7th Edition). It will be formatted and edited for the target journal following submission. Author guidelines can be found in Appendix D.

Abstract

Disproportionate rates of compulsory detention in ethnic minority groups compared to White-British groups has been a longstanding issue in the UK, despite several initiatives aiming to address this. There is limited qualitative research exploring this issue, and most research has focussed on Black people's experiences; however disproportionate rates of detention exist for all ethnic minorities. The current research aimed to explore ethnic minority experiences of compulsory detention in the UK. Semi-structured interviews were conducted with six participants. Data were analysed using Interpretative Phenomenological Analysis. Five Group Experiential Themes were found: 1) *'Our voices don't matter'*, 2) *'Disproportionate use of force and power'*; 3) *'Racialised and culturally invalidated'*; 4) *'Feeling held back'*; 5) *'A bittersweet experience'*. Findings suggest that participants felt untimely help contributed to their detention which was related to help being dismissed, lack of social support, and cultural stigma. Participants experienced lack of choice and autonomy in their care leaving them feeling powerless, and were subject to coercive treatment. Participants reported unequal and racialised treatment related to intra-ethnic and inter-ethnic differences in staff-patient relationships. Anti-racist practices should be embedded into services, and policies and procedures should be led by ethnic minority service-users to inform appropriate service-delivery. Further research should explore staff perspectives to provide further context around the issues and inform meaningful change.

Keywords: ethnic minority, compulsory, detention, experiences

Introduction

Disproportionate rates of compulsory detention and readmission under the Mental Health Act (1983; 2007) (MHA) amongst ethnic minority populations has been a longstanding issue for a number of decades in the United Kingdom (UK) (Care and Quality Commission (CQC), 2020; Department of Health and Social Care (DHSC), 2018). Black people are most likely to be compulsorily detained than White-British people, with latest figures from 2022-2023 showing Black adults were three-and-a-half times more likely to be compulsorily detained despite White-British people making up the majority of the UK population (NHS Digital, 2024). Research also indicates that other ethnic minority and migrant groups are also at increased risk of compulsory detention, with South Asian people being at second most increased risk of detention, and greater risk of adverse pathways into psychiatric services are apparent in ethnic minorities overall (Barnett et al., 2019).

A recent review exploring reasons for overrepresentation of ethnic minorities in compulsory detention found common reasons such as increased perceived risk of violence, police contact, mistrust of General Practitioners (GPs), language barriers, poorer detection of mental illness, higher stigma, higher comorbid drug use, ethnic disadvantages and societal racism, and higher prevalence of psychosis (Barnett et al., 2019). A rapid review highlighted that coercive treatment for Black people under the MHA and underuse of specialist mental health services by South Asian people have been key concerns of health researchers (NHS Race and Health Observatory, 2023); the latter of which may precipitate disproportionate compulsory detention rates. To add further context, increased rates of detention and readmission of people from ethnic minority backgrounds is said to be influenced by avoiding engagement with services due to fear of stigma, racism, and control, which therefore delays help-seeking until crisis (Barnett et al., 2019). Evidence suggests differences in treatment may relate to cultural differences in attitudes, beliefs, and expectations around mental illness. This could influence how ethnic minority groups view complex mental health problems, for example if they are perceived as religious, social, or emotional difficulties, it can prevent help-seeking (Bhui et al, 2018; Clement et al., 2015). However conflicting findings suggest that help was sought from professionals by

Black people but help was ignored, which led to crisis (Solanki et al., 2023). Similarly, mixed findings show that Black Caribbean people are more likely to be referred to specialist services by GPs and not supported in primary care (Bhui et al., 2003), whilst other research suggests lower referral rates to secondary care services for ethnic minority groups (Mercer, et al., 2019).

Eurocentric psychological frameworks have been criticised in not effectively meeting the needs of ethnic minority groups (Mercer, et al., 2019). Fernando (2017) has argued that Western mental health systems have failed to adapt to multicultural realities leading to poorer outcomes, therefore possibly longer detention, readmission rates, and mistrust in services (Prajapati & Liebling, 2021). Additionally, it has been argued that ethnic minorities are more likely to be treated as ‘problems to be managed’ with increased use of coercive treatment and medicalisation (Fernando, 2017). This can be understood by Foucault’s (1965) ideas of social control where institutions can use power to restrict autonomy rather than to restore wellbeing, especially in marginalised groups, resulting in disempowerment and silencing.

Research further suggests ethnic minority groups have lesser access to community care and therapy (Freitas et al., 2022; Jankovic et al., 2020), and lower education and insecure living arrangements (Oduola et al., 2019), which impacts compulsory detention (Smith et al., 2020). This may reflect broader socio-economic issues of disempowerment (Bhui et al., 2018). Socioeconomic inequalities have also been noted by an Independent Review of the Mental Health Act (IRMHA) as well as more adverse pathways into compulsory detention via the criminal justice system (CJS) (DHSC, 2018).

The significant ethnic inequalities in compulsory detention has garnered substantial attention from the UK government with several initiatives and legislations proposed in attempt to reduce this. The IRMHA described these ethnic inequalities as “longstanding discrimination and deprivation” with “crucial gaps in trust between service-users and providers” (DHSC, 2018, p.20). It suggests that ethnic inequalities in mental health are engendered by structural issues, which influence racism and stereotyping (DHSC, 2018). The IRMHA proposed recommendations including

greater representation of ethnic diversity in workforces, training on bias and cultural awareness, culturally appropriate advocacy, co-production of care amongst racialised communities, and a Patient and Carer Race Equality Framework (PCREF) to promote organisational accountability for racial equity (DHSC, 2018); with the PCREF only recently becoming mandatory within services (CQC, 2025; NHS England, 2024). Despite initiatives, ethnic disparities continue to persist (Race Equality Foundation (REF), 2021) which could reflect institutional racism (Fernando, 2017; McKenzie & Bhui, 2007). The difficulty in reducing detention rates may also be impacted by limited research exploring the lived experiences of ethnic minority groups compulsorily detained under the MHA which can offer contextual and in-depth information. Importantly, service-users (National Survivor User Network, 2018), the IRMHA (DHSC, 2018) and the REF (2021) highlight the importance of understanding ethnic minority lived experiences in order to address the inequalities, and inform development of appropriate services.

Qualitative research exploring how compulsory detention is experienced by ethnic minorities is limited, however existing research provides important insights. For example, Solanki et al. (2023) found that Black people experience racism, discrimination, mistreatment, neglect, lack of choice and early help, with psychological treatments largely absent or feeling insignificant. Mayers and Gordon (2023) highlighted experiences of disempowerment and racial stereotyping amongst Black men, including lack of involvement in decision-making, increased use of coercive measures, obligation to comply in the hopes of being discharged, and stronger medication than White-counterparts, raising questions of whether they were perceived as more dangerous. These findings reflect broader patterns of racial inequalities, power imbalances, and oppression. Similarly, Lawrence et al. (2021) found negative experiences created vicious cycles of disempowerment and mistrust, contributing to resistance, or passive acceptance of psychological/psychiatric interventions amongst Black people.

Given that Black people are subject to the highest rates of compulsory detention, it is understandable that existing research has predominantly focussed on these groups (Halvorsrud et al., 2019). However, all ethnic minorities are affected by increased risk of compulsory detention including people from South Asian, mixed ethnic

backgrounds, White-other, and migrant populations (Barnett et al., 2019), yet less is known about these populations or their experiences of compulsory detention. There is a need for more in-depth qualitative research involving ethnically diverse populations and their lived experiences to promote equitable care for all ethnic minority groups and to provide context to quantitative studies (Barnett et al., 2019).

To add to the literature, the current research aims to explore how adults from any ethnic minority group, as identified by UK Census² (Office for National Statistics, 2022), experience compulsory detention under the MHA, including representative voices from Asian or Asian British, African Caribbean and Mixed or multiple ethnic groups. Ethnically diverse voices in this area are considerably under-researched, particularly South-Asian and Mixed-groups (Bhui et al., 2018). This research is needed to add diverse voices to the limited qualitative research on the experiences of compulsory detention amongst different ethnicities. It aims to help engender equality and inform service delivery, which may help inform the reduction in disproportionate detention rates in line with service-user needs and government aims (DHSC, 2018; The Parliamentary Office of Science and Technology, 2022).

Research question: What are the experiences of ethnic minority adults who have been compulsorily detained?

Method

Ethics

Ethical approval was obtained from the University of Staffordshire Ethics Committee, the NHS Research and Ethics Committee and HRA Approval, and Trust Research Ethics Panels (Appendices E, F, G, respectively).

Participants were informed of potentially distressing topics through the Participant Information Sheet (Appendix I). Steps were taken to regularly check participants'

² Specifically, this refers to Asian or Asian British (Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background (e.g., Nepalese, Sri Lankan); Black, Black British, Caribbean, African (Caribbean, African, Any other Black); Mixed or multiple ethnic groups.

well-being during interviews, including the right to not answer questions, and terminate the interview. Participants were debriefed following interview, and offered an opportunity for reflection; they were given a list of support services (Appendix L) and reminded they could speak to their care team if required.

All participants received a £10 Amazon voucher following interview. Whilst consideration was made that this could incentivise participants to engage with the study, the payment was not considered disproportionate to the research demands (King, 2019). Payment supports more equal partnerships between the researcher and participants which is imperative when working with people who are possibly already disadvantaged in regards to privilege and power dynamics (National Institute of Health and Care Research, 2022).

Design

As the research aimed to explore the experiences of adults from ethnic minority backgrounds who have been compulsorily detained in secure settings, an Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022) methodology was used. This was deemed most suitable since IPA adopts a double hermeneutic approach which enables the researcher to make sense of and interpret the participants sense-making of their experiences at a deeper level. It is an idiographic-approach that aims to understand personal experiences from an individual's perspective (Smith et al., 2022). It focuses on relatively small samples of homogenous groups of people who have something in common and therefore this approach was utilised to allow the detailed exploration of unique experiences of detention. This is in contrast to Reflexive Thematic Analysis (Braun & Clarke, 2021) which focuses on shared themes across participant groups, rather than on personal and group experiences.

Epistemological position

The researcher held a critical realist position which integrates realist ontology and relativist epistemology and bridges the gap between an objective reality and

interpretivism (Grix, 2019). Critical realism suggests that whilst there is a reality independent of one's own perceptions, reality is inevitably influenced by social, cultural, and historical contexts, and seeks to uncover the underlying mechanisms and structures which shape that reality. Therefore, this allows for an objective reality (ethnic minority detention under the MHA) to be researched, whilst also considering the subjective experiences of participants with lived experiences.

Reflexivity

This section will use the pronoun 'I' to reflect the presence of the researcher.

Reflexivity is a process of critically examining how one's own backgrounds, experiences, and beliefs influence interpretation and understanding of research. Due to the double hermeneutic process of IPA, it was important to maintain self-reflexive processes throughout. This was especially important being a British-Indian Trainee Clinical Psychologist with personal experiences of discrimination and extensive work experience in secure settings. These experiences shaped my interest in the research and shaped my values of justice and equality. Admittedly, I entered this research with pre-existing assumptions and an expectation to hear more frequent accounts of racialised experiences. When this did not always emerge, I recognised the need to reflect on how my own expectations might influence interpretation as well as my emotional reactions of anger, frustration, and sadness in response to distressing accounts described in interviews. To temporarily suspend the influence of potential bias in interpretation of data, I practiced bracketing (Smith et al., 2022) by keeping a reflexive diary (Engward & Goldspink, 2020) throughout the research journey and regularly revisited interviews and transcripts to remain grounded in participants' own words. I engaged in supervision to reflect on data analysis and interpretations to ensure that analysis remained data-driven; these processes enabled me to stay reflexively attuned and open to participants unique experiences even when they differed from my own. I member-checked interpretations of two participants' data with them to explore whether my interpretations resonated with how they saw their experiences, and to invite an opportunity for reflective dialogue without the intention to invalidate the analysis (Motulsky, 2021). Although member-checking is not

recommended as a formal step in IPA as it can conflict with the double hermeneutic (Hall & Melia, 2021), member-checking can be appropriate with single-case or limited-check scenarios to enhance reflexivity without undermining analytic authority (Larkin & Thompson, 2011). Since it was only applied with two participants and not generalised across the whole sample, it does not conflict with IPA's philosophical position and methodological rigour. Furthermore, additional strategies to ensure trustworthiness and rigor were implemented alongside this which included use of supervision, using direct quotes from original datasets, and keeping audit trails evidencing the process of analysis.

Recruitment and Procedure

In keeping with IPA methodology and research aims, purposive sampling was used (Smith et al., 2022). To ascertain feasibility of research recruitment, the researcher contacted NHS and non-NHS Trusts between May-August 2023 including inpatient and community teams. Meetings with psychologists and wider teams were conducted via email and/or video calls to discuss the research and scope for recruitment support. Support was agreed by three Trusts.

Following ethical approvals (June 2024-September 2024) the researcher disseminated research posters (Appendix H) to organisations to advertise in hospitals and clinics through link-persons. Participants could directly contact the researcher to express interest, or contact the link-person. A participant information sheet (Appendix I) was disseminated to Trusts to offer further information for people expressing an interest, alongside a copy of the consent form to detail what participants would be consenting to (Appendix J). All participants were provided an opportunity to discuss the research with the researcher and ask questions before deciding to participate, and were given a minimum of 24-hours to decide whether they wanted to take part. Following this, for participants wanting to take part, capacity to consent was confirmed by contacting their Responsible Clinicians and an interview was arranged. Consent was taken at time of interview. Pseudonyms were used for participants to maintain anonymity and confidentiality and all identifiable information was removed including names of Trusts and locations. At time of interview, participants received a copy of the interview schedule and were given time

to review this ahead of the interview. Participants were given a further opportunity to ask questions, and reminded of their right to not answer questions or terminate the interview. Participants were also reminded of the withdrawal process.

Semi-structured interviews (Appendix K) informed by similar research in the field (Solanki et al., 2023) were conducted and audio-recorded using Microsoft Teams. Interviews ranged from 33-52 minutes (M=42 minutes). Participants had opportunity to reflect on the interview following completion, ask questions, and were debriefed. They received a £10 Amazon voucher, along with debrief sheet and additional support contact information, and reminded they could seek support from care professionals in their team (Appendix L).

Participants

Six participants were recruited from forensic services between June 2024-January 2025. A small sample aligns with guidance for doctoral IPA research (6-10 participants) to support the idiographic commitment to in-depth and nuanced exploration of unique lived-experiences, emphasising depth over breadth (Smith et al., 2022). IPA aims to centre the meaning-making of each participant allowing for detailed case-by-case analysis, versus focussing on broad thematic generalisation (Gauntlett et al., 2017). All interviews were conducted face-to-face in a confidential room located within the Trust wards.

Participant eligibility criteria and participant characteristics are detailed in Table 1 and Table 2 respectively.

Table 1:

Participant eligibility criteria

Inclusion Criteria	Exclusion Criteria
Aged 18+	Under the age of 18
Self-identify as being from an ethnic minority background	White-British adults
Experience of compulsory detention under the MHA (1983)	Experience of voluntarily admission only
Capacity to consent	Lack capacity to consent
Identify as any gender	Non-English-speaking
English-speaking	

Six inpatient participants (5 male, 1 female) consented to take part in the study. Ethnicity included Black British Caribbean (3), Mixed White/Black Caribbean (2), and Asian British Pakistani (1). Mean age was 40 years. Most participants were in their first admission (4). Some participants were uncertain of their diagnosis (4) or section (2). All participants had prior contact with police or CJS.

Table 2:*Participant characteristics*

Participant	Gender	Age	Ethnicity	Section	Diagnosis	Number of compulsory admissions	Length of current admission
Josh	Male	38	White/Black Caribbean	37/41	Paranoid Schizophrenia	1	5 years
Leon	Male	53	Black British Caribbean	'40... 37... not sure'	Paranoid schizophrenia or PD	1	11-12 years
Sammy	Male	36	Asian British Pakistani	3	'Not sure'	7-8	Since 2022
Michael	Male	30	White/Black Caribbean	3	Paranoid Schizophrenia	2	A year
Tyler	Male	45	Black British Caribbean	'Prison transfer one'	Schizophrenia or PD – unsure	1	Since 2020
Chloe	Female	38	Black British Caribbean	37	Bipolar/Schizophrenia	1	~2 years

Data Analysis

All interviews were transcribed verbatim and the steps for IPA were followed (Smith et al., 2022). This involved re-listening to the recordings, and reading and re-reading of data for immersion and increasing familiarity. The researcher then wrote initial exploratory notes focussing on descriptive, linguistic, and contextual content on the right margin. Personal experiential statements (PES) were developed from exploratory notes and noted on the left margin (Appendix M). PES were then transferred onto slips of paper and randomly distributed to tangibly identify connections between statements to cluster and identify Personal Experiential Themes (PETs) and subthemes (Appendix N). This process was carried out on a case-by-case basis for each participant. PETs and subthemes for each participant were then collated and randomly distributed to find connections or divergences on a group level to develop Group Experiential Themes (GETs) and subthemes (Appendix P). These were put into a table to show relevant quotes within each theme (Appendix R). Results were discussed with the research supervisor and peers during group supervision for consultation, triangulation, and credibility. Theme names were amended where necessary. Member-checking was undertaken with two participants to review their PETs and invited to reflect on overall themes (Motulsky, 2021).

Results

Analysis of data revealed 5 GETs and 8 subthemes (Table 3). A limited number of excerpts are used to reflect participant experiences (Smith et al., 2009); further excerpts can be found in Appendix R. Each subtheme was supported by at least half of the participants (Appendix Q). All themes appeared to have an undercurrent of powerlessness or feeling disempowered to varying degrees.

Table 3:

Themes

GETs	Subtheme(s)
1. Our voices don't matter	1.1. Untimely help 1.2. An object of care
2. Disproportionate use of force and power	
3. Racialised and culturally invalidated	3.1. Targeted because of race? 3.2. Clash of cultures
4. Feeling held back	4.1. Feeling stuck 4.2. Urgency for freedom
5. A bittersweet experience	5.1. Being held or holding each other 5.2. Therapy as intrusive or insufficient?

