Experiences of adults from a Black Minority Ethnic (BME) background who have been detained as inpatients under the Mental Health Act (1983)

J. Solanki

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School of Health and Social Care
University of Essex

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Research Summary

Aims: To explore the experiences of adults from a Black Minority Ethnic (BME) background detained as inpatients under the Mental Health Act (1983; 2007).

Background: Significantly more people from a BME background are detained under the Mental Health Act (1983; 2007) than people from White ethnic backgrounds, and this has been consistent for decades. Research has largely focussed on exploring this quantitatively, through correlations between a number of variables. Contrastingly, qualitative research into the lived experiences of detention for BME people has been sparse.

Methodology: A critical realist research paradigm was used to qualitatively explore BME experiences of detention. This incorporated semi-structured interviews with a purposive sample of 12 self-identified BME participants, all of whom were currently detained as inpatients under the Mental Health Act (1983; 2007).

Results: An inductive thematic analysis was used to interpret four themes and fifteen sub-themes: ‘help is decided by others, not tailored to me’; ‘I am not a person; I am a Black patient’; ‘mistreated or neglected instead of cared for’; and ‘sectioning can be a space for sanctuary and support’.

Conclusion: BME people have a unique experience of detention that is racialised and racist, as well as shared experiences with others who have been detained. This reflects systemic, psychodynamic and cognitive theories of race and has implications for legislation, clinical practice and further research.

CHAPTER ONE: INTRODUCTION

Chapter Overview

This chapter provides a background to the present study, underpinned by relevant research and theoretical perspectives. Firstly, the Mental Health Act (1983; 2007) is outlined in its historical and contemporary context. Secondly, the relationship between ethnicity and inpatient detention is critically considered. Thirdly, the perspectives of minority ethnic people using mental health services are explored, including a systematic review to synthesise academic research therein. This conceptualises the rationale for the present study and thus proposes the research aim.

The Mental Health Act (1983; 2007). The Mental Health Act ("the Act", 1983; 2007[1]) is a piece of legislation that relates to the "reception, care and treatment of mentally disordered patients" (s.1.1) in England and Wales. Accompanying the legislation is a Code of Practice and a Reference Guide published by the Department of Health and Social Care (DHSC, 2015a; 2015b). The Act states that a person may be detained as an inpatient in hospital on the grounds of meeting three main criteria, although there are further variations. Firstly, a person must be "suffering from mental disorder of a nature or degree that warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment)" (s.2.2a). The Act defines mental disorder as "any disorder or disability of the mind" (s.1.2). In the context of the National Health Service (NHS), where the Act is mostly implemented[2], this is based on the World Health Organization's *Classification of Mental and Behavioural Disorders* (10th ed., ICD-10[3]; 2019) (NHS Digital, 2018). The ICD-10 states that disorder is not an exact term but implies "the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions" (WHO, 1992, p.5). Secondly, a person "ought to be so detained in the interests of their[4] own health or safety or with a view to the protection of other persons" (s.2.2b), although there is little explicit definition or criteria for this in the legislation or accompanying documents. Lastly, the Act states that detention is only lawful if

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[1] The legislation was established in 1983, but was amended in 2007. As a result, references to "the Act" will henceforth relate to the amended legislation, while the 1983 legislation will be referred to fully as the Mental Health Act (1983).

[2] It is acknowledged that the Act is also implemented in independently provided services, but these are considered to be broadly subject to the same processes and policies.

[3] The ICD-11 was published in 2018, but this had not yet been officially adopted by the NHS.

[4] The legislation uses "his".

“appropriate medical treatment is available” (s.3.2d). The Reference Guide highlights that this includes nursing, psychological intervention and rehabilitation as well as treatment through medication (s.1.17, DHSC, 2015b). The decision to detain is made on the recommendation of psychiatrists, though other professionals are also involved and a ‘nearest relative’ has recently been included (DHSC, 2015b, s.1). In addition, police officers have emergency powers under the Act to detain people needing “care or control” in public places (DHSC, 2015b, s.7.16). The implementation of the Act in England is regulated independently by the Care Quality Commission (CQC). In order to fully understand the Act, it is important to consider the history of detention (Ion and Beer, 2003).