1. Our voices don't matter

This theme draws together participants' experiences of how untimely help led to detention, and the impact of poor communication and lack of collaborative care and treatment during their mental health journey.

1.1 Untimely help

Participants described how throughout their journeys, requests for help were either ignored, inadequate care was received, or how cultural stigma contributed to admission to hospital. Sammy recalled desperate pleas for help and confusion that his father's concerns about him were not taken seriously by the doctor as early as when Sammy was 12 or 13-years-old:

My dad still says to me yet to that day, he goes if they had said something then, diagnosed you or realised it's something... my dad always says, he goes 'I could

see it in you son'. He goes 'I could see that you had signs of mental health' [...] I don't know what he [doctor] was thinking. He could have even referred me to team prevent like... saying at such a young age, saying things like that, you didn't do nothing... he just didn't do nothing" (Sammy, pp.8-9)

Nostalgic grief is expressed in recalling what could have been a pivotal turning point where participants' lives could have taken a different trajectory had someone helped.

Chloe described a neighbourhood conflict which resulted in multiple arrests and court exposures where she felt disproportionately targeted and punished, and was left homeless. Lack of social support meant her mental health was "declining from the amount of times that I've been arrested and moved around and remanded" (p.4). Inadequate explanation about legal processes and a restraining order resulted in Chloe's imprisonment for returning home despite being unaware she was not allowed. Lack of mental health support in prison led to her eventual detention to hospital. She clearly stated what would have helped during her crisis: "I don't think that I needed to be detained. I think I needed somewhere to live; I was walking the streets homeless" (p.10).

Josh and Tyler also described a lack of mental health support available in prison, with it being a stigmatising environment if vulnerability is shown: "I've seen it when other people have left prison to go hospital, up until they leave, like everyone like, everyone picks on them and beats them up" and staff "don't care, and they're this is his problem, so there's no help in prisons" (Tyler, p.22). Lack of help in prison led Josh to self-medicate which exacerbated his difficulties: "it all started in jail and I lost my nan. I started using mamba" (p.3).

Cultural stigma also prevented participants from accessing timely help. Tyler spoke about his reluctance to access support in the community due to a fear of being judged as 'crazy' and being outcasted by his community after witnessing their reactions to people who had mental health difficulties:

they've been like 'oh look here's that nutter' and they just like take the piss out of him and then leave. And then I think, hang on here, if people think you're a nutter,

they don't- they aint gonna know you or they don't got time for you or...*nothing*
(Tyler, p.4)

1.2 An object of care

This subtheme highlights that participants, particularly in early stages of admission, experienced lack of communication from professionals and did not feel involved in their care or decision-making, therefore feeling 'done to' and powerless. Michael stated: "I was detained, erm...without my consent and I wasn't happy about it" (p.3).

Participants described a heightened sense of threat and 'fight/flight' responses during admission due to lack of communication about what was happening, leading to loss of control and safety. Chloe described an abrupt transition of being "dumped in hospital with nothing explained to me" (p.15) leaving her feeling disposable and not respected enough to receive proper orientation, which resulted in resistance and shutting down.

cuffed from a prison and then brought in a room full of people.... I don't know who they are and they're all talking about me, and *to* me, about things that I don't know anything about, they're using terminology that I don't understand... I felt like a fish out of water, I just didn't know *what*, what they were talking about. So, then I didn't want to listen yeah (Chloe, p.15)

'Like a fish out of water' depicts a heightened sense of confusion and disorientation, and was shared by other participants. Sammy described "kicking the door. I think you know, where am I?"..."Nah, I didn't understand, nah"; he was "pinned" on the floor and "injected" in response (pp.11-12).

Participants described not knowing they could have a voice, and felt obligated to be submissive to treatment. Tyler's experience suggested an absence of communication around his rights, and expectation to comply because: "decisions are being made like, *about* me. But I didn't really understand how this hospital settings worked". He compared hospital to being like prison, where being an object of care meant "we can just do whatever we want with ya, and that's it" (p.12).

Sammy felt he did not have a say in his preference for therapy over 'prescribing medications' (p.13).

Some participants described how they did have rights, for example, to choice of medication, but that ultimately their voice did not matter, therefore feeling disempowered with a false sense of autonomy. Josh discussed how doctors may ask his views on medication but ultimately, they will make the decision, making this process feel meaningless: "I've got a say, but say... I really can't. It's just what the doctor thinks" (p.12).

2. Disproportionate use of force and power

This theme draws on the experiences of how misuse of power left four participants feeling powerless, violated, and dehumanised, contributing to a loss of faith in the system.

Michael spoke of how mistreatment in hospital was retraumatising due to previous police abuse: "I've had a taser shot at me, um I've been beaten up by the police... when I was 14"..."and when you're bashing 14-year-olds, that kind of degrades that trust" (p.3).

Michael's historical experiences of abuse felt replicated in hospital: "I already mentioned to two members of staff about the guy who put his knees on my testicles and why did nobody say anything" (p.13), and consequently spoke of hopeless mistrust in staff where "there's a culture...a closed, closed culture in this institution. So bad things can happen and they get away with it" (p.14). He suggested that concerns are not taken seriously, leading to passive acceptance.

Unnecessary use of power was depicted in other areas of participants' lives. Leon spoke about feeling "under a control" (p.6) and described the inhumane response of staff handcuffing him at a family funeral, seeing family distressed, and not being able to "hold my family", alongside being denied basic human rights of using the toilet with dignity:

They wouldn't release one of the handcuffs. I had to, when I had to undo my fly, the handcuff was cutting into my wrist [...] They didn't have to put handcuffs on me, they didn't have to. Yeah, they didn't have to. They didn't have to put them on me. Especially when you go to a funeral that you've gone with four people, why would you need to handcuff somebody? You know what I'm saying? (pp.5-6)

Repetition of 'they didn't have to' highlights the unnecessary humiliation Leon suffered at a time of shared grief which depicts the shame and powerlessness felt at being physically restrained at a time when supporting his family was critical. He recalls an apology not being enough which questions how seriously his concerns were taken.

Participants spoke about the use of restraint, medication, and seclusion to manage behaviour, leaving them feeling dehumanised and violated, whilst feeling overpowered by staff: "bunch of strangers holding me down, pinning me down, pulling my butt out, this is just craziness" (Chloe, p.17). Participants felt that not only were these actions dangerous, for example, Sammy likened his experiences of restraint to "physical abuse", "not physically hit, but like overdoing it... like restrained" (p.22), but they were enforced medication that could have been "dangerous", likening it to a "tranquilliser" (Sammy, p.19), when communication was preferred: "I don't know what they were injecting me with, it could have been anything [...] I would have liked them to, like, have a discussion...or maybe say, try this medication" (Sammy, p.20).

Feeling powerless resulted in helpless resignation to coercive treatment. Sammy described not feeling listened to when telling staff "I don't want to fight with you and they'd say 'alright get on the floor'" and he would "just lie down on the floor" (p.20). Sammy spoke of envisioning a future of inhumane and animalistic treatment towards patients, "don't need to like, send 20, 30 people...they can just shoot a dart at ya, you know what they do to bears" (p.19).

3. Racialised and culturally invalidated

This theme reflects participant experiences of race and culture as a social construct, and as a direct result of their treatment. Five participants spoke about how race or cultural differences between them and staff impacted upon their detention and the detention of other ethnic minorities. This left participants feeling singled out, treated like an 'outsider', or dismissed.

3.1 Targeted because of race?

Leon spoke about how himself, and Black people more widely, are unfairly mistreated in the system by being 'stuck' longer, having stronger medication, and not having the same privileges as White people:

I've noticed mostly it was happening, it was Black people, like myself, all going through the same thing...[talking] to the people on the ward and then started to listen to their stories and they'd rise.... they said injustice is what they've been through (pp.4-7)

The use of 'injustice' to describe the experiences of Black people suggests significant wrongdoing and unethical care. 'Rising' shows the anger that Leon heard in others' stories, which brought about a sense of validation and reinforced his beliefs that the system fails Black people, leading to a loss of trust in the system. Leon described an underlying sense of wariness and hypervigilance about ongoing racism: "Actually there's racism going on but its undercover, they're trying to be smart and trying to cover it, but there is racism in here. Yeah, there is." (p.4).

Leon spoke of his unfair treatment by some White doctors and preferential treatment of White patients over Black patients: "They [white patients] was unescorted, they lost their unescorted, three weeks later they got it back" (p.9). Leon felt blocked in his progress when he experienced increased supervision, and felt he had to work harder and for much longer than White patients to prove himself and regain professionals' trust before having the same conditions in place: "You gotta do this and that before you go somewhere so how can I make progress if I'm supposed to get unescorted and they haven't given me, how can I make progress?" (p.15)

Chloe and Leon felt directly targeted and singled out because of their race: “I felt as a black woman I’d been targeted” (Chloe, pp.9-10), and: “my colour and my hair, yeah and that’s why they holding me back” (Leon, p.5).

3.2 Clash of cultures

Participants felt cultural differences between them and staff influenced the differential treatment experienced by them. Although Chloe, Leon, and Tyler highlighted a presence of Black members of staff, they emphasised that they were African and non-Caribbean staff (therefore not similar to them) which left them feeling different to them and brought about a sense of discomfort and tension: “In the end, I did kind of feel a little bit more comfortable, but in the beginning, I didn’t feel comfortable” (Chloe, p.8).

Tyler described some African staff being more dismissive of his needs, and therefore chose to disengage from them. He spoke about a long-held belief in cultural differences and tensions between Caribbean and African people, which influenced his interaction on the ward:

There is one or two African staff that are alright [...] the rest, it’s like, they don’t wanna interact. Like if you ask them [African staff], they’re like ‘ooh I’m busy, oh this’. So, I don’t like-...them people, I don’t even bother (Tyler p.20)

As an Asian, Sammy reported feeling safer around White staff but goaded by Jamaican or African/Caribbean staff when White staff were not present in his previous admission, being ‘provoked’ (p.3), or harassed. Leon stated, “it’s hard to spot racism because you got Black and White working together” (p.9).

4. Feeling held back

This theme draws together participants’ feelings of anger, helplessness, stagnation, and anxiety of being stuck in the system and lacking control. Participants described detention like a “sentence” (Leon, p.5), or needing to be “released” (Josh, p.10),

suggesting that detention feels more akin to prison and punishment rather than a place of rehabilitation.

4.1 Feeling stuck

Leon spoke about how he felt his detention was “time wasting” and “wasting me” (p.17). Throughout 11 years of detention, he said “I aint moved on [...] they aint helped me” (p.16). His helplessness and need to get “free” and “back to life” meant “I’m just going to give up and let them do what they've got to do” (p.5).

A quieter frustration about feeling stuck was expressed by Josh: “Um, sometimes I feel like I’m better than I was (laughs) and um... good enough to be released. I think they’re saying I’m good enough to be released but they just want me to finish my psychology” (p.10). Josh echoed other participants’ experiences of frustration with the system, of interventions being delivered too late or confusion around how and whether he could progress: “Just the psychology work, I started it late I think, I should have started it a lot earlier” (p.12). He stated, “I just feel stuck in here now, it’s time for me to go home now” (p.8).

For some, witnessing the ‘stuckness’ of other ethnic minorities who had been detained for “*years and years*” (Tyler, p.20), left them with an underlying anxiety that this could happen to them, resulting in an internal conflict of hope versus fear. Tyler said if he was in that position, it would “frustrate” him and expressed anxiety about his future: “Maybe if, like come next year when my sentence is finished, if they was like, you know, ‘you’re not going, we’re not going to recommend discharge’ or whatever, then I’ll probably start feeling down” (p.21).

4.2 Urgency for freedom

Participants expressed frustration and desperation that they need to be ‘moved on’. Feeling stuck led to reflections on a life missed out and life that could be. Leon expressed anger and despair around his “11 years” of detention, and ‘needing things to be eased up so he can move forward’ (p.17). He said, “we need to get on the outside” (p.18), referring to Black people and the impact being held back has on them collectively. He expressed hopelessness at professionals’ lack of faith in him,

and perceptions of being criminally dangerous or not fit for release to society which was keeping him stuck:

'he's gonna commit a crime and be back in'. You can't keep doing that, that's wrong. Because you never know, he might change, he might turn his life around. He might be a Christian then he goes to church and then he turns himself to God and he believes and lives a Godly life, he never gets in trouble ever again. Yeah, it could be that. Yeah. (p.18)

Urgency for freedom was also expressed in a desperation to be around family, make a meaningful life, and fulfil responsibilities held elsewhere. For example, Tyler spoke about being the oldest child in his family and particularly his aging mother's dependency on him: "she desperately needs me, and my brothers and sisters need me, and a lot of people need me" (Tyler, p.15).

5. A bittersweet experience

This final theme draws together participants' experiences of what supported their rehabilitation, whilst also highlighting what was missed out on. Although meaningful experiences offered empowerment and hope in an otherwise disempowering context, they did not necessarily negate from the distress experienced. Instead, these experiences show what could be possible if care was more inclusive, collaborative, and compassionate; thus, making the overall experience bittersweet. Five participants described their current experience as better than previous admissions or better than it used to be, however some participants still highlighted that more needs to be done.

5.1 Being held or holding each other

Participants described how collaborative and caring relationships with staff enabled them to feel seen, heard, and like they mattered. This comfort and connection fostered feelings of safety for participants when they were offered choices and had their voices considered, enabling them to feel they had some power in an otherwise powerless environment. Tyler described staff's encouragement to engage which

strengthened his trust in some staff as he felt cared for which positively impacted his progress: “They’d be like, come on, come have a game of pool [...] eventually I would and then they’d be like okay tomorrow I want another game” (Tyler, p.11). Choice was also important for Leon: “I’ve got choices, you know. So, if I got like a tablet or whatever [...] I could go to the doctor and say, well, this don’t agree with me [...] they’ve always changed my medication” (Leon, p.10).

However, when respect and compassion was not present for participants, it left them in a state of passive acceptance and feeling silenced, not conducive to their recovery: “members of staff, that weren’t, weren’t being very nice, I’ve learned to just cut, cut that. Keep myself to myself. Um, pointless, pointless trying to reason with them” (Michael, p.14).

Friends and family offered support for some participants who felt encouragement in their journey toward feeling more empowered with others advocating on their behalf: “My friends and family were like look, just stick with that, don’t go on anything high or anything different even [medication], just stick with this”... “I thought, okay, I’ll listen to it and I’m glad I did.” (Tyler, p.16)

Peer support was also invaluable for participants: “it’s only through, it’s through the other patients that I managed to navigate my way” (Chloe, p.7). Due to negative experiences faced by participants, participants highlighted the importance for them to be a voice for peers and protect them from mistreatment: “It is awful... I feel erm, almost like a duty of care to the other patients” (Michael, p.8).

5.2 Therapy as intrusive or insufficient?

Most participants saw some benefit in psychology, with some acknowledging its importance in their rehabilitation: “she keeps telling me I’m not a bad person and it wasn’t my fault which makes me feel a bit grateful” (Josh, p.10). Whilst Josh expressed gratitude for the help and understanding he received from psychology work, he also stated: “I do think I’ve um been here for too long, longer than I’ve meant to be here. My psychologist just goes through every little thing about my life... and stuff like that (laughs)” (p.10). Josh’s laugh conveys an underlying sense of powerlessness, that he believes he has done enough, but feels compelled to comply

further to a somewhat intrusive experience without clear understanding of why. Rather than helpful, this makes him feel stuck. This may raise the question of who is therapy benefitting.

Some participants did not agree psychology benefitted them. Leon completed six years of psychology and said, “most of it doesn’t fit me” (Leon, p.11). Psychology was not always perceived as particularly suitable for participants’ needs. Chloe said psychology was “helpful” (p.14) but indicated a lack of person-centred therapy: “there’s no counselling, there's like no support for domestic abuse for women. There's no... just little things of therapeutic services” and highlighted a need for community connections such as “close liaisons...like homeless shelters” (p.13).

Discussion

Disproportionate rates of compulsory detention exist for ethnic minority groups (Barnett et al., 2019) but research exploring lived experiences is limited. IPA was used to explore the experiences of ethnic minority adults who have been compulsorily detained in secure settings. Where most qualitative research has focussed on experiences of Black people, this research aimed to include ethnically diverse voices. Five GETs were found: 1)Our voices don’t matter; 2)Disproportionate use of power; 3)Racialised and culturally invalidated; 4)Feeling held back; 5)A bittersweet experience. Whilst some of the findings echo more universal experiences seen in compulsory detention, like coercion, seclusion, and restraint (Akhter et al., 2019), this research highlights how these are experienced through an additional layer of racialisation and cultural differences. Whilst these experiences are traumatising for many, for ethnic minority groups, they can be shaped by intersectional experiences of race, culture, and power, making their experiences uniquely complex and possibly more harmful.

In the current findings, participants described how they felt requests for help were ignored, and how if calls for help were taken seriously, detention could have been prevented. This included directly asking for help but being dismissed which supports Solanki et al.,’s (2023) findings. Participants also described a lack of social support leading to deterioration in mental health and crisis, which eventually led to detention.

This supports findings that suggest ethnic minority adults can experience social inequalities and detention is related to social factors such as homelessness; the inadequate implementation of existing community recommendations contributes to ethnic inequalities (Bansal et al., 2022). Mental health stigma was also found to impact help-seeking which suggests that stigma continues to exist in Black cultures and prevents help-seeking due to fear of social isolation, supporting previous findings (Barnett et al., 2019).

All participants had contact with the CJS, which is consistent with findings indicating that ethnic minority groups have more coercive pathways to detention (Barnett et al., 2019; DHSC, 2018). Participants spoke of how prisons are not rehabilitative; inadequate support was received in prisons which were uncaring and stigmatising environments, leading to compulsory detention. This supports recommendations calling for more integration between prisons and mental healthcare, which might reduce detention rates among ethnic minority groups (Kothari et al., 2022).