Historical Context of Mental Health Detention. Legal detention has been recorded since Medieval England, where individual cases were reported of people being detained due to perceived madness and danger to themselves or others (Noble, 1981). Industrialisation led to a larger population of people and institutions were thus established for ‘pauper lunatics’ under the County Asylums Act (1808) (Nolan, 1993; Sheridan, 2016). Accounts of these asylums vary and include reports of curative care, such as medication and surgeries, as well as torturous abuses (Scull, 1980; Porter, 1991). Asylums were largely based on a biomedical theory of madness, with concerns about bowel movements and brain structures and treatments including physical restraint and tranquilisation (Maudsley, 1891; Tuke, 1976; Prior, 1991). Later institutions demonstrated a model of care that moved towards a ‘moral treatment’, incorporating leisure, religion and relationships (Tuke, 1813; Charland, 2007). Asylums and detention legislation became widespread across Europe and, later, extended across the globe through colonisation (Cohen et al., 2014). By the nineteenth century, asylums had become contentious in England, with parliament addressing public concerns of poor conditions and wrongful detention (Noble, 1981). Subsequent legislation, such as the Lunacy Act (1890) and the Mental Treatment Act (1930), began a process of restricting the size and number of institutions and focussed the power to detain onto medical professionals (Shorter, 2007; Takabayashi, 2017). This ‘deinstitutionalisation’ of mental health care continued across Western Europe throughout the twentieth century alongside increases in community care, advances in psychiatric medicine, concerns about costs and patient campaigns (Rogers and Pilgrim, 2001; Cohen et al., 2014). The twentieth century also saw the introduction of the first Mental Health Act (1959), which introduced the conditions of mental disorder, risk and treatment that are now described in the current legislation (Kenyon, 1968). Despite deinstitutionalisation, there has remained an argument for specialist inpatient beds on this basis, extended by the Mental Health Act (1983), which included further rights for patients (Johnson et al., 2001; Thornicroft and Tansella 2004; Edgley et al., 2006).

Mental health detention has historically been criticised by theories of social control, with asylums described as a convenient place to get rid of inconvenient people (Scull, 1980; 1993). Notably, Foucault (1965; 2004; 2006) suggested that mental disorders were socially constructed to present certain people as animalistic, violent or economically unproductive in order to detain them. Goffman (1961) described asylums as ‘total institutions’ which consume such people in a custodial rather than caring capacity. Psychiatry has similarly drawn historical criticism for advancing a biomedical theory of mental disorder as a basis for detention in order to advance professional and financial interests (Rothman, 1971; Guze, 1992; Takabayashi, 2017). Dissident psychiatrists Laing and Cooper suggest that such mental disorders were an inappropriate representation of familial, social and politically capitalist contexts (Laing and Esterson, 1964; Cooper, 1967; Carmichael, 2015). Further criticism comes from theories of the impact of institutions, which include experiences of isolation, mistreatment, loss of contact with the outside world, loss of opportunities and constant surveillance (Barton, 1959; Elmer, 2003). Barton (1959) describes the impact of this as a discrete disorder, ‘institutional neurosis’. Theories of social control have been criticised for being oversimplified and biased by hindsight, with critics suggesting that practices were humane in their historical context (Allderidge, 1979; Hilton, 2019). Moreover, biomedical theories have been defended as attempts to understand and treat mental disorders rather than ideological tools of control (Digby, 1985; Shorter, 2007). Porter and Wright (2003) recognise the contribution of Foucault and Scull in revealing the function of asylums as a means of social control, however, they also recognise that helpful and humane practices were observed in these institutions in addition to abuses.

Contemporary Context of the Act. The number of detentions has consistently increased since the Mental Health Act (1983) and the NHS reports a 2% increase for 2018 to 2019 (Keown et al., 2018; NHS Digital, 2019). Smith et al. (2020) further note a specific increase in detention since the Act’s introduction in 2007, using a prediction analysis which compared published detention rates from the periods before and after. Both Smith et al. (2020) and Keown et al. (2018) conclude that the reasons for the increase in detentions are unclear and refer to correlations rather than causations. It is broadly suggested that better identification of and response to mental illness, as well as socio-economic factors related to the recession and austerity policies, are possible explanations. Of particular concern is that the increase in detention rates has not seemed to corresponded with provisions for those detained under the Act. Keown et al. (2011) report a decrease in mental health beds despite the increase in detention from a regression analysis on published data. Moreover, independent analyses, an independent commission and a regulatory report all highlight a shortage of beds and poor-quality inpatient care (King's Fund, 2015; 2017; Crisp et al., 2016; CQC, 2020a). These decreases in resources may be additionally linked to the ability of staff to implement and maintain appropriate human rights practices (Kinderman and Butler, 2006).