Lack of communication throughout detention perpetuated feelings of powerlessness, mistrust, and unsafety, often exacerbated by feeling reduced to objects of care. Consistent with previous research (Mayers & Gordon, 2023; Solanki et al., 2023), participants described limited choice, needing to comply due to not understanding their rights, and medication used as a first line of treatment and forcibly administered, sometimes without being offered psychological intervention. Coercive measures like medication, restraint, and seclusion were used to manage behaviour which was experienced as dehumanising and violating. This was retraumatising, especially when participants had prior experience of systemic harm, including police abuse which perpetuated mistrust. Coercive treatment resulted in resistance, fear, disengagement, or helpless resignation to treatment, supporting prior research (Hassen et al., 2023; Keating & Robinson, 2004; Lawrence et al., 2021). These dynamics support Foucault's (1965) ideas of how institutional power can disempower individuals and reduce them to objects of care as a means of control. The current findings may help explain the lack of progress in tackling ethnic inequalities, as superficial or lack of collaboration fails to culminate meaningful engagement and rehabilitation (Bansal et al., 2022) and can perpetuate feelings of being stuck.

Lack of communication during admission processes resulted in participants feeling vulnerable and under threat as 'nothing was explained' to them. This resulted in a threat response, where some participants 'shut down' and others responded with 'fight'. Unfamiliarity with surroundings and staff increased feelings of unsafety, and a 'fight' response could be inferred as participants being perceived as dangerous (Bloom, 2006). These impressions can become a held narrative amongst staff and impact how treatment is given, keeping patients stuck in services (Sweeney et al., 2016). When considering interpersonal dynamics, the 'fight' response reported by participants can be understood as a means to obtain control in an environment where all control feels lost, particularly during traumatic experiences of detention (Foucault, 1965; Gordon & Kirtchuk, 2008).

The findings show that appropriate communication, choice, and respect are imperative in rehabilitation, as participants described more positive and empowering experiences which were underpinned by the quality of relationships with others, including staff encouragement and collaboration. This cultivated feelings of trust and safety. Giving choice and respect promoted feelings of control and autonomy, and consequently hope, which may contribute to better outcomes (DHSC, 2018). When absent, peer support was essential, where participants described a 'duty of care' to peers due to lack of faith in the system being able to protect patients from harm. Additionally, family support and advocacy were essential for participants' wellbeing.

Participants described mixed experiences about psychological treatment. Whilst many participants saw a value in psychology, some felt it was 'not for them' despite years of engagement, or felt they had done enough but helplessly continued. Similar to Solanki et al. (2023), this questions the significance or therapeutic benefit of psychology in participants' experiences, and questions whether Eurocentric models wholly meet the needs of ethnic minorities. This has been critiqued by Fernando (2017) where western mental health systems can fail to adapt to multicultural experiences, impacting poorer outcomes. Furthermore, one participant suggested that more needed to be done such as more community connections from within hospital. This suggests psychological treatment did not feel person-centred or holistically meet their needs.

Although the impact of race and culture intersected across themes for some participants, it was also found as a standalone theme. Participants reported feeling treated differently and unfairly because of their race. This could be interpreted as institutional racism, which is outlined as a collective failure of an organisation to provide appropriate and professional service to people due to their race, culture, or ethnicity (Macpherson Report, 1999). This prejudice was not just felt from White staff but also ethnic minority staff, consistent with Solanki et al.'s (2023) findings. Participants described 'White and Black [staff] work together', or felt mistreated by staff who were also an ethnic minority but of a different cultural background. This suggests racial discrimination was felt as intra-ethnic and inter-ethnic discrimination. Critical Race Theory (Delgado & Stefancic, 2023) suggests that racism is not always overt or interpersonal, but can be embedded into institutional practices and patient-staff interactions. Therefore, it is possible for any staff to act in ways that reinforce racial bias or systemic inequality, particularly in services shaped by western culture (Fernando, 2005).

Participants spoke about concerns not being taken seriously, at times due to the racial discrimination felt, leading to further feelings of oppression, and feeling silenced (Foucault, 1965). Solanki et al. (2023) note that there are systems for staff to report racism, but these are lacking for patients; their recommendations for appropriate systems for patients to report incidents may help effectively monitor and inform development of anti-racist care.

Implications and recommendations

Collaboration and joined-up working for mental healthcare services with systems such as prisons is recommended (Kothari et al., 2022), as well as with community-based services such as homeless shelters (Bansal et al., 2022), and working with communities to support mental health awareness and reduce stigma. Failing to improve knowledge about mental health continues to prevent help-seeking during mental health crises that lead to compulsory detention.

Participants described a lack of meaningful collaboration in their care, leaving them feeling disempowered. It is recommended that existing policies and initiatives which help reduce disproportionate rates of detention and promote equitable treatment and care are embedded into organisations, like the PCREF (DHSC, 2018). Services should prioritise meaningful co-production (Robert et al., 2024) and cultural humility, particularly during admission processes, and implement trauma-informed care that accounts for personal experiences of racism to help rebalance power differentials (Bansal et al., 2022). Policies and interventions should also include meaningful service-user involvement from people from racialised communities (DHSC, 2018; Bhui et al., 2018).

The current research highlights that ethnic minority groups experience inequality and racialised treatment as part of their experiences in compulsory detention. Intra-ethnic and inter-ethnic discrimination were reported in patient-staff relationships; however, this requires further exploration as broad generalisations cannot be made due to the small sample. Nevertheless, this is important to consider, as despite recommendations for greater representation of ethnic minority groups in key professions to help combat institutional racism (DHSC, 2018; Kline, 2020), the current findings suggest that representation alone may not be enough, and requires services to engage more deeply in how race, culture, and power shape care, to decolonise Western mental health systems (Beresford & Rose, 2023; Fanon, 1952). Services should commit to training and supervision to reflect on internalised biases, and racial and cultural differences, to mitigate from unintentionally replicating patterns of discrimination that can retraumatise individuals (DHSC, 2018). Anti-racist practices should be embedded in services and not viewed as a specialist interest (Hassen et al., 2021).

Strengths and Limitations

This research expands on limited research that exists exploring the experiences of Black people subjected to compulsory detention, and adds diverse voices to the literature by including other disproportionately detained ethnic groups who are considerably under-researched in this area (South Asian and Mixed-group experiences) (Bhui et al., 2018). A limitation includes possible gate-keeper bias

(Bashir, 2023) as consent was ‘gatekept’ by Responsible Clinicians and clinical teams. This highlights a power dynamic which echoes the themes of control and disempowerment which emerged in participant’s accounts, and raises important questions about access, autonomy, and whose voices are heard in research. Nevertheless, the findings contribute to how race and culture might impact ethnic minority experiences of detention, adding insight to a limited evidence-base, and context to quantitative research. The findings suggest that ethnic minority groups face similar experiences of inequality due to racialised treatment in care.

Future research

Future research should continue to explore experiences of ethnic minority groups who have been compulsorily detained, and may benefit from exploring experiences leading to detention, to provide more specific context about *why* disproportionate rates exist. Staff perspectives should be explored to provide further nuance and context to patient-staff interactions and dynamics.

Conclusion

This research suggests that ethnic minority adults experience feelings of powerlessness in compulsory detention which is related to a lack of collaborative care. The findings indicate that ethnic groups experience mistreatment due to their race or culture and suggests that institutional racism can operate in subtle ways which exists between intra- and inter-ethnic staff-patient relationships. This requires relational, structural, and reflective shifts in how organisations understand and respond to racialised distress.

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Appendix D- Author guidelines

Target Journal: Cultural Diversity Ethnic Minority Psychology

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

<https://www.apa.org/pubs/journals/cdp>

Single-study reports

Single-study reports of quantitative and qualitative research are between 4,000 and 6,000 words of text (including abstract). The word limit does not include reference pages, tables, and figures. Theoretical, conceptual, and integrative review manuscripts also must adhere to this word limit.

Journal Article Reporting Standards

Authors are to adhere to the [APA Style Journal Article Reporting Standards](#) (JARS) for [quantitative, qualitative, and mixed methods](#) research.

Include guidelines on reporting on registration (including making protocols public); participant characteristics, including demographic characteristics; inclusion and exclusion criteria; psychometric characteristics of outcome measures and other variables; and planned data diagnostics and analytic strategy.

Appendix E- University Ethical Approval



INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Krishna Chauhan
Title of Study	Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons
Status of approval:	Approved

Thank you for your submission to the Independent Peer Review (IPR) Panel. Your application is now approved.

Action now required:

You must now apply to the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without Health Research Authority (HRA) approval, and relevant site-specific approvals. Please note that the University Sponsor contact to be named on the form is Prof Nachi Chockalingam.

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received HRA approval, and participating Trusts/organisations have confirmed their capacity and capability to support your study, you can commence your research. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved application.

When your study is complete, please send an end of study report to Dr Edward Tolhurst: e.tolhurst@staffs.ac.uk. A template can be found on the ethics Blackboard site.

Comments for your consideration: None

A handwritten signature in black ink, appearing to read 'E Tolhurst'.

Signed: Dr Edward Tolhurst
University IPR coordinator

Date: 21st February 2024

Appendix F- HRA Approval



Miss Krishna Chauhan
Staffordshire University
Leek Road
Stoke-on-Trent
ST4 2DF

24 June 2024

Dear Miss Chauhan



Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons.

IRAS project ID: 338095

REC reference: 24/SW/0057

Sponsor: Staffordshire University

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "[After Ethical Review – guidance for sponsors and investigators](#)", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **338095**. Please quote this on all correspondence.

Yours sincerely,

Michael Pate
Approvals specialist

Email: approvals@hra.nhs.uk

Copy to: Dr Kim Gordon – Sponsor contact

Appendix G- Trust Ethical Approvals

Charity/Trust 1



T:01604 616088

Tuesday 25 June 2024

Dear Krishna

RE: #259_ Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons

I am pleased to advise that we are now able to give final approval for you to conduct your research project, as described in your application, at [REDACTED]

Roles & responsibilities

Role	Who
Principle investigator	Krishna Chauhan
Sponsor	Staffordshire University
Funder	Staffordshire University
Clinical research advisor	Dr Inga Stewart
Data controller	Staffordshire University
Data processor	Krishna Chauhan
Ethics approval	NHS REC reference: 24/SW/0057
St Andrew's review	SERAC conditional approval 02/02/24
Authorship details	TBA

Expectations

In relation to projects conducted at [REDACTED] you will be required to:

- Update the department on a regular basis – **the first update will be required in October 2024**
- Comply with [REDACTED] policies & procedures, and with any request to audit compliance
- Contact the Research Centre to discuss a substantial amendment to your approved application prior to implementing said change (NB/ an updated application may be required)
- Advise the Research Centre if you change any contact details or move to a different employer; in the latter case, [REDACTED] who are leaving will need to discuss project arrangements prior to finishing at the [REDACTED]
- Follow authorship good practice (see over)
- Send a draft of all publications [REDACTED] prior to final publication
- Adhere to the data retention schedule, as detailed in the approved project

Project completion

Receipt of the final project report in the form of an executive summary by the Research Centre will mark the completion of your project. You will no longer be required to provide regular updates; however, do let us know about any dissemination activities or evidence of impact for our files and account reporting.

You may also be invited to present the results of your research to a wider audience within [REDACTED]

Authorship good practice

It is good practice to discuss and agree the expected roles, contribution and responsibilities, including authorship, at the very start of the research process. This includes the appropriate recognition of any substantial intellectual contribution from staff at [REDACTED], such as:

- Conception or design of the work
- Acquisition, analysis or interpretation of data for the work
- Drafting the work or revising it critically for important intellectual content

Please note that your [REDACTED] referenced in any publications relating to this project, including journal articles, posters, and other conference materials. Please use the following wording: [insert title, e.g., Visiting Researcher], [REDACTED]

Good luck with your project!

Yours sincerely



Lucy Lee
Research Administrator

Copied to:

Dr Kim Gordon
Dr Inga Stewart

Trust 2

 Outlook

RE: IRAS 338095 – Confirmation of Capacity and Capability at [REDACTED]

From Christopher Flanagan ([REDACTED])
Date Wed 21/08/2024 16:17
To Krishna Chauhan <c042180m@student.staffs.ac.uk>
Cc Chantel-Lea Grocott ([REDACTED]); Kim Gordon <Kim.Gordon@staffs.ac.uk>

Dear Krishna,

RE: IRAS 338095 – Confirmation of Capacity and Capability [REDACTED]

Full Study Title: **Ethnic minority experiences of detention in secure settings**

On behalf of Ruth Lambley-Burke (Director of R&I), this email confirms that [REDACTED] has the capacity and capability to deliver the above referenced study; please find the agreed *Organisation Information Document/Clinical Trial Agreement* attached as confirmation.

[REDACTED] Trust agrees to start this study from today.

If you wish to discuss further, please do not hesitate to contact me; good luck with your study.

Many thanks,
Chris

Chris Flanagan
Research Support Administrator
Branch Chair – [REDACTED]
Pronouns: he/him #pushforpronouns

[REDACTED]
Working days – Monday, Wednesday, Thursday, Friday

Trust 3

 Outlook

IRAS: 338095- Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds - Confirmation of Local Capacity and Capability at [REDACTED]

From RESEARCH-AND-DEVELOPMENT [REDACTED]

Date Thu 26/09/2024 13:58

To Krishna Chauhan <c042180m@student.staffs.ac.uk>; Kim Gordon <Kim.Gordon@staffs.ac.uk>; [REDACTED]

Cc [REDACTED]

 2 attachments (554 KB)

Organisation_Information_Document_NonCommercial_v1-6+(1)_NC_V1.1 BSMHFT.pdf; Krishna NHS to NHS letter of access 17 September 2024.pdf;

Dear Krishna

IRAS: 338095 - Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds - Confirmation of Local Capacity and Capability at [REDACTED]

This email confirms that [REDACTED] Trust has the capacity and capability to deliver the above referenced study. Please find attached the agreed Organisation Information Document as confirmation and a Letter of Access.

Start and end dates:

We agree to start this study on **with immediate effect**.

We understand that recruitment will end on 25/04/2025 - We are aware that at this point, archiving is the responsibility of Kim.Gordon@staffs.ac.uk .

Recruitment figures:

Please note that you will be contacted by the R&D department periodically to obtain your current recruitment figures.

The target date for first patient recruited is 26/10/2024 – 30 days post confirmation of local capacity and capability.

During your study:

During the study, researchers are required to fulfil the following duties:

- Inform R&D of any amendments to the study, both substantial or non-substantial
- Inform R&D when the study has completed at the Trust - Inform R&D of the total recruitment number at the Trust - Submit a final report to the R&D department.

All of the above can be submitted to [REDACTED]

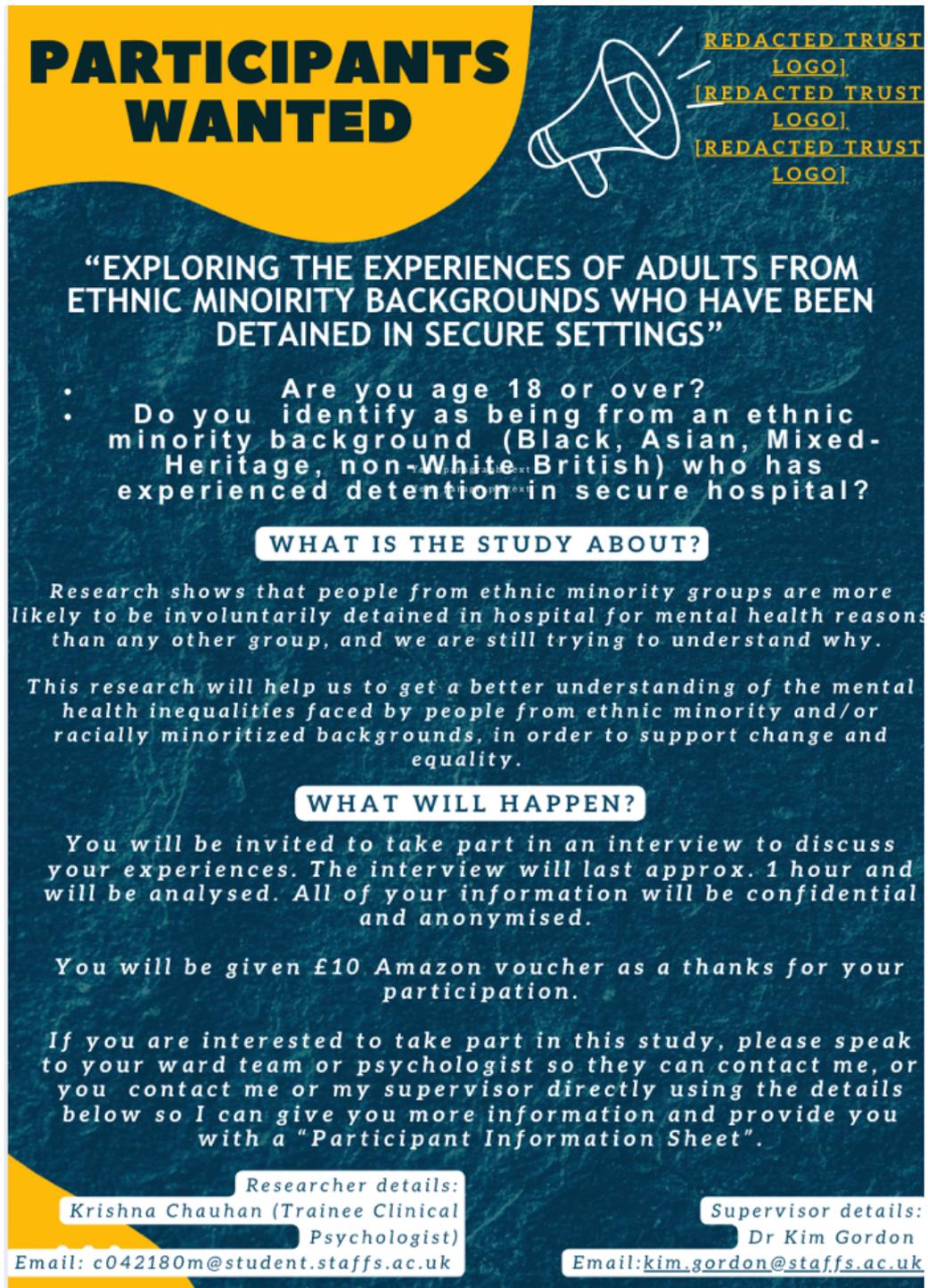
If you wish to discuss further please do not hesitate to contact us.