The Act is contextualised by a conflict between the risk to society and the protection of an individual's rights under the European Convention on Human Rights (Glover-Thomas, 2011). The ECHR (1953) allows detention of persons "of unsound mind", but also outlines protection from inhumane treatment and respect for autonomy and family life. The United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD, 2006), adopted by the United Kingdom (UK) in 2009, further demands that persons with disabilities, including mental illness, are not discriminated against or deprived of their liberty unlawfully (Articles 1 and 14). The UN's Human Rights Council (2020) also suggested that involuntary psychiatric treatment, even when intended as a medical necessity, can constitute psychological torture. Although there can be an international focus on human rights abuses through detention in developing countries, the UN-CRPD (2017) highlights that there are nevertheless abuses in countries considered to be developed. Indeed, it directly recommended that the Act is repealed. However, these frameworks have wide definitions of what deprivation of liberty is, which are difficult to operationalise and can conflict with the government's own policy (Cairns et al., 2010). This is demonstrated by Fistein et al.'s (2016) thematic analysis of assessments under the Act, which identified themes describing difficulty with respect to decisions to detain and disagreement about how effective the Act was at safeguarding human rights. Dixon et al. (2019) reported a similar difficulty from a thematic analysis of semi-structured interviews with Approved Mental Health Practitioners. In its 2018/19 annual report, the CQC also highlighted that services found it difficult to navigate the Act and associated rights (CQC, 2020a).

Patient Perspectives. The Act is further contextualised by the "mentally disordered patients" (s.1.1) who are subject to it and an impetus for their inclusion in policy and practice. Although the Act refers to "mentally disordered patients" (s.1.1), the Code of Practice and Reference Guide acknowledge that different terms are used to refer to people subject to the legislation (DHSC, 2015a, p. 7; 2015b, s.1.22). Christmas and Sweeney (2016) summarised from three questionnaire studies that people in the UK prefer the term patient or client (Mcguire-Snieckus et al., 2003; Keaney et al., 2004; Simmons et al., 2010). The term patient is therefore used here to reflect these findings and the language used in the Act, although it is recognised that ‘service user’, ‘survivor’ and ‘experts by experience’ may be more appropriate and preferred in different contexts[5]. Patient involvement has been reflected generally in government legislation and policy, as well as professional guidelines (Baggot, 2005; Nursing and Midwifery Council, 2015; Royal College of Psychiatrists, 2014; British Psychological Society, 2017; NHS England, 2017). Specifically, the Code of Practice for the Act (DHSC, 2015a) included an ‘Expert Reference Group’ of nine service users with experiences of detention under the Act. The National Survivor User Network also exists as a network of 4,000 individuals with lived experience of mental distress and aims for a stronger voice in policy and services (NSUN, 2016). Despite the scope of the movement, there are concerns that this involvement can be tokenistic, professionally dominated and dismissive of service users’ credibility (Rush, 2004; Campbell, 2005; Rose and Lucas, 2007). Peck et al. (2002) reviewed interview data from service users and professionals in England and concluded that, although service user involvement had increased, service users had little control and their involvement was dependent on professionals. Moreover, patient involvement is often not defined and remains an ambiguous concept. Mockford et al. (2012) conducted a systematic review using narrative analysis of 28 studies of service user involvement in the UK from 1997 to 2009. The authors reported that few studies defined involvement or reported the activity that actually took place.

Nevertheless, there have been some accounts of people’s experiences of detention since the days of the asylums and these have largely advocated against detention (Caldicott et al., 1999; Crossley, 1999; Barnes and Bowl, 2001; Hilton, 2007). Recently, Akther et al. (2019) conducted a qualitative meta-synthesis review of 56 studies published since the Mental Health Act (1983), with 30 from the UK. The review concluded five themes relating to experiences of detention. Firstly, patients reported mostly poor experiences of not having access to information as well as experiences of coercion and restrictive practices. Secondly, patients discussed concerns with the quality of the environment, with comparisons to prison and references to a lack of stimulation and exposure to harassment. Thirdly, patients emphasised staff relationships, which were largely considered kind and respectful despite high demands, but also included neglectful, disrespectful and coercive experiences. Fourth,

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[5] Where such terms are used in the referenced literature, they are repeated here.

patients reflected on the impact of detention on their self-worth, which included feeling dehumanised by a lack of autonomy and the stigma of being detained. Finally, patients discussed the emotional impact of detention, which included positive emotions such as appreciation, but mostly negative emotions such as anger, confusion and fear. The scope of this review is a strength as well as a limitation; although it reflects a range of universal themes regarding detention, it also includes studies spanning multiple contexts that may not be comparable. Still, the findings reflect previous reviews which reported a similar mix of experiences (Katsakou and Priebe, 2006; 2007; Seed et al., 2016). Seed et al. (2016) published a theoretical framework to conceptualise experiences of detention, which included a key interaction between patients' perspectives and professional practices.

Independent Review of the Act. In response to concerns about the rates of detention, patient experiences and human rights, the UK government launched an independent review of the Act in 2017 (DHSC, 2017; 2018). This sought input from a wide variety of sources and included surveys, workshops and focus groups with service users, professionals and organisations. The review engaged with specific groups, such as service users and carers, and called for submissions of evidence on topics including predictors of detention. The final report concluded that detention powers should remain, though with a reformed commitment to rights through four principles. Firstly, service users should have choice and autonomy, facilitated by respect and dignity from professionals. Secondly, service users should experience the least restriction possible, with better and earlier alternatives to detention and documented involvement in their care. Thirdly, detention should have therapeutic benefit, which includes investment in physical environments that have so far been neglected or limited by risk-averse procedures. Finally, service users should be seen as individual people and not as diagnoses. The final report received criticism from NSUN, who argued that it predominantly focussed on a medical model, rather than human rights, and therefore fell short of UN-CRPD recommendations (NSUN, 2020). Other organisations welcomed the recommendations but highlighted the need for appropriate resources and commitment to fulfil them (Royal College of Psychiatrists, 2018; Mind, 2019). A crucial concern of the independent review was the "disproportionate number of people from black and minority ethnicities detained under the act" (DHSC, 2017). As the final report articulates, "one of the most troubling and difficult areas we have considered is the fact that those from ethnic minority communities are far more likely to be subject to compulsory powers under the Act" (DHSC, 2018, p.30).

Understanding Ethnic Minority. NHS publications regarding the Act refer to ethnic groups categorised according to the 2001 Census, which distinguishes ‘broad’ and ‘detailed’ groupings (Table 1)[6]. A ‘White’ ethnic group is defined as being the largest ethnic group in England and Wales and, thus, the remaining groups are ethnic minorities (Race Disparity Unit, 2020b). Government publications compare ethnic minority groups against the ‘White British’ group for context (Race Disparity Unit, 2020c). The government acknowledges that these groups are not fully representative, but provide no accompanying definition of ethnicity. The government’s standardised categories of race facilitate monitoring and scrutiny, but there is also a need to reflect ethnicity as a heterogenous construct which includes a person’s heritage, self-identification, sense of belonging and attitudes (Phinney, 1990; Bhopal, 2004; Burton et al. 2008). The definition of ethnicity is also contextualised by sociopolitical theory, which suggests that census classifications and concepts of majorities and minorities may represent Foucauldian ideas of social control (Goldberg, 1997; Jenkins, 2008). The power of perspectives from a White majority system in defining ethnicity is further argued to reflect a systematic problem (Mills, 2004; Garner 2007).

The definition of ethnicity is further complicated by its synonymous use with race, which relates to historical and prejudicial beliefs about people based on imagined genetic differences (Baumann, 1999; Jorde and Wooding, 2004; Fernando, 2010; 2017). Some argue that ethnicity is in fact a euphemistic conceptualisation of race, used to create distance between historical associations of racism (Jenkins, 2008). Racism is here defined as a multi-dimensional concept that has evolved throughout history, but which broadly reflects “a way of thinking that places superior white people in a position of power over racially inferior peoples of various other races” (Fernando, 2017, pp. 12). In this context, ethnic group classification represents a more palatable mechanism for power over others that was previously wielded by biological classifications of race in a context of colonialism and slavery (Hacking, 2009; Fernando, 2010). Nevertheless, Baldwin (1980) suggests that definitional racial groups exist and have importantly distinct worldviews. Burton et al. (2008) conclude that ethnicity in the UK must ultimately be represented by a number of measures and approaches for a comprehensive understanding. ‘Black and Minority Ethnic (BAME)’ is common to literature regarding ethnicity and is used by those detained under the Act, as well as professional bodies and service user organisations (Faulkner, 2014; British Psychological

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[6] The government’s Race Disparity Unit (2020a) actually recommends eighteen ethnic groups for reporting ethnicity, with some variations to the NHS categorisation.