Finally, we would like to wish you all the best with your research.
Kind regards
Research & Innovation

Donna Allin 

Appendix H- Research posters

Inpatient



PARTICIPANTS WANTED

“EXPLORING THE EXPERIENCES OF ADULTS FROM ETHNIC MINORITY BACKGROUNDS WHO HAVE BEEN DETAINED IN SECURE SETTINGS”

- Are you age 18 or over?
- Do you identify as being from an ethnic minority background (Black, Asian, Mixed-Heritage, non-White-British) who has experienced detention in secure hospital?

WHAT IS THE STUDY ABOUT?

Research shows that people from ethnic minority groups are more likely to be involuntarily detained in hospital for mental health reasons than any other group, and we are still trying to understand why.

This research will help us to get a better understanding of the mental health inequalities faced by people from ethnic minority and/or racially minoritized backgrounds, in order to support change and equality.

WHAT WILL HAPPEN?

You will be invited to take part in an interview to discuss your experiences. The interview will last approx. 1 hour and will be analysed. All of your information will be confidential and anonymised.

You will be given £10 Amazon voucher as a thanks for your participation.

If you are interested to take part in this study, please speak to your ward team or psychologist so they can contact me, or you contact me or my supervisor directly using the details below so I can give you more information and provide you with a “Participant Information Sheet”.

Researcher details:
Krishna Chauhan (Trainee Clinical Psychologist)
Email: c042180m@student.staffs.ac.uk

Supervisor details:
Dr Kim Gordon
Email: kim.gordon@staffs.ac.uk

Community Teams

PARTICIPANTS WANTED



[REDACTED TRUST LOGO]
[REDACTED TRUST LOGO]
[REDACTED TRUST LOGO]

“EXPLORING THE EXPERIENCES OF ADULTS FROM ETHNIC MINORITY BACKGROUNDS WHO HAVE BEEN DETAINED IN SECURE SETTINGS”

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You will be given £10 Amazon voucher as a thanks for your participation.

If you are interested to take part in this study, please speak to your care team who can contact me, or you can contact me or my supervisor directly using the details below so I can give you more information and provide you with a “Participant Information Sheet”.

Researcher details:
Krishna Chauhan (Trainee Clinical Psychologist)
Email: c042180m@student.staffs.ac.uk

Supervisor details:
Dr Kim Gordon
Email: kim.gordon@staffs.ac.uk

Appendix I- Participant Information Sheets

Inpatient

Participant information sheet

IRAS Project ID: 338095

Staffordshire University

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

www.staffs.ac.uk

School of Health, Education, Policing and Sciences



Project Reference Number: SU_23_066

Title of study: Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons.

Invitation Paragraph

My name is Krishna Chauhan and I am a Trainee Clinical Psychologist at Staffordshire University. I would like to invite you to participate in my research project exploring the experiences of people from ethnic minority and racially minoritized backgrounds (Black, Asian, Mixed Heritage, migrant populations) who have been involuntarily detained in hospital for mental health reasons.

This study will form part of my doctoral research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take your time to read the following information carefully which can be used as a guide to explain the research further. You can ask questions or discuss this with others or myself if you wish. Ask me if there is anything that is not clear or if you would like more information.

This piece of research has been ethically reviewed and approved by Staffordshire University Ethics Committee and South West-Central Bristol Research Ethics Committee. Staffordshire University holds appropriate insurance that applies to this study.

Midlands Partnership University NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, and St Andrew's Healthcare have been involved in supporting recruitment for this project.

Please note that by taking part in this research will not affect your care or treatment.

What is the purpose of the study?

The study aims to look at the experiences of people from ethnic minority and racially minoritized backgrounds (Black, Asian, Mixed Heritage, migrant populations) who have been involuntarily detained in hospital for mental health reasons. People from ethnic minority or racially minoritised backgrounds (particularly Black and South Asian backgrounds) are more likely to be involuntarily detained in hospital for mental health reasons than White British groups yet this is an under-researched area. This research will help us to get a better understanding of why this might be the case and work to help reduce the inequalities faced by people from ethnic minority backgrounds.

Please note that by taking part in this research will not affect your care or treatment.

Why have I been invited to take part?

You have been invited to take part as I believe hearing your experiences about being detained in inpatient settings will be invaluable in helping our understanding as to why there seems to be higher rates of detention amongst people from ethnic minority or racially minoritised backgrounds to help to reduce the inequalities faced.

What will happen if I take part?

After reading this information sheet, if you agree to participate in this study, please let your ward psychologist know you are interested if this has not yet been directly discussed with you. If you have further questions or would like more information about the study, you can let a member of ward staff or ward psychologist know and I will get in touch with you to discuss this further. You will have the opportunity to ask me any questions that you may have and to make sure that you fully understand what the study will involve and how you will be asked to participate. Following this, you will have at least 24 hours to decide whether you want to take part, and you are encouraged to discuss your participation in the study with people you trust or ward staff to help you make your decision. If you decide to take part, you will be provided with a consent form and will be asked to sign this.

The research will involve myself interviewing you on the ward in a private and confidential space for approximately 45-60 minutes at a mutually convenient time. You will be asked about your age, gender, ethnicity, and diagnosis at the start of the interview. You will be able to take breaks during the interview if you need. You have the right to stop the interview at any point, or choose not to answer questions if you wish and will not have to give any reason for doing so. The interviews will be audio-recorded using Microsoft teams or an audio-recorder which I will then transcribe. All of your personal information such as names will remain anonymised and non-identifiable. After the research has been written up, I am happy to discuss it with you if you wish or you can be provided with a written summary of the findings. Names and any identifying information will remain anonymised and non-identifiable. After the research has been written up, I am happy to discuss it with you if you wish or you can be provided with a written summary of the findings.

There are no right or wrong answers as this study is seeking *your* experience.

Will taking part cost me anything?

No, the study will only require some of your time.

Do I have to take part?

No. 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 or impact your care of treatment. Once you have read the information sheet, please let your ward psychologist know so that they or I can speak to you and support you with any questions that will help you make a decision about taking part. If you decide to take part, you will be asked to sign a consent form before participating in the interview.

What are the possible benefits of taking part?

Taking part in this research will help to gain a better understanding of what it is like to be detained under the Mental Health Act (1983) as adults who identify as being from ethnic minority or racially minoritised backgrounds. This is an area that is under-researched and is important because people from these backgrounds are at higher risk of being involuntarily detained when compared to White-British groups. You may find it helpful and empowering to talk about your experiences.

As a token of thanks for your participation in the study you will also be given £10 Amazon voucher at the end of the interview.

What are the possible risks of taking part?

We understand that talking about your experiences which led up to your detention in hospital and your experiences from then on may cause some emotional distress. However, this will be kept in mind throughout your interview and the researcher will have had experiencing working with people who experience emotional distress. You will have opportunities to take breaks during the interview should you wish. You do not have to answer particular questions if you do not want to and have the right to stop the interview at any point. At the end you will have an opportunity to discuss the interview and ask any questions. Your participation is voluntary and you can withdraw from the research at any point up to two weeks after the interview has taken place.

Details of what you share in the interview will not be shared with your care team. The only information that may be shared would be if there were any significant concerns around your safety and wellbeing. I would discuss this with you beforehand if this was the case.

Data handling and confidentiality

research project.

This information will include your:

- Name
- Contact details
- Age

- Ethnicity
- Diagnosis
- Length of detention
- Number of admissions to hospital
- Dates of inpatient stay (admission to discharge if applicable))

People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by sending an email to c042180m@student.staffs.ac.uk (lead researcher) OR kim.gordon@staffs.ac.uk (research supervisor) OR Sarahjane.jones@staffs.ac.uk (sponsor representative)
- by ringing us on 01782 284000

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

All data will be fully anonymised and assigned to a unique identifier that is generated by yourself, rather than identified by your name and will be kept in a secure location at all times. The specific location or name of the Trust or ward will not be identified in the write-up of the project. Both myself and my thesis supervisors (who will only have access to anonymised data), will have access to the data for analysis and potential publication purposes. It may also be possible that Staffordshire University or NHS Trust may need access to some data too for audit purposes. Electronic copies will be stored on a password-protected university computer in encrypted files in line with the British Psychological Society's code of ethics (2019) and University policy. As data will be combined, it will not be possible to identify any individual in any publication arising from this research. All of the data will be stored securely by the university for 10 years in line with university guidelines, and destroyed thereafter. Should the data

need to be transferred, a data transfer agreement will be in place, which will ensure that data continues to be held in compliance with GDPR (UK data protection standards).

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.

What if I change my mind about taking part?

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You can email me to withdraw your data from the study up until two weeks after the interview has taken place. After that point, it will no longer be possible to withdraw your data because it will have been anonymised for analysis. To protect the validity of the study, I will only analyse data which has been collected up to the point of withdrawal.

To withdraw, please email me using the email address linked below and reference your unique identification number and state that you would like to withdraw from the study.

What will happen to the results of the study?

You have the choice if you would like to be contacted after the research project is completed, and if you would like to provide feedback on the research project, or receive a summary of the research report itself. You can select either 'yes' or 'no' to opt in or opt out on the Consent Form to indicate your choice.

Once all the information has been collected and analysed, the findings may be published in a peer reviewed academic journal. We also may aim to share the results with other healthcare professionals and researchers at conferences. Finally, a summary report of the findings will also be written for participants. If you would like a copy of this summary report, please let me know by speaking to your ward psychologist or ward staff or contacting me via email below and I will provide you with a copy of this once the study has finished. We will need to keep your contact details in order to send this to you.

Who should I contact for further information?

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

Principal Researcher:

Krishna Chauhan (Trainee Clinical Psychologist)

Email: c042180m@student.staffs.ac.uk

Supervisor:

Dr Kim Gordon

Email: kim.gordon@staffs.ac.uk

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Community Teams

Participant Information Sheet

Version 1.6 (14/06/2024)

IRAS Project ID: 338095

Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons.

Staffordshire University

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

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School of Health, Education, Policing and Sciences



Project Reference Number: SU_23_066

Title of study: Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons.

Invitation Paragraph

My name is Krishna Chauhan and I am a Trainee Clinical Psychologist at Staffordshire University. I would like to invite you to participate in my research project exploring the experiences of people from ethnic minority and racially minoritised backgrounds (Black, Asian, Mixed Heritage, migrant populations) who have been involuntarily detained in hospital for mental health reasons.

This study will form part of my doctoral research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take your time to read the following information carefully which can be used as a guide to explain the research further. You can ask questions or discuss this with others or myself if you wish. Ask me if there is anything that is not clear or if you would like more information.

This piece of research has been ethically reviewed and approved by Staffordshire University Ethics Committee and South West-Central Bristol Research Ethics Committee. Staffordshire University holds appropriate insurance that applies to this study.

Midlands Partnership University NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, and St Andrew's Healthcare have been involved in supporting recruitment for this project

Please note that by taking part in this research will not affect your care or treatment.

What is the purpose of the study?

The study aims to look at the experiences of people from ethnic minority and racially minoritised backgrounds (Black, Asian, Mixed Heritage, migrant populations) who have been involuntarily detained in hospital for mental health reasons. People from ethnic minority or racially minoritised backgrounds (particularly Black and South Asian backgrounds) are more likely to be involuntarily detained in hospital for mental health reasons than White British groups yet this is an under-researched area. This research will help us to get a better understanding of why this might be the case and work to help reduce the inequalities faced by people from ethnic minority backgrounds.

Why have I been invited to take part?

You have been invited to take part as I believe hearing your experiences about being detained in inpatient settings will be invaluable in furthering our understanding as to why there seems to be higher rates of detention amongst people from ethnic minority or racially minoritised backgrounds to help to reduce the inequalities faced.

What will happen if I take part?

After reading this information sheet, if you agree to participate in this study, please let your ward psychologist know you are interested, if this has not yet been directly discussed with you. If you have further questions or would like more information about the study, you can let a member of ward staff or ward psychologist know and I will get in touch with you to discuss this further. You will have the opportunity to ask any questions that you may have and make sure that you fully understand what the study will involve and how you will be asked to participate. Following this, you will have at least 24 hours to decide whether you want to take part, and you are encouraged to discuss your participation in the study with other people you trust or members of your care team to help you make your decision. If you decide to take part, you will be provided with a consent form and will be asked to sign this.

The research will involve myself interviewing you in a safe and confidential space either online using Microsoft Teams for a duration of approximately 45-60 minutes, or in face-to-face setting that we will agree together at a time and place that suits us both. You will be asked to answer a few introductory questions asking about your age, gender, ethnicity, and diagnosis at time of detention at the start of the interview. You will be able to take breaks during the interview if you need. You have the right to stop the interview at any point, or choose not to answer questions if you wish and will not have to give any reason for doing so. The interviews will be audio-recorded using the Microsoft Teams recording feature or an audio-recorder which I will then transcribe. Names and any identifying information will remain anonymised and non-identifiable. After the research has been written up, I am happy to discuss it with you if you wish or you can be provided with a written summary of the findings.

There are no right or wrong answers as this study is seeking *your* experience.

Will taking part cost me anything?

No, the study will only require some of your time.

Do I have to take part?

No. 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 let your ward psychologist know so that they or I can speak to you and support you with any questions that will help you make a decision about taking part. If you decide to take part, you will be asked to sign a consent form before participating in the interview.

As a token of thanks for your participation in the study you will also be given £10 Amazon voucher at the end of the interview.

What are the possible benefits of taking part?

Taking part in this research will help to gain a better understanding of what it is like to be detained under the Mental Health Act (1983) as adults who identify as being from ethnic minority or racially minoritised backgrounds. This is an area that is under-researched and is important because people from these backgrounds are at higher risk of being involuntarily detained when compared to White-British groups. You may find it helpful and empowering to talk about your experiences.

What are the possible risks of taking part?

We understand that talking about your experiences which led up to your detention in hospital and your experiences from then on may cause some emotional distress. However, this will be kept in mind throughout your interview and the researcher will have had experiencing working with people who experience emotional distress. You will have opportunities to take breaks during the interview should you wish. You do not have to answer particular questions if you do not want to and have the right to stop the interview at any point without any questions asked. At the end you will have an opportunity to discuss the interview and ask any questions. Your participation is voluntary and if you can withdraw from the research at any point up to two weeks after the interview has taken place.

Details of what you share in the interview will not be shared with your care team. The only reasons information would be shared with your care team you shared any information which made me concerned about your safety or wellbeing, but I would discuss this with you beforehand if this was the case.

Data handling and confidentiality

We will need to use information from you, your care team, and your clinical records for this research project.

This information will include your:

- Name
- Contact details
- Age
- Ethnicity
- Diagnosis
- Length of detention
- Number of admissions to hospital
- Dates of inpatient stay (admission to discharge if applicable))

People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Where can you find out more about how your information is used?

You can find out more about how we use your information at:

- www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by sending an email to c042180m@student.staffs.ac.uk (lead researcher) OR kim.gordon@staffs.ac.uk (research supervisor) OR Sarahjane.jones@staffs.ac.uk (sponsor representative)
- by ringing us on 01782 284000

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

All data will be fully anonymised and assigned to a unique identifier that is generated by yourself, rather than identified by your name and will be kept in a secure location at all times. Both myself and my thesis supervisors who will only have access to anonymised data), will have access to the data for analysis and potential publication purposes. It may also be possible that Staffordshire University Staffordshire

University or NHS Trust may need access to some data too for audit purposes. Electronic copies will be stored on a password-protected university computer in encrypted files in line with the British Psychological Society's code of ethics (2019) and University policy. As data will be combined, it will not be possible to identify any individual in any publication arising from this research. All of the data will be stored securely by the university for 10 years in line with university guidelines, and destroyed thereafter. Should the data need to be transferred, a data transfer agreement will be in place, which will ensure that data continues to be held in compliance with GDPR (UK data protection standards).

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.

What if I change my mind about taking part?

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You can email me to withdraw your data from the study up until two weeks after the interview has taken place. After that point, it will no longer be possible to withdraw your data because it will have been anonymised for analysis. To protect the validity of the study, I will only analyse data which has been collected up to the point of withdrawal.

To withdraw, please email me using the email address linked below and reference your unique identification number and state that you would like to withdraw from the study.

What will happen to the results of the study?

You have the choice if you would like to be contacted after the research project is completed, and if you would like to provide feedback on the research project, or receive a summary of the research report itself. You can select either 'yes' or 'no' to opt in or opt out on the Consent Form to indicate your choice.

Once all the information has been collected and analysed, the findings may be published in a peer reviewed academic journal. We also may aim to share the results with other healthcare professionals and researchers at conferences. Finally, a summary report of the findings will also be written for participants. If you would like a copy of this summary report, please let me know by contacting me via my email below or ask your care co-ordinator or suitable clinician to do this on your behalf and I will make sure that you get a copy of this once the study has finished. I will need to keep your contact details in order to send this to you.

Who should I contact for further information?

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

Principal Researcher:

Krishna Chauhan (Trainee Clinical Psychologist)

Email: c042180m@student.staffs.ac.uk

Supervisor:

Dr Kim Gordon

Email: kim.gordon@staffs.ac.uk

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Appendix J- Consent forms

Inpatient

Staffordshire University

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

www.staffs.ac.uk

School of Health, Education, Policing and Sciences



Research Project Consent Form

Title of Project: Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons.