Society, 2017; Griffiths, 2018; NSUN, 2018). This perhaps suggests it is a somewhat useful working definition, if only by virtue of its ubiquity. BAME broadly refers to all other groups than White British in the government categorisation.

Table 1. NHS Classification of Ethnicity

Broad Ethnic Groups	**Detailed Ethnic Groups**
Asian/Asian British	Indian Pakistani Bangladeshi Any other Asian background
Black/African/Caribbean/Black British	African Caribbean Any other Black/African/Caribbean background
Mixed/Multiple Ethnic groups	White and Black Caribbean White and Black African White and Asian Any other Mixed/Multiple Ethnic background
Other Ethnic Groups	Chinese Any other ethnic group
White	English/Welsh/Scottish/Northern Irish/British Irish Any other White background

BME Detention Under the Act. The independent review of the Act noted a long-established over-representation of BAME people being detained and this has been reported since the Mental Health Act (1959) (Ineichen 1986; DHSC, 2018). Specifically, people from the Black/African/Caribbean/Black British ethnic group outlined by the government (Table 1) are more likely to be detained (DHSC, 2018). This group will be described as ‘Black Minority Ethnic (BME)’ in the present research to differentiate from the wider BAME group. It is recognised that BME is not a comprehensive term, but it does provide a working definition for the focus of the present research. Contemporary NHS data reports that BME people were more than 4 times more likely to be detained than White people in 2017/18 and this has increased from previous years[7] (NHS Digital, 2019a; NHS Digital, 2019b). People in the 'Black other' group had the highest rates of detention, however it is suggested that this is an overestimate because this group is used to record unknown ethnicities, reflecting a limitation of this classification. Otherwise, the highest rates of detention by specific ethnic group were found in the 'Black Caribbean' group, followed by the 'Black African' group. The same data suggests that young BME men in particular have higher detention rates. The CQC emphasises these disproportionate rates of detention for BME people, stating that "there is little evidence that this situation is improving or that there is a system-wide commitment to effect change" (CQC, 2020a, p.5). Similar concern and criticism has come from NSUN (2018) and the UN-CRPD (2017). Government policies such as the Delivering Race Equality Programme and the Race Equality Action Plan have explicitly addressed ethnic differences in detention and aimed to reduce the number of detentions for BME groups, though this has not been achieved (Wilson, 2010). This is further compounded by limited data on appeals against detention. Nilforooshan (2009) analysed data from patient administration systems over a one-year period and reported that BME groups were less likely to appeal.

Singh et al. (2007) conducted a systematic review and meta-analysis of 19[8] studies with raw data comparing ethnic groups under detention of the Mental Health Act (1983). The review similarly concluded that people from a BME group were four times more likely to be detained compared to the White group, but this effect reduced if only high-quality studies were included. Bhui et al. (2003) also found that BME people were more likely to be detained from a systematic review using meta-analysis and narrative analysis. The independent review of the Act included an expanded systematic review and meta-analysis of 64[9] studies comparing ethnic groups and compulsory detention from 1984 to 2017 (Barnett et al., 2019). The authors reported that BME groups were more likely to be detained and these findings remained when only high-quality studies were included. The authors also reported additional variables for detention including those who were migrants, Black Caribbean or female. In addition, the review concluded that studies in the UK had higher rates of BME detention, suggesting an important local context. All of these reviews reported considerable heterogeneity between participants and how ethnicity was categorised, arguing a need to reflect the diversity of ethnic groups beyond broad categories. Barnett et al. (2019)

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[7] The data showed that, 306.8 BME people out of 100,000 were detained in 2017/18, compared to 72.9 people in the White group.

[8] 49 studies were included in the review, but only 19 included data appropriate for meta-analysis.

[9] 71 studies were included in the review, but only 64 included data appropriate for meta-analysis.

demonstrated this by finding that Black Caribbean people were more likely than other BME groups to be re-detained. The reviews also found that the significance of the relationship between ethnicity and detention decreased with more recent publications, which is explained in terms of more rigour in contemporary research rather than a decrease in detention for BAME people. Taken together, these organisational and research findings appear to agree that there are higher rates of detention in BME groups.