Researcher: Krishna Chauhan

I have read and understood the information sheet, have been given the opportunity to ask questions, and have had these answered satisfactorily. Yes No

I confirm that I am eligible to participate in the study based on the inclusion criteria presented Yes No

I understand that my participation in this study is entirely voluntary and that I can withdraw from the study up until 2 weeks after the interview has taken place Yes No

I understand that the interview will be recorded, transcribed and analysed. All personally identifiable information will be anonymised. 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 future research, but I understand that all data will be presented anonymously. Yes No

I understand that all data will be stored 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 hereby give consent to take part in this study Yes No

I would like to be contacted after the research is completed Yes No

Name Participant (print)

Date

Signature

Krishna Chauhan (Chief Investigator)

Date

Signature

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Community

Version 1.5 (03/05/2024)
IRAS Project ID: 338095

Staffordshire University

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

www.staffs.ac.uk

School of Health, Education, Policing and Sciences



Research Project Consent Form

Title of Project: Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons.

Researcher: Krishna Chauhan

I have read and understood the information sheet, have been given the opportunity to ask questions, and have had these answered satisfactorily. Yes No

I confirm that I am eligible to participate in the study based on the inclusion criteria presented Yes No

I understand that my participation in this study is entirely voluntary and that I can withdraw from the study up until 2 weeks after the interview has taken place Yes No

I understand that the interview will be recorded, transcribed and analysed. All personally identifiable information will be anonymised. 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 future research, but I understand that all data will be presented anonymously. Yes No

I understand that all data will be stored 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 hereby give consent to take part in this study Yes No

I would like to be contacted after the research is completed Yes No

Name Participant (print)

Date

Signature

Krishna Chauhan (Chief Investigator)

Date

Signature

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Appendix K- Interview Schedule

Interview Schedule (subject to adaptation)

Version 1.5 (03/05/2024)

IRAS Project ID: 338095

Staffordshire University

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

www.staffs.ac.uk

School of Health, Education, Policing and Sciences



Confidentiality statement (including unexpected disclosure related to risk or safeguarding concerns)

Demographic Information

Name, age, ethnicity, currently detained/current status/dates and period of detention, reason/rationale for detention, diagnosis, duration, number of detention periods

Circumstances of detention:

- Can you tell me about what happened that led to you coming into hospital?
- What was your understanding of what was happening at the time of being admitted? (including diagnosis)
-

Experience of detention/hospitalisation

- How appropriate do you feel your detention was at the time? Did this change over time?
- Do you think anything could have prevented your detention?
- What are/were (for community participants) your experiences of detention whilst being on the ward? (Including support, relationships with staff/other service-users/family opinions??)
- Can you tell me about your experiences of treatment? (How much do you feel you were involved in decision-making around your treatment?)
- How do you feel you were treated in the service? (follow up: Why do you think you were treated that way?)

Only ask the following question if participant answered that they were not treated well or fairly in detention:

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

Continue with interview questions for all participants:

- Can you tell me what you have found helpful while you were in hospital?
- Can you tell me what you have found harmful while you were in hospital?

- Is there anything else you would like to add about your experiences of being detained?

Adapted from: Solanki, J., Wood, L., & McPherson, S. (2023). Experiences of adults from a Black ethnic background detained as inpatients under the Mental Health Act (1983). *Psychiatric Rehabilitation Journal*, 46(1), 14.
<https://doi.org/10.1037/prj0000537>

Appendix L- Debrief sheets

Inpatient

Staffordshire University

249 Leek Road

Stoke-On-Trent

ST4 2BP

Telephone: 01782 294000

www.staffs.ac.uk

School of Health, Education, Policing and Sciences



Debriefing Sheet

Title of study: Exploring the lived experiences of adults from ethnic minority and racially minoritised backgrounds who have been involuntarily detained in hospital for mental health reasons.

Thank you for taking part in this study. Your involvement is very much appreciated. I would like to remind you that you have up until two weeks after taking part in the interview to withdraw your data from the study.

This study was looking at exploring the experiences of adults who self-identify as being from an ethnic minority and/or racially minoritised background who have been involuntarily detained in inpatient hospital settings for mental health reasons. Hearing about your lived experiences is really important as the current research shows that people from these backgrounds are more likely to be involuntarily detained than any other group and therefore this needs more research to identify what might be contributing to this and help to make change in this area.

As a reminder - all anonymised data will be kept in encrypted files that only my supervisor(s) and I will have access to, on an encrypted university computer to ensure full security. The data will be destroyed in a secure manner after 10 years of completing this study.

If you no longer wish for your data to be used as a part of this study, then please ask your ward psychologist to contact me using the contact information provided below up to two weeks after the interview has taken place.

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 speak to your ward clinicians.

For further support, please refer to the following services:

- **Mind:** you can find the phone number and email address for your local service on <https://www.mind.org.uk/information-support/local-minds/>
- **Samaritans:** <https://www.samaritans.org/how-we-can-help/health-and-care/>. Samaritans are open 24/7 for free calls on **116 123**
- **SHOUT: Text 85258** – this is a free 24/7 mental health text support service. <https://giveusashout.org>
- **The Black, African and Asian Therapy network** Website: <https://www.baatn.org.uk/> Email: eugene@baatn.org.uk
- Mind Equality Improvement Team and Young Black Men Programme
Email: quality@mind.org.uk.
- **Living Well UK**
Website: <https://livingwellconsortium.com/>
Telephone: 0121 663 1217

If you have any questions about this research study, please feel free to ask your ward psychologist to email me or my supervisor about this using our contact details provided below:

Contacts and further information- Researcher details:

Krishna Chauhan (Trainee Clinical Psychologist)

Email c042180m@student.staffs.ac.uk

Supervisor details:

Dr Kim Gordon

Email: kim.gordon@staffs.ac.uk

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Community

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As a reminder - all anonymised data will be kept in encrypted files that only my supervisor(s) and I will have access to, on an encrypted university computer to ensure full security. The data will be destroyed in a secure manner after 10 years of completing this study.

If you no longer wish for your data to be used as a part of this study, then please contact me or my supervisor using the contact information provided below up until two weeks after the interview or ask your clinician to contact me or my supervisor on your behalf.

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 speak to your care co-ordinator or clinician or please refer to the following services:

- [You can visit your local GP in the first instance, attend](#) your local walk in Centre or dial NHS 111 for any health/wellbeing advice. In the event where you feel unable to keep yourself safe you can attend A&E or in the event of an emergency please dial 999

Additional Support:

- **Mind:** you can find the phone number and email address for your local service on <https://www.mind.org.uk/information-support/local-minds/>
- **Samaritans:** <https://www.samaritans.org/how-we-can-help/health-and-care/>. Samaritans are open 24/7 for free calls on **116 123**
- **SHOUT: Text 85258** – this is a free 24/7 mental health text support service. <https://giveusashout.org>
- **The Black, African and Asian Therapy network Website:** <https://www.baatn.org.uk/>

Email: eugene@baatn.org.uk

- **Mind Equality Improvement Team and Young Black Men Programme**
Email: quality@mind.org.uk.
- **Living Well UK**

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

Telephone: 0121 663 1217

If you have any questions about this research study, please feel free to email me or my supervisor about this using our contact details provided below:

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Supervisor:

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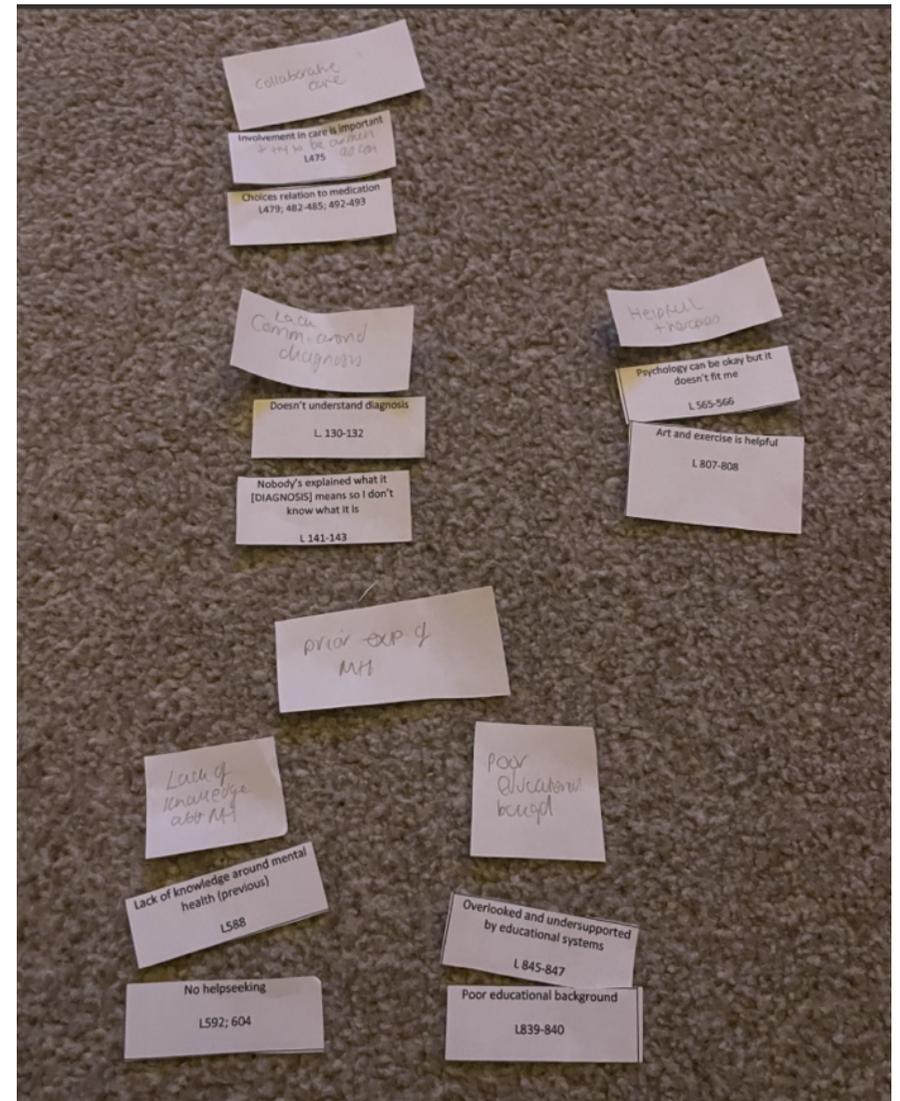
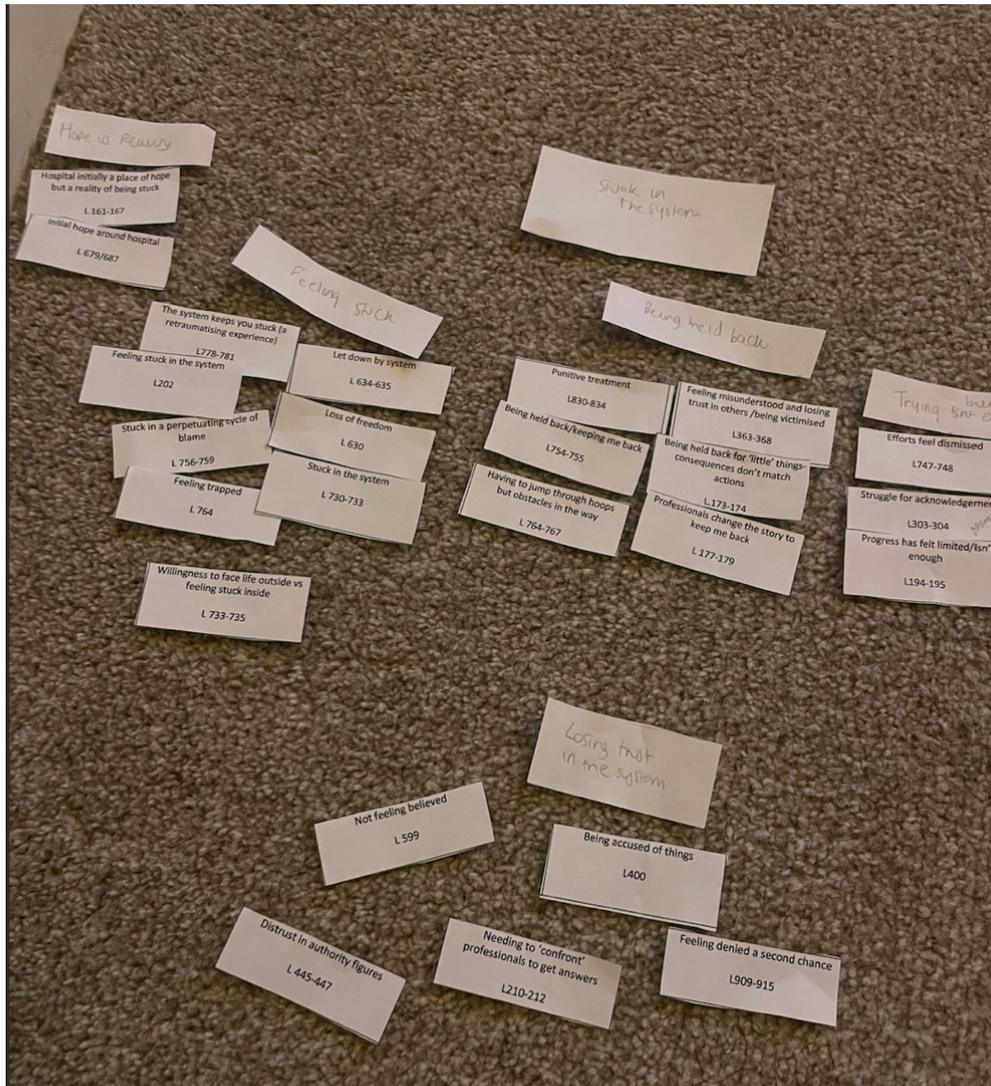
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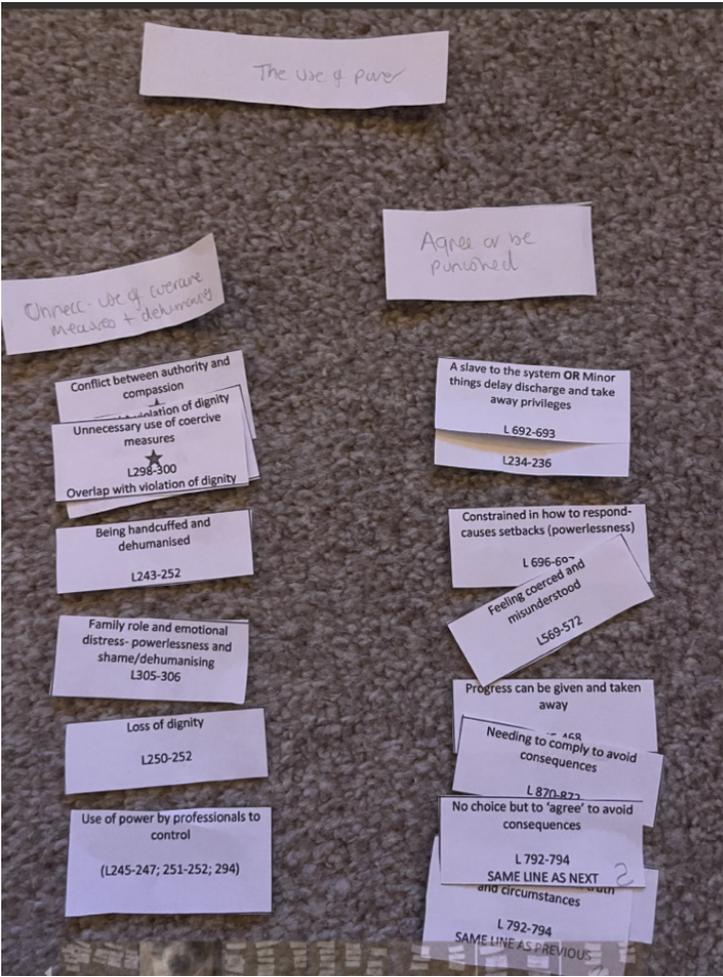
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Appendix M- Example of exploratory noting (right) and experiential statements (left)

Example of Leon

<p>The system has prolonged his stay for too long</p> <p>Willingness to face life outside versus feeling stuck inside</p> <p>(Mourning the loss of a life that could have been)</p> <p>A focus on getting old and uncertainty about life</p> <p>Desire and urgency for freedom and agency</p> <p>Sense of lost time</p> <p>Trying to make the effort to engage but feels dismissed</p> <p>Black people in the system need to be moved on (a shared experience)</p> <p>They're keeping me back</p> <p>Feeling stuck and a perpetuating</p>	<p>732 You see? I probably would have been gone. I probably would</p> <p>733 have been free. And then I wouldn't... I'd have to deal with life</p> <p>734 outside, whatever it was then, but they prolonged it for too</p> <p>735 long. It's been prolonged. They're keeping it back.</p> <p>736</p> <p>737 I: <u>Mhmm</u></p> <p>738</p> <p>739 P: And the more, the more I stay in... I'm not scared of it,</p> <p>740 yeah? But if you know what's yours on Earth, you'll go and get</p> <p>741 it. I'm getting old now, you gotta remember this...when I'm</p> <p>742 living life now, anything can happen... Yeah, it's not...I'm not</p> <p>743 guaranteed the next 20 years. Yeah, I'm not guaranteed it.</p> <p>744 Now, you know what I mean I just live, I just go along as time</p> <p>745 goes. From here, I'm here today, today I could have just been</p> <p>746 in my bed still sleeping now, you could have come along and I</p> <p>747 could have been still sleeping, but a man see put the effort</p> <p>748 and get out of bed yeah. And so at the end of the day, I need</p> <p>749 to move on. Yeah, and and they need to get... And see it's not</p> <p>750 just me I'm talking about, there's black people in the system,</p> <p>751 they need to be moved on. (Pause). Yeah, because even if they</p> <p>752 get rid of all of us, somebody else is coming. People are trying</p> <p>753 to come to hospital and in prison. Yeah, there's loads of lists</p> <p>754 trying to come. I've already served my... 11, probably 11 years</p> <p>755 in it. What's the point in holding me any longer? And then</p> <p>756 you're going to talk about my index offence, 'you're not</p> <p>757 owning up to it', so hold me longer. And if you if you're not</p> <p>758 talking about the index offence, you're talking about what I</p>	<p>Talks again about freedom, held back, prolonged detention</p> <p>'would have been free' repeated- significant delay</p> <p>'Deal with life'- awareness of challenges post-release but willingness to face them vs feeling stuck inside</p> <p>Prolonged- system is to blame for delay</p> <p>Feels unnecessary/doesn't understand</p> <p>Philosophical?_ wish to pursue opportunities</p> <p>Focus on age, getting old... death looming – what he's missed and what he may continue to miss</p> <p>(sadness? Urgency? Contemplation?)</p> <p>Day-to-day acceptance- but anything can happen- got out bed illustrates active engagement with life whenever possible</p> <p>He is trying- overlooked?</p> <p>It's more than him- more black people in the system who are stuck- they need to be moved on</p> <p>Served 11 years- sufficient time completed</p> <p>Focus on index offence- being judged on the past which is not true for him</p> <p>Feeling like he <u>can't</u> win with anything he says- either feels wrong – trying to find reasons to keep him in longer?</p> <p>Laughs (fed up, angry).</p>
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Leon's example of organising experiential statements into PETs – typed version

PETs	Subthemes (with some example PES)
<p>Racism in the system</p>	<p>It happens to black people like me</p> <ul style="list-style-type: none"> - White and black people treated differently (L417; 418-419;429) - It happens to people like me (black people (L204-206) - Black people in the system need to move on (L749-751) - Black people get held back (L213-216) - Physical appearance of being black (holds you back) (L228-229) <p>Shared black experience of injustice</p> <ul style="list-style-type: none"> - Transition from isolation to emerging sense of community - Shared sense of injustice - Shared experience of injustice (L342-345) - Validation through shared stories (L341) - Shared experience of not being listened to (L884) - Shared experience of anger towards system (L878) <p>A value not reciprocated</p> <ul style="list-style-type: none"> - Strong identity of accepting diversity not reciprocated (L363) - A value of fairness not reciprocated (L642) <p>It's hard to spot racism</p> <ul style="list-style-type: none"> - Cultural disconnect and importance of finding similar others (L331;333) - Complexity of identifying racism (L443) - Racism is covert/undercover (L220) - Tension between apparent diversity and felt racism (:443; 439) - Black and white work together
<p>A life missed out and a life that could be- a dream deferred?</p>	<p>A wasted life and a wasted me</p> <ul style="list-style-type: none"> - A wasted life and a wasted me (:867) - Time is passing (L905) - Sense of lost time - Not getting any younger (losing time) (L867) - Importance of family - Loss of family is worst thing (L236) - Loss of important people (L335) <p>A fight and urgency for freedom- time is running out</p> <ul style="list-style-type: none"> - Loss of loved ones and anxiety of losing others (L658) - Getting old and uncertainty about life (L739) - A fight for freedom (L436) - Even tolerable circumstances have limits (L728) - Importance of freedom (L612) - Urgency to move forward (L906; 872) - Desire to be free (I734) - Increased distress and urgency to be with loved ones (L658) <p>Still holding hope?</p> <ul style="list-style-type: none"> - Holding hope for the future (L857) - A support to others (L877)

	<ul style="list-style-type: none"> - A need to speak out (L816)
Stuck in the system	<p>Feeling stuck</p> <ul style="list-style-type: none"> - The system keeps you stuck (L778) - Let down by the system (L634) - Loss of freedom (L630) - Suck in the system (L730; 202) - Feeling trapped (L764) - Stuck in a perpetuating cycle of blame (L778) - Willingness to face life on outside vs feeling stuck inside (L773) <p>Being held back</p> <ul style="list-style-type: none"> - Punitive treatment (L830) - Keeping me back (L754) - Feeling misunderstood and losing trust in others (L363) - Having to jump through hoops but obstacles in the way (L764) - Being held back for 'little things'- consequences don't match actions (L173) - Professionals change story to keep me back (L177) <p>Trying but it isn't enough</p> <ul style="list-style-type: none"> - Efforts feel dismissed (L747) - Struggle for acknowledgement (L303) - Progress has felt limited (L194) <p>Hope vs reality</p> <ul style="list-style-type: none"> - Hospital initially a place of hope but reality of being stuck (L161) - Initial hope around hospital (L679) <p>Losing trust in the system</p> <ul style="list-style-type: none"> - Not feeling believed (L599) - Being accused (L400) - Feeling denied a second chance (L909) - Needing to 'confront' professionals to get answers (L210) - Distrust in authority figures (L445)
The use of power	<p>Unnecessary use of coercive measures</p> <ul style="list-style-type: none"> - Conflict between authority and compassion - Unnecessary use of coercive measures (L298) - Violation of dignity (L300) - Handcuffed and dehumanised (L243) - Powerlessness/shame/dehumanised at family funeral (L305) - Loss of dignity (L250) - Use of power by professionals to control (L245;251;294) <p>Agree or be punished</p> <ul style="list-style-type: none"> - A slave to the system (L692) - Constrained in how to respond- causes setback (powerless) (L696) - Feeling coerced and misunderstood (L569) - Progress can be given and taken away (L468) - Needing to comply to avoid consequences (L870) - No choice but to agree to avoid consequences (L792)

Lack of communication	<ul style="list-style-type: none"> - Didn't understand diagnosis (L130) - Nobody's explained anything (141)
Helpful resources	<ul style="list-style-type: none"> - Psychology can be okay but doesn't fit me (L565) - Art and exercise helpful (L807)
Collaborative care is important	<ul style="list-style-type: none"> - Involvement in care is important (L475) - Choices relating to medication (L479; 482) - A support to others (L877)
Prior experiences	<p>Lack of knowledge re. mental health</p> <ul style="list-style-type: none"> - Lack of prior knowledge (L588) - No help-seeking (L592; 604) <p>Poor educational background</p> <ul style="list-style-type: none"> - Overlooked and under supported by educational systems (L845) - Poor educational background (L839)

Appendix O- Audit trail example of PETs and transcript lines

Example of Chloe

<p>The communication wasn't enough</p> <p>Stumbling upon a diagnosis</p>	<p>I just got told one day that I've got an appointment with the doctor, and then the doctor asked me a series of questions which I answered no to. He says are you hearing voices and I said no, he says do you think people are talking about you, I said I couldn't care if people are talking about me. Um, and then, then I was... then I was sent to the hospital.</p> <p>There was no diagnosis, it was only one day I looked when I was getting my medication and I saw the paper saying, it said schizophrenia, and I thought 'who's got schizophrenia?'</p>
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<p>Nobody explained anything (all throughout journey)</p>	<p>I think it... but I don't know if it was the hospital or it was me, like I said because I wasn't receptive to listening to anything and <i>nothing</i> was explained to me so I'd had this... I'd just been dumped in hospital with nothing explained to me... from a prison... <i>cuffed</i> from a prison and then brought in a room full of people....Of the, of the team, which is really intimidating... and then I don't know who they are and they're all talking about me, and to me, about things that I don't know anything about, they're using terminology that I don't understand... I felt like a fish out of water, I just didn't know <i>what</i>, what they were talking about, <u>So</u> then I didn't want to listen yeah.</p> <p>And then when I got to the other <u>hospital</u> they put me on Olanzapine. Again, nothing was explained.</p> <p>They didn't give me any information about the act but it's a sort of tool that they use within prisons for those that have got mental health or if they're concerned about somebody with mental health.</p> <p>I just got told one day that I've got an appointment with the doctor, and then the doctor asked me a series of questions which I answered no to.</p> <p>He says are you hearing voices and I said no, he says do you think people are talking about you, I said I couldn't care if people are talking about me. Um, and then, then I was... then I was sent to the hospital.</p> <p>I'm somebody that's never even really taken paracetamol... so they put me on Quetiapine, and I had to ask what is this tablet? Like how strong is it, and I asked the pharmacist, I says you sure they're giving me the right dose? Nothing was</p>
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An example of organising GETs- typed up

<p>Our voices don't matter</p> <p><u>Untimely help</u> Early concerns not taken seriously Pleas for help ignored Lingering 'what if' Let down by the system Grief at time lost and what could have been Detention could have been prevented I'm not a nutter (stigma) Nobody explained anything to me (I didn't understand legal processes) Disproportionate blame, extreme consequences Fear of social rejection and being labelled Clash with identity Stigma in media Untimely help led me here Unsure how to get help Prison not rehabilitative environment I didn't need hospital, I needed help No help in prisons</p> <p><u>An object of care</u> Object of care Detained without my consent Disorientating and confusing experience of being detained Lack of control and safety</p>	<p>Disproportionate use of force and power</p> <p>The use (misuse) of power Abused by police Medication to manage behaviour Repeated abuse of power by authorities Lack of trust and safety Traumatizing and unnecessary restraint Inhumane and invasive treatment Powerless Like an animal in a cage Isolated alone and helpless Unnecessary use of coercive measures Agree or be punished Punished and isolated Loss of trust and betrayal by staff A wall of silence I wish they'd have talked to me Concerns not taken seriously Powerless and helpless Enforced medication and physical violation</p>	<p>[Racialised and culturally invalidated]</p> <p><u>Targeted because of race?</u> Racism in the system It's hard to spot racism Shared black experience of injustice Value not reciprocated It happens to people like me Targeted as a black woman Targeted and goaded</p> <p><u>Clash of cultures</u> An observation on ethnicity (Witnessing systemic indifference to black people) Safer around white staff, targeted by black staff Cultural clashes Difference in cultures and comfort Role of culture and ethnicity It's hard to spot racism</p>	<p>[Feeling held back]</p> <p><u>Feeling stuck</u> Heading down a road of institutionalisation Feeling stuck A quiet frustration Bittersweet ambivalence Feeling confined Reduced to record keeping Feeling stuck Being held back Stuck in the system Hope vs reality Losing trust in the system Hopeless and defeated Hopeful about discharge but underlying anxiety Urgency for freedom Disbelief at others' stuckness</p> <p><u>Urgency for freedom</u> A wasted life and a wasted me A life missed out and life that could be- a dream deferred? Missing out on life Urgency to get out- people need me A fight and urgency for freedom- time is running out Time for me to go home (losing out on time)</p>	<p>A bittersweet experience</p> <p>[Being held or holding each other]</p> <p>Shifting levels of comfort Meaningful and traumatic dialect Holding hope Fluctuation in communication and involvement Now my voice counts Collaborative care(is important) My voice counts Now we matter Feeling cared for Supported by family and professionals A different experience to the others Helpful staff Kindness of staff Value in communication and collaboration Comfort and connection through patients A duty of care to the other patients Lack of meaningful interaction Bittersweet experience Supporting other patients</p> <p>[Therapy as intrusive or insufficient?]</p>
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<p>The communication wasn't enough I didn't know why I was here Surrounded by strangers Lack of communication Uncollaborative care Stumbling upon a diagnosis (nobody explained anything) Nobody explained anything Didn't know what was happening Helplessness Lack of meaningful interaction Not involved in decision-making Dumped in hospital Lack of choice Lack of communication Surrendering to the power Medication as first line of treatment Powerless to have a say but fear of medication Stripped of rights Freedom is a privilege Passive object in care False sense of autonomy Basic human rights taken away Powerless</p>				<p>Psychology is helpful Psychology reduced shame but still necessary? Helpful support <i>now</i> Helpful resources (<i>psychology okay but doesn't fit me</i>) More needs to be done (it's not enough) Confined and cut off from the community Treatment offered isn't for me Value in psychology Hospital is too restrictive</p>
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Josh

Leon

Sammy

Michael

Tyler

Chloe

Appendix Q- Themes and participants contributing to themes

	Our voices don't matter <i>Untimely help</i>	Our voices don't matter <i>An object of care</i>	Disproportionate use of force and power	Feeling held back <i>Feeling stuck</i>	Feeling held back <i>Urgency for freedom</i>	Racialised and culturally invalidated <i>Targeted because of race?</i>	Racialised and culturally invalidated <i>Clash of cultures</i>	A bittersweet experience <i>Being held or holding each other</i>	A bittersweet experience <i>Therapy as intrusive or insufficient?</i>
Josh	X	X		X	X			X	X
Leon		X	X	X	X	X	X	X	X
Sammy	X	X	X			X	X	X	X
Michael		X	X	X	X		X	X	X
Tyler	X	X		X	X		X	X	X
Chloe	X	X	X	X		X	X	X	X

Appendix R - Example of GETS and excerpts organised into table

GETs	Subthemes
<p>Our voices don't matter</p>	<p><u>Untimely help</u></p> <p><i>“When I was younger at 12 years old or 13 years old, my dad contacted [doctor]. And I went to see him there”... “I’m saying these things to him, and he looked at me for like 15 and a half hours and he goes to my dad, he goes to him, your son can go with you, you can go, there’s nothing wrong with him. My dad still says to me yet to that day, he goes if they had said something then, diagnosed you or realised it’s something... my dad always says, he goes I could see it in you son. He goes I could see that you had signs of mental health...I think maybe... you’re probably... thinking, you know, I don’t know what he was thinking. He could have even referred me to team prevent like... saying at such a young age, saying things like that, you didn’t do nothing... he just didn’t do nothing”. (Sammy, pp.8-9)</i></p> <p><i>“My mental health was declining from the amount of times that I’ve been arrested and moved around and remanded” (Chloe, p.4)</i></p> <p><i>“I’ve been to court 30 times for the same thing.” (Chloe, p.4)</i></p> <p><i>“I didn’t understand anything about it. I didn’t know what... I didn’t know there was the police conditions, bail conditions. I never heard the term bail conditions. I’ve never been in trouble with the law, the courts didn’t make it clear that I wasn’t allowed to go back to my house” (Chloe, p.3)</i></p> <p><i>“I don’t think that I needed... I don’t think that I needed to be detained. I think I needed somewhere to live I was walking the streets homeless.” (Chloe, p.10)</i></p> <p><i>You know. I got charged with common assault, I’d been treated, I felt like I’d been treated like I’d committed a murder, that’s how it felt” (Chloe, p.10)</i></p> <p><i>“It all started when I was in jail, and I lost my nan. I started using mamba, and I changed my religion to Islam. And that’s where it started. I started hearing the voices and seeing things.” (Josh, p.3)</i></p> <p><i>“I’ve seen it when other people have left prison to go hospital, up until they leave, like everyone like, everyone picks on them and beats them up and all that, and I’m like, that’s not nice at all. And then staff in there, they don’t care, and they’re this is their problem, so there’s no help in the prisons” (Tyler, p.22)</i></p> <p><u>An object of care</u></p>

	<p><i>"I just got told one day that I've got an appointment with the doctor, and then the doctor asked me a series of questions which I answered no to. He says are you hearing voices and I said no, he says do you think people are talking about you, I said I couldn't care if people are talking about me. Um, and then, then I was... then I was sent to the hospital." (Chloe, p.6)</i></p> <p><i>"thought that this was like kind of like prison settings basically, so, we can just do whatever we want with ya, and that's it. So that was like, I just thought I can't request things is that's what's gonna happen then, that's what's gonna happen" (Tyler, p.12)</i></p> <p><i>"Cos at the time I just went along, cos I was like he's the doctor, he knows what he's on about. And like, but luckily, they like take your bloods every week or two weeks. And like, yeah, if your bloods are green, then you're OK. But if they're not, then they take you off it. And luckily my blood didn't agree with that it, so it was like, you can't stay on this, we've got to put you on something different because you can't be on this because your bloods." (Tyler, pp.15-16)</i></p> <p><i>"The other ones, they just... what they were doing, they were prescribing medications, you take it. Yeah, there wasn't much input"... "like you know when somebody sits down and talks to you about like psychology and stuff?" (Sammy, p.13)</i></p> <p><i>"I've got a say, but say... I really can't. It's just what the doctor thinks" (Josh, p.12)</i></p> <p><i>"I go to the doctor would I be able to go to my son's first birthday party at home. First, he said yes, and then the next day before his birthday, he goes you can't go because you're a risk." (Sammy, p.9).</i></p>
<p>Disproportionate use of force and power</p>	<p><i>"Yeah, under a control. And remember the sentence, what I done, my sentence what I got from prison, when I was in prison, that was 3 years and 11 months before parole. When I had arrived here, it had already finished. So, I didn't have that. They didn't have to put handcuffs on me, they didn't have to. Yeah, they didn't have to. They didn't have to put them on me. Especially when you go to a funeral that you've gone with four people, why would you need to handcuff somebody? You know what I'm saying? That's what I'm trying to tell ya, yeah. So obviously, I believe I'm being a victim. I need to complain and they gave me an apology. An apology is not good enough. You know I'm there, my family's all crying and upset, and I can't hold my family" (Leon, p.6)</i></p> <p><i>"I've been put in an illegal chokehold, I've had uh someone put their knees on me testicles and put all of his weight on it" (Michael, p.8).</i></p> <p><i>"Forcibly injected, when I didn't like the injection. Uh, they grabbed me, they pulled me trousers down and injecting me." (Michael, p.9)</i></p>