The independent review states that the reason for higher rates of detention in BME groups is “multifactorial, involving longstanding experiences of discrimination and deprivation, with a lack of understanding of the human dynamics of what is happening and some crucial gaps in trust between service users and providers” (DHSC, 2018, p. 20). This reflects a conflict around the extent to which racism plays a part (Singh and Burns, 2006; McKenzie and Bhui, 2007). In both Singh et al.’s (2007) and Barnett et al.’s (2019) reviews, the authors specifically extracted explanations for ethnic differences in detention rates and the evidence for them. Singh et al. (2007) concluded that only assumptions emerged, rather than conclusions based on the evidence in the studies. Barnett et al. (2019) similarly sought to extract explanations that were evidenced by primary data and found that almost half of the studies either had no explanation or had explanations that were not evidenced by primary data. Explanations with no supporting primary evidence included higher rates of comorbid drug use in BAME groups, poorer detection and diagnosis of mental illness, greater stigma in BAME groups and cultural incompetence of services. The authors highlighted the danger of making such conclusions about explanatory factors without evidence, especially for a such a heterogenous group. The authors concluded five main explanations supported by evidence: increased prevalence of psychosis, ethnic disadvantages and societal racism, increased perceived risk of violence, increased police contact and absence of or mistrust of general practitioners (GPs). These explanations were conclusions based on correlations from the data in each study. All but the latter overlap with the explanations found for the overall increased rates of detention (Walker et al., 2019). This suggests that patient experiences of mental health services are uniquely significant for BME rates of detention.

Cognitive Theory. Disparities between groups of people may be conceived as a result of the way such groups are conceptualised cognitively. The classification of ethnicity itself has been theorised as a function of cognitive structures, or schemas, which represent sets of ideas about people (Brubaker et al., 2004). Conceptualisations of race, including biases and prejudices, have similarly been described as social cognitions (Hamilton, 1981; Hamilton and

Trolier, 1986). These have been considered as inherent cognitive structures which help individuals navigate a complicated world (Wellman, 2007). Tajfel (1969; 1981) theorised that there are cognitive aspects to prejudice which involve the prejudgement of others based on their membership to a group. He argued that categorising others into groups is cognitively efficient but, problematically, also allows for distortions of reality. Tajfel outlined that these categorisations are not developed by the individual per se, but are rather assimilations of what is available from the wider culture. He further explained that individuals will endorse categorisations that protect their self-image and align with wider world views. These cognitive aspects are therefore underpinned by both a desire to understand others as well as a desire to protect oneself (Billig, 2002). The conceptualisations of BME people in wider culture can be pernicious and lead to individuals internalising negative views of BME people (Hooks, 1992). Hooks (1992) described contemporary conceptualisations of BME people as sexualised and violent and explains how these conceptualisations are also internalised by BME people themselves. Such perceptions of BME groups have been described as historically prejudiced due to a chronic emphasis on hierarchies between ethnic groups, based on categorisations such as sexual restraint and aggressive tendencies (Rushton, 1988; Banks et al., 1983; Fernando, 2017). From this perspective, it is suggested that higher rates of detention for BME groups may reflect prejudiced cognitive structures about them. These may over-identify BME individuals with wider schemas or social cognitions about BME groups.

Psychoanalytic Theory. Conceptualisations of BME people are also central to psychoanalytic theory about BME experiences and specifically acknowledge the consequences of racism and racialisation. In a seminal psychoanalytic theory, Fanon (2008) contextualised the BME experience through the history of colonisation. He outlined how BME people are conceptualised as ‘phobogenic’ objects, meaning that they induce fear in White people and are responded to as such (Hook, 2004). Fanon built on Klein’s (1946) concept of projective identification and argued that BME people are subjected to projections by White people who identify them with inferiority, aggression, sexualisation and animalism. Klein (1946) also discussed a ‘paranoid-schizoid’ position, which broadly involves splitting objects into good or bad, with little integration. In Fanon’s (2008) theory, a paranoid-schizoid position is therefore maintained by a White majority, where integration of the BME person’s humanity is defended against and, instead, demonisation and dominance over BME people is pursued (Clarke, 1999; 2000). Fanon theorised that BME people are thus alienated as Black in a context that aspires to and enforces White supremacy. This has also been described in psychology