	<p><i>"I think it's just a culture... It's a closed culture, I think I believe uh the correct terminology is... Erm a closed culture"... "I think at the moment they call it the wall of silence"... "But I already mentioned to two members of staff about the guy who out his knees on my testicles and why did nobody say anything... they started getting angry" (Michael, p.13)</i></p> <p><i>"I don't know who you are... bunch of strangers holding me down, pinning me down, pulling my butt out, this is just craziness and this was, I think this was the second day that I was there...I was frightened. I was genuinely scared. I'm surprised I didn't beat everybody up, I was that [inaudible] cos I was like what is going on." (Chloe, p.17)</i></p> <p><i>"I don't know what they were injecting me with, it could have been anything. So, I would have liked them to like have a discussion... or maybe say, try this medication, or try, try put me on some medication. They kept me in there [seclusion]" (Sammy, p.19)</i></p> <p><i>I don't want to fight with you and they'd say alright get on the floor. Everyday they used to come every day whenever there was 5, 6, 7 of them at the door, I'd just lie down on the floor"... "I would have liked to have been supported to come out of seclusion by talking". (Sammy, p.20)</i></p> <p><i>"not physically hit, but like overdoing it... like restrained, yeah" (Sammy, p.22)</i></p> <p><i>"Like you know what I mean like, sooner or later, I can see this happening. They're gonna, like, the rooms are going to be like, cages. Just the door part. You're gonna put man in your room and they don't need to, like, send 20, 30, people... They can just shoot a dart at ya, you know what they do to bears (laughs). I can that happening you know, in the future... I can see that" (Sammy, p.19)</i></p>
<p>Racialised and culturally invalidated</p>	<p><u>Targeted because of race?</u></p> <p><i>"they're the little things that are holding me back, that's what they're saying. I've been held back from that time, and I ain't gone anywhere from then.... Yeah, yeah, I'm feeling stuck in the system, yeah. And you know, I'm not the only one. On my travels through the prison hospital system, I've met lots of people on different wards. Um, I've noticed mostly it was happening, it was black people, like myself, all going through the same thing" (Leon, pp.4-7)</i></p> <p><i>"I obviously I confronted the doctor, I told him, asked the doctor, why is it this? And then they always tell me everybody's case is different, which is not true. If I'm in here, there's three black people and they ain't going anywhere. They come here before me, and they're not indefinitely in hospital so I talk to them and they've been held back, there's gotta be something wrong. Yeah, there's something wrong in here. Yeah there's um, actually there's racism going on but its undercover, they're trying to be smart and trying to cover it, but there is racism in here. Yeah, there is" (Leon, p.4)</i></p>

"Yeah... cos of my colour, my colour and my hair, yeah and that's why they holding me back, yeah that's what it is." (Leon, p.5)

"it's when I was actually going outside on the yard to smoke. And that's when was there with them, but I didn't really mix with people much, but that's when I started to talk to the people on the ward and then started to listen to their stories and they'd rise. They said injustice is what they've been through." (Leon, p.7)

"Yeah, they've improved. You know, I mean, they've, they've gotten better. Yeah, but, you know, there's still racism in the system, you know? I mean, there's still a lot of it." (Leon, p.8)

"You know, cos in 'ere, it's hard to spot racism because you got black and white working together. Yeah. But then as a patient, I would be around white doctors or whoever it is. And then I'm fighting for my freedom and I'm trying to say I need to be free, the time I've been here too long. It's time for me to move on. And the white doctors don't want me to move on." (Leon, p.8)

"I felt, as a black woman I'd been targeted that's how I felt." (Chloe, pp.9-10)

"There wasn't any black people [patients]... Well, I'm Black British Caribbean. These are African... so there's a culture difference that wouldn't... there'd be culture differences. Um so there's a lot, there was a lot of African staff...- In the end, I did kind of feel a little bit more comfortable, but in the beginning, I didn't feel comfortable" (Chloe, p.8)

"And they were saying how Black Lives Matter. And he was screwing his face one day, and he said, 'oh Black lives matter? What? White lives matter too' and whatever else. And I just thought to meself, but it's not white people have been killed..." (Michael, p.5)

Clash of cultures

"Yeah like, I've always been told from growing up Caribbean and African people don't get along. My experience is of growing up like, coming across African guys and that like, we've just not got along. Well, we can be civil, but we can't be like, 'oh, yeah, he's my friend or whatever'. So like there is one or two African staff that are alright. And like the rest, like, it's like they don't wanna interact. Like if you ask them, they're like 'ooh I'm busy, oh this'. So I don't like... them people, I don't even bother like, don't wanna waste my time like alright that's it." (Tyler, p.20)

"But when you know, when there's no white person on the, on the shift, if there's all, like Jamaicans or Afro Caribbean people, that they would like provoke me and like say things to me, or point at me, or give my vape to somebody and then deny it" (Sammy, pp.3-4)

"There wasn't any black people [patients]... Well, I'm Black British Caribbean. These are African... so there's a culture difference that wouldn't... there'd be culture differences. Um so there's a lot, there was

	<p>a lot of African staff...- In the end, I did kind of feel a little bit more comfortable, but in the beginning I didn't feel comfortable." (Chloe, p.8)</p>
<p>Feeling held back</p>	<p><u>Feeling stuck</u> <i>"My detention is time wasting. I'm not getting no younger, I'm getting older, so it's wasted my life, you know what I mean? It's wasting me. That's what it is, its wasting my life. The thing when I'm in trouble when they've got me into trouble, there's conditions and certain things you've got to do. And that's what... I can't get over, I can't get past them, I'm already been kept back. So, I need some of the things to be eased up so I can move forward"</i> (Leon, p.17)</p> <p><i>"I'm just going to give up and let them do what they've got to do. But my goal at the end of the day, is to get free and get back to life cos on this sentence, I've actually lost my dad and cousin, I've lost loads on this"</i> (Leon, p.5)</p> <p><i>"I just feel stuck in here now, I think it's time for me to go home now"</i> (Josh., p.8)</p> <p><i>"they wrote a report, and that report gets read by someone else, then they make reports, then that report gets read by someone else, and they make reports... Before you know it, you've got a whole portfolio on ya, um... saying how crazy you are"</i> (Michael, p.7)</p> <p><i>"Um, sometimes I feel like I'm better than I was (laughs) and um... good enough to be released. I think they're saying I'm good enough to be released but they just want me to finish my psychology"</i> (Josh, p.10)</p> <p><i>"they've been in here for years and years. And I'm thinking if I was in that position, then that would frustrate me, cos I'm thinking, if you can let me go, why am I flipping here for so long. Maybe if, like come next year when my sentence is finished, if they was like, you know, 'you're not going, we're not going to recommend discharge' or whatever, then I'll probably start feeling down"</i> (Tyler, pp.20-21)</p> <p><u>Urgency for freedom</u> <i>"We need to get on the outside and get on well 24/7. Yeah, cos we're not getting no younger. Everything's going up in age. Yeah, we're not getting no younger! So they need to start moving people on. You know what I mean? Then you can't... You can't be, 'oh, he's going to commit a crime, he's gonna be outside, he's gonna commit a crime and be back in'. You can't keep doing that, that's wrong. Because you never know, he might change, he might turn his life around. He might be a Christian then he goes to church and then he turns himself to God and he believes and lives a Godly life, he never gets in trouble ever again. Yeah, it could be that. Yeah."</i> (Leon, p.18)</p> <p><i>"Yeah cause, I'm the oldest one out of all the kids yeah, and my mom's getting old. So I'm thinking she desperately needs me, and my brothers and sisters need me, and a lot of people need me. And I'm thinking now I'm doing this for myself, and then I'm gonna do it for them as well"</i> (Tyler, pp.14-15).</p>

	<p><i>“My mum when you coming out, everybody said next time you come out, we might be dead. She might die. That's what I'm hearing. She's old. My dad's dead, dead at 90. And she's a woman. Yeah, so obviously. They're fed up me being away from them, yeah, my sisters, are angry. My nephews are angry. They're all angry, everybody's angry, yeah...Yeah, it's not...I'm not guaranteed the next 20 years” (Leon, p.13)</i></p> <p><i>“A bit uh... pissed off really, I should be out before then. It's my son's birthday in October next year but...(sighs) it's a bit hit and miss really” (Josh, p.11)</i></p> <p><i>“Just held me back business wise, family.... Erm, my [INAUDIBLE] wouldn't say I was institutionalised, yeah, but it's going down that path.” (Michael., p.12)</i></p>
<p>A bittersweet experience</p>	<p><u>Being held or holding each other</u></p> <p><i>“I think it's the staff that got me out at first like. They'd be like, come on, come have a game of pool [REDACTED], come on, come on. And then eventually I would and then they'd be like okay tomorrow I want another game” (Tyler, p.11)</i></p> <p><i>“And the doctor went through my diagnosis as well for the first time, that was after about eight months, she sat down and she printed off some things on schizophrenia and some things on bipolar” (Chloe, p.16)</i></p> <p><i>“The staff, the the staff, the patients and the staff and the kindness of the staff, and the type of staff. The staff here are really good.” (Chloe, p.18)</i></p> <p><i>I have got choices... I've got choices, you know. So if I got like a tablet or whatever... I could, I could go to the doctor and say, well, this don't agree with me”...” they've always changed my medication. Yeah, they haven't said you've got to stay on that. They've always changed it.” (Leon, p.10)</i></p> <p><i>“My friends and family were like look, just stick with that, don't go on anything high or anything different even, just stick with it this and months down the line, you'll be alright. I thought, okay, I'll listen to it and I'm glad I did.” (Tyler, p.16)</i></p>

"it's only through, it's through the other patients that I managed to navigate my way" (Chloe, p.7)

"...members of staff, that weren't, weren't being very nice, I've learned to just cut, cut that. Keep myself to myself. Um, pointless, pointless trying to reason with them" (Michael, p.14)

"I hear patients, clients and they're feeling sick every day. They hear noises, they're on medication. The doctor won't take them off their medication, they feel sick on the medication. I've been on the medication, what they've been on, like Clozapine, yeah, and it made me sick. Yeah, and they're on it and it's making them sick. And when they're crying to the doctor, the Doctor's not listening." ... "I'm a support for the patients, yeah, I'm supporting them. Yeah, that's me" (Leon, pp.17-18)

"It is awful... I feel erm, almost like a duty of care to the other patients" (Michael, p.8)

Therapy as intrusive or insufficient?

"My psychologist, she like, brings, like, piece pieces of information. Like, she'll say keep this, I take it, I read stuff with them, you know, like, I tell her my experiences, and it does help here." (Sammy, p.14)

" She [Psychologist] keeps telling me I'm not a bad person and it wasn't my fault which makes me feel a bit grateful... that they understand me, that they understand."... "It's been a long time, the longest for me since it all started, that I've been voice free , ... so I'm grateful, it's been good. But I do think um... I do think I've um been here for too long, longer than I've meant to be here. My psychologist just goes through every little thing about my life... and stuff like that (laughs)" (Josh, p.10)

"And like even in myself, I feel better than mentally, physically... and I haven't felt this good for a long, long, long time. And I'm thinking if I didn't come here, and I just stayed in prison, there's no chance that I would be like this." (Tyler, p.21)

"It's helpful to listen to what kind of questions are coming from the person, but most of it doesn't fit me." (Leon, p.11)

"I've actually done psychology before. Yeah, I've done. I've done a few, I've done drama therapy. Yeah, you know, I've had a lot of people visiting me come up in the hospital. I've been doing... I've done it for over six years, so I've had it, I think... Yeah, yeah I've done a lot." (Leon, p.11)

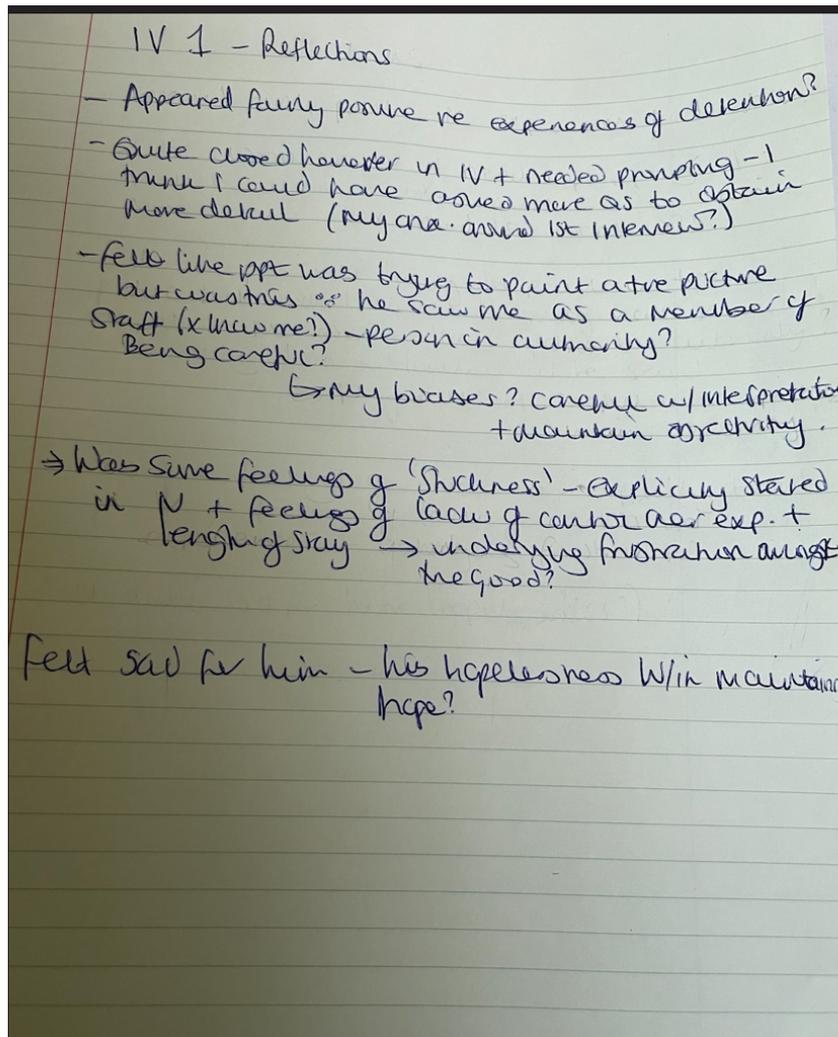
"I don't find that the hospital services to be very therapeutic. Like there's no counselling, there's like no support for domestic abuse for women. There's no... just little things of therapeutic services such as those. You would think that you would have them in the mental health service... you think that that cover all types of mental like things, like traumas that would affect your mental health. There's like, there's not a

	<i>lot of close liaison or workings like even like homeless shelters” (Chloe, p.13)</i>
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Appendix S: Changes to theme titles post-viva

Pre-viva theme titles	Post-viva theme titles
<p>1. Our voices don't matter 1.1. Untimely help led me here 1.2. An object of care versus feeling cared for</p>	<p>1. Our voices don't matter 1.1. Untimely help 1.2. An object of care</p>
<p>2. Disproportionate use of force and power</p>	<p>2. Disproportionate use of force and power</p>
<p>3. Role of race/culture in treatment 3.1. Targeted because of race? 3.2. Clash of cultures</p>	<p>3. Racialised and culturally invalidated 3.1. Targeted because of race? 3.2. Clash of cultures</p>
<p>3. You're still keeping me back 4.1. Feeling stuck 4.2. Urgency for freedom</p>	<p>4. Feeling held back 4.1. Feeling stuck 4.2. Urgency for freedom</p>
<p>5. A bittersweet experience 5.1. Quality of relationships matter 5.2. 'Psychology' is not enough?</p>	<p>4. A bittersweet experience 5.1. Being held or holding each other 5.2. Therapy as intrusive or insufficient?</p>

Appendix T - Example of excerpts from reflexive diary



Discussion w/ Research Supervisor

Feeling overwhelmed w/ no. of GS + PETS + trying to find best fit of themes to represent PPTS voices.

Worried how much I've felt I've given back + how w/ identifying themes + subthemes to ensure I can do the best I can to represent our voices in best way I can, particularly w/ it being such an important + sensitive topic + not wanting to do an injustice to their experiences.

Didn't realise how non-linear process of id. themes was going to be (though expected to some extent) - also the difficulty in managing overlap b/w themes + can be hard to sep. completely.

Reflected on how power plays through as indication of PPTS exp. to varying degrees/levels (powerless/disempowered) → could discuss this w/ respect to each get vs One large theme! (This felt more containing!)

Also discussed trying to fit in the 'good' exp + to be mindful about objectivity - not wanting to misrepresent exp., but are they nec. 'good' in a system where we must be 'compliant' - power that plays a role?

Paper 3a: Executive Summary



“I’m just going to give up and let them do what they’ve got to do... My goal at the end of the day, is to get free and get back to life”:
Exploring the experiences of ethnic minority adults who have been compulsorily detained in secure settings

Krishna Chauhan
Word count: 2259

This executive summary is intended for participants who took part in the study, service-users, and services. This paper has been reviewed with a participant from the study for feedback.

Aims of the research

This research aimed to explore the experiences of ethnic minority adults who have been compulsorily detained under the Mental Health Act (1983; 2007). The term 'ethnic minority' included people who identified as being Black (African/Caribbean), Asian, Mixed, White-other groups, and migrant populations.

Why is this important?

- ❖ Ethnic minority groups are more likely to be compulsorily detained and readmitted to hospital for mental health difficulties compared to White-British adults in the UK. This has been a longstanding issue for a number of decades (Department of Health and Social Care, 2018).
- ❖ Black people are at the highest risk of being compulsorily detained. Recent figures showed that Black people were 3.5 times more likely to be compulsorily detained than White-British people (NHS Digital, 2024), and detention rates for Black people have been excessively higher than any other ethnic group for more than 30 years.
- ❖ Other ethnic minority groups also at higher risk of being compulsorily detained compared to White-British groups, includes Asian or Asian British, Mixed, or multiple ethnic groups, and migrant populations.
- ❖ Many initiatives and recommendations have been suggested to help reduce the rates of compulsory detention for ethnic minorities, but they have not proven to be very effective.
- ❖ Reasons suggested for disproportionate rates of compulsory detention amongst ethnic minority groups have included: higher rates of psychosis, police contact, delayed help-seeking, language barriers, lack of social support, drug use, and mental health stigma (Barnett et al., 2019).
- ❖ It has also been suggested that societal racism is related to increased detention rates (this is when ethnic minority groups are more likely to be treated unfairly by

systems, and denied equal opportunities for example, with employment, housing, and quality of education).

- ❖ Although limited, some studies exploring the experiences of Black people who have been compulsorily detained found that they did not get help when they asked for it, they did not feel involved in decision-making in their care, they were more likely to be given stronger medication which left them feeling like they were more dangerous, and they experienced racism and mistreatment in services (Mayers & Gordon, 2023; Solanki et al., 2023).
- ❖ There is still not enough research exploring the lived experiences of how ethnic minority groups feel about their detention, and even less about ethnic minority groups who are not Black. Hearing lived experiences might offer important insights into supporting equal treatment and care for ethnic minority groups.
- ❖ Service-user networks have highlighted that hearing lived experiences is important to help address the inequalities faced by ethnic minority groups and to help develop appropriate services (National Survivor User Network, 2018).

Who approved the research?

The research was approved by the University of Staffordshire Ethics Committee, the NHS Research and Ethics Committee and HRA Approval, and Trust Research Ethics Panels.

Who was invited to take part?

Anyone who:

- ❖ Was age 18+
- ❖ Self-identified as being from an ethnic minority background (including Black African, Black Caribbean, Asian, Mixed groups, White-other)
 - ❖ Had experienced compulsory detention under the Mental Health Act
 - ❖ Had capacity to consent
 - ❖ Was English-speaking

Who took part?

Below is a table of participants who took part in the study. Capacity to consent was approved by Responsible Clinicians.

Name	Gender	Age	Ethnicity
Josh	Male	38	Mixed White/Black Caribbean
Leon	Male	53	Black Caribbean
Sammy	Male	36	Asian Pakistani
Michael	Male	30	Mixed White/Black Caribbean
Tyler	Male	45	Black Caribbean
Chloe	Female	38	Black Caribbean

What was the process?

- ❖ Research posters were distributed to wards in different Trusts to advertise the research.
- ❖ Participants who wanted to take part contacted the researcher using the email provided on the poster or asked their ward psychologist to contact the researcher by email on their behalf.
- ❖ The researcher offered to talk to participants to give them more information about the study and answer any questions they had.
- ❖ Participants were given at least 24-hours to decide whether they wanted to take part.
- ❖ Participants who consented, took part in a face-to-face interview which lasted up to 1 hour. Interviews were audio-recorded using Microsoft Teams.
- ❖ The interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). This analysis helps the researcher to make sense of and interpret how participants make sense of their experiences.
- ❖ All participants were given anonymous names to maintain their confidentiality and anonymity.

What were the findings?

❖ 5 Group Experiential Themes and 8 subthemes were found:

1. Our voices don't matter

Untimely help

Participants spoke about how in the past, they had asked for help but this was ignored, they did not get the right support they needed, and that mental health stigma might have contributed to admission to hospital.

"My dad still says to me yet to that day, he goes if they had said something then, diagnosed you or realised it's something... my dad always says, he goes 'I could see it in you son' [...] he [Doctor] just didn't do nothing" (Sammy)

"I don't think that I needed to be detained. I think I needed somewhere to live; I was walking the streets homeless" (Chloe)

Participants spoke of there being *"no help"* in prisons for mental health and described that prison staff *"don't care"* (Tyler). Lack of support in prison led to deterioration in mental health and detention to hospital.

An object of care

Participants talked about how they felt they did not receive appropriate communication by professionals throughout their journeys, during admission and during detention. They described admission to hospital as a frightening and threatening experience.

"I'd just been dumped in hospital with nothing explained to me... from a prison... cuffed from a prison and then brought in a room full of people....Of the, of the team, which is really intimidating... and then I don't know who they are and they're all talking about me, and to me, about things that I don't know anything about, they're using terminology that I don't understand... I felt like a fish out of water, I just didn't know what, what they were talking about, so then I didn't want to listen yeah."

(Chloe)

Participants felt they had a lack of choice and involvement in their care and that decisions were made about them, leaving them feeling disempowered.

“I was like thinking decisions are being made like, about me [...] And I just, I just thought that this was like kind of like prison settings basically, so, ‘we can just do whatever we want with ya’, and that’s it” (Tyler)

2. Disproportionate use of force and power

Four participants spoke about how the use of excessive force, such as being injected with medication against their will, being restrained, or secluded was unnecessary.

They described feeling violated and dehumanised.

“I don’t want to fight with you and they’d say, ‘alright get on the floor’. Every day, they used to come every day whenever there was 5, 6, 7 of them at the door, I’d just lie down on the floor”...“I would have liked to have been supported to come out of seclusion by talking” (Sammy)

3. Racialised and culturally invalidated

Targeted because of race?

Participants spoke about how they felt mistreated and unfairly treated because of their race which brought about feelings of anger and injustice.

“Yeah... cos of my colour, my colour and my hair, yeah and that’s why they holding me back, yeah that’s what it is” (Leon)

Clash of cultures

Difference in cultures between participants and staff was described to bring about feelings of tension, even when participants and staff shared the same racial background. They felt dismissed or goaded by certain staff who were of a different cultural background to them, which led to participants disengaging from certain staff.

“I’ve always been told from growing up Caribbean and African people don’t get along. My experience is of growing up like, coming across African guys and that like,

we've just not got along. [...] So like there is one or two African staff that are alright. And like the rest, like, it's like they don't wanna interact. Like if you ask them, they're like 'ooh im busy, oh this'. So I don't like- [...], I don't even bother like, don't wanna waste my time." (Tyler)

4. Feeling held back

Feeling stuck

Participants spoke about how they felt stuck in the system and felt unable to make progress despite years of detention. Some participants felt no choice but to helplessly comply to what they felt was required of them from professionals in the hopes of getting closer to freedom.

"I just feel stuck in here now, it's time for me to go home now" (Josh)

"I'm just going to give up and let them do what they've got to do. But my goal at the end of the day, is to get free and get back to life" (Leon)

Urgency for freedom

Participants felt a sense of urgency to be discharged. Participants talked about a life missed out, a life that could be, and a desperation to make a life of their own and be around family to fulfil other responsibilities.

"Yeah cause, I'm the oldest one out of all the kids yeah, and my mom's getting old. So I'm thinking she desperately needs me, and my brothers and sisters need me, and a lot of people need me. And I'm thinking now I'm doing this for myself, and then I'm gonna do it for them as well" (Tyler).

A bittersweet experience

Being held or holding each other

Participants described that when they felt heard and involved in their care, and when staff meaningfully engaged with them, they felt more hopeful and empowered in a journey that felt disempowering. Support from other patients and family also helped

participants feel less isolated and brought about feelings of connection, safety, and comfort. Whilst meaningful examples show what helped patients feel more empowered and hopeful in an otherwise disempowering environment, they did not necessarily negate from their distressing experiences, therefore making the overall experience bittersweet.

*“it's only through, it's through the other patients that I managed to navigate my way”
(Chloe)*

“I think it's the staff that got me out at first like. They'd be like, come on, come have a game of pool, come on, come on. And then eventually I would and then they'd be like okay tomorrow I want another game” (Tyler)

When this was not present and participants had negative experiences, they spoke of needing to support one another:

“I feel erm, almost like a duty of care to the other patients” (Michael)

Therapy as intrusive or insufficient?

Participants spoke about how psychology generally could be helpful, but sometimes they did not understand why they had to continue when they felt better, which left them feeling confused.

“She [psychologist] keeps telling me I'm not a bad person and it wasn't my fault which makes me feel a bit grateful” ... “I do think I've um been here for too long, longer than I've meant to be here. My psychologist just goes through every little thing about my life” (Josh)

Some participants spoke about there not being the right type of therapy available in hospital or that it did not meet their needs wholly:

“there's no counselling, there's like no support for domestic abuse for women. There's no... just little things of therapeutic services” (Chloe)

What did the research show?

- ❖ Ethnic minority adults experience feelings of powerlessness throughout their journey: before admission, during admission, and throughout detention.
- ❖ A lack of communication and collaborative care led to feelings of lack of control, safety, and mistrust in professionals and the system as participants felt like an object of care rather than feeling cared for.
- ❖ Coercive treatment (restraint, medication, and seclusion) felt unnecessary, dehumanising and violating. Participants would have preferred communication.
- ❖ Feelings of powerlessness in hospital felt retraumatising, especially when participants had experienced forms of injustice or oppression (unjust treatment) before being detained in hospital.
- ❖ Because of this, some participants felt they had no choice but to comply with treatment because they felt helpless; or they became resistive, fearful, or disengaged. This suggests that a lack of respect, choice, autonomy, and therapeutic treatment might lead to participants disengaging with professionals, which can keep them feeling stuck in the system for longer.
- ❖ This research also showed that some participants experienced racial discrimination and felt they were treated unfairly or differently because of their race and/or culture.
- ❖ This was not only experienced by White staff, but also ethnic minority staff who were of a different racial or cultural background to participants (e.g., Caribbean participants felt treated differently by some African staff, and Asian participants felt treated differently by some Black staff). This suggests that cultural differences exist within and between ethnic groups which may result in differential treatment of ethnic minority patients.

What does this mean for practice?

- ❖ There is a need for joined-up working with systems such as prisons, community-based services, and working with communities to support mental health awareness and reduce stigma. This might help reduce crises which lead to compulsory detention.

- ❖ Current policies and recommendations (DHSC, 2018) should be embedded in services to support treatment and care of ethnic minority groups and bring about a better power balance, and services should prioritise meaningful co-production.
- ❖ Policies and interventions should include meaningful service-user involvement with people from racialised communities to inform appropriate service delivery.
- ❖ Whilst there are recommendations for greater workforce diversity and leadership representation of ethnic minority groups in key professions (DHSC, 2018), the current research suggests that representation alone is not enough. There needs to be a deeper level of engagement from services to consider how race, culture, and power shape care; for example, through staff training and reflective supervision to reflect on internalised biases. Anti-racist practices should be embedded in services and not only viewed as a specialist interest.

Strengths and Limitations

This research adds diverse ethnic minority voices to the limited literature exploring experiences of ethnic minority adults who have been compulsorily detained and includes groups who are considerably under-researched. A limitation includes possible gate-keeper bias as consent was 'gate-kept' by clinical teams and Responsible Clinicians. This raises important questions about access, autonomy and whose voices are heard in research.

What should future research do?

- ❖ Continue to explore lived experiences of ethnic minority groups who have been compulsorily detained.
- ❖ Explore ethnic minority groups' experiences leading up to detention which might provide further information about *why* disproportionate rates of detention exist.
- ❖ Explore staff perspectives to provide further context around staff-patient relationships and dynamics.

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Paper 3b: Executive Summary (Service-user shortened summary)



“I’m just going to give up and let them do what they’ve got to do... My goal at the end of the day, is to get free and get back to life”:
Exploring the experiences of ethnic minority adults who have been compulsorily detained in secure settings

Krishna Chauhan

This executive summary is a shortened version of the full executive summary intended for service-users.

Background

- ❖ Ethnic minority groups are more likely to be compulsorily detained and readmitted to hospital for mental health difficulties in the UK when compared to White-British adults. This has been a longstanding issue for a number of decades (Department of Health and Social Care, 2018). Despite lots of government attention and recommendations put in place to reduce this inequality, not much has changed and it is unclear why.
- ❖ It is important to hear-lived experiences of ethnic minority groups who have experienced compulsory detention to understand what might support more equal treatment and care.

AIM: This research aimed to explore the experiences of ethnic minority adults who have been compulsorily detained under the Mental Health Act (1983; 2007). The term 'ethnic minority' included people who identified as being Black (African/Caribbean), Asian, Mixed, White-other groups, and migrant populations.

Who took part?

Six participants consented to take part in the study and were interviewed about their experiences of compulsory detention. All participant names were anonymised to maintain confidentiality.

Name	Gender	Age	Ethnicity
Josh	Male	38	Mixed White/Black Caribbean
Leon	Male	53	Black Caribbean
Sammy	Male	36	Asian Pakistani
Michael	Male	30	Mixed White/Black Caribbean
Tyler	Male	45	Black Caribbean
Chloe	Female	38	Black Caribbean

Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). This analysis helps the researcher to make sense of and interpret how participants make sense of their experiences.

What were the findings?

5 group themes and 8 subthemes were found.

1. Our voices don't matter

Untimely help

Participants spoke about how in the past, they had asked for help but this was ignored, they did not get the right support they needed, and that mental health stigma might have contributed to admission to hospital.

"My dad still says to me yet to that day, he goes if they had said something then, diagnosed you or realised it's something... my dad always says, he goes 'I could see it in you son' [...] he [Doctor] just didn't do nothing" (Sammy)

"I don't think that I needed to be detained. I think I needed somewhere to live; I was walking the streets homeless" (Chloe)

Participants spoke of there being "*no help*" in prisons for mental health and described that prison staff "*don't care*" (Tyler). Lack of support in prison led to deterioration in mental health and detention to hospital.

An object of care

Participants talked about how they felt they did not receive appropriate communication by professionals throughout their journeys, during admission and during detention. They described admission to hospital as a frightening and threatening experience.

"I'd just been dumped in hospital with nothing explained to me... from a prison... cuffed from a prison and then brought in a room full of people.... I don't know who they are and they're all talking about me, and to me, about things that I don't know anything about, they're using terminology that I don't understand... I felt like a fish out of water, I just didn't know what, what they were talking about, so then I didn't want to listen yeah." (Chloe)

Participants felt they had a lack of choice and involvement in their care and that decisions were made about them, leaving them feeling disempowered.

"I was like thinking decisions are being made like, about me [...] And I just, I just thought that this was like kind of like prison settings basically, so, 'we can just do whatever we want with ya', and that's it" (Tyler)

2. Disproportionate use of force and power

Four participants spoke about how the use of excessive force, such as being injected with medication against their will, being restrained, or secluded was unnecessary. They described feeling violated and dehumanised.

“I don’t want to fight with you and they’d say, ‘alright get on the floor’. Every day, they used to come every day whenever there was 5, 6, 7 of them at the door, I’d just lie down on the floor”...“I would have liked to have been supported to come out of seclusion by talking”
(Sammy)

3. Racialised and culturally invalidated

Targeted because of race?

Participants spoke about how they felt mistreated and unfairly treated because of their race which brought about feelings of anger and injustice.

“Yeah... cos of my colour, my colour and my hair, yeah and that’s why they holding me back, yeah that’s what it is” (Leon)

Clash of cultures

Difference in cultures between participants and staff was described to bring about feelings of tension, even when participants and staff shared the same racial background. They felt dismissed or goaded by certain staff who were of a different cultural background to them, which led to participants disengaging from certain staff.

“I’ve always been told from growing up Caribbean and African people don’t get along. My experience is of growing up like, coming across African guys and that like, we’ve just not got along. [...] So like there is one or two African staff that are alright. And like the rest, like, it’s like they don’t wanna interact. Like if you ask them, they’re like ‘ooh im busy, oh this’. So I don’t like- [...], I don’t even bother like, don’t wanna waste my time.” (Tyler)

4. Feeling held back

Feeling stuck

Participants spoke about how they felt stuck in the system and felt unable to make progress despite years of detention. Some participants felt no choice but to helplessly comply to what they felt was required of them from professionals in the hopes of getting closer to freedom.

“I just feel stuck in here now, it’s time for me to go home now” (Josh)

“I’m just going to give up and let them do what they’ve got to do. But my goal at the end of the day, is to get free and get back to life” (Leon)

Urgency for freedom

Participants felt a sense of urgency to be discharged. Participants talked about a life missed out, a life that could be, and a desperation to make a life of their own and be around family to fulfil other responsibilities.

“Yeah cause, I’m the oldest one out of all the kids yeah, and my mom’s getting old. So I’m thinking she desperately needs me, and my brothers and sisters need me, and a lot of people need me. And I’m thinking now I’m doing this for myself, and then I’m gonna do it for them as well” (Tyler).

5. A bittersweet experience

Being held or holding each other

Participants described that when they felt heard and involved in their care, and when staff meaningfully engaged with them, they felt more hopeful and empowered. Support from other patients and family also helped participants feel less isolated and brought about feelings of connection, safety, and comfort. This did not always necessarily take away from distressing experiences of detention, therefore making the overall experience bittersweet.

“it’s only through, it’s through the other patients that I managed to navigate my way” (Chloe)

“I think it’s the staff that got me out at first like. They’d be like, come on, come have a game of pool, come on, come on. And then eventually I would and then they’d be like okay tomorrow I want another game” (Tyler)

When this was not present and participants had negative experiences, they spoke of needing to support one another:

“I feel erm, almost like a duty of care to the other patients” (Michael)

Therapy as intrusive or insufficient?

Participants spoke about how psychology in general could be helpful, but sometimes they did not understand why they had to continue when they felt better, which left them feeling confused.

“She [psychologist] keeps telling me I’m not a bad person and it wasn’t my fault which makes me feel a bit grateful” ... “I do think I’ve um been here for too long, longer than I’ve meant to be here. My psychologist just goes through every little thing about my life” (Josh)

Some participants spoke about there not being the right type of therapy available in hospital or that it did not meet their needs wholly:

“there’s no counselling, there’s like no support for domestic abuse for women. There’s no... just little things of therapeutic services” (Chloe)

Key messages

- ❖ Ethnic minority adults experience feelings of powerlessness throughout their journey: before admission, during admission, and throughout detention.
- ❖ Participants felt like an object of care rather than feeling cared for. This led to feelings of lack of control, safety, and mistrust in professionals and the system.
- ❖ Disproportionate use of force and power felt unnecessary, dehumanising, and violating. Participants would have preferred communication.
- ❖ Participants felt they had no choice to comply with treatment. They became resistant, fearful, or disengaged in response. This kept some participants feeling stuck in the system.
- ❖ Some participants experienced racial discrimination and felt treated differently or unfairly because of their race and/or culture. This was not only felt by White staff but also ethnic minority staff were of a different racial or cultural background to participants (e.g., Caribbean participants felt treated differently by some African staff, and Asian participants felt treated differently by some Black staff).

What does this mean for practice?

- ❖ There needs to be more joined-up working with prison systems, community-based services, and working with communities to reduce mental health stigma. This might help reduce crises which lead to compulsory detention.
- ❖ Policies and recommendations that already exist to support ethnic minority groups should be embedded into services.
- ❖ Ethnic minority service-users should be involved in policy making and recommendations to support meaningful change.
- ❖ Services needs to have a deeper level of engagement in considering how race, culture, and power shape care; for example, through staff training and reflective supervision to reflect on internalised biases and support equal treatment.

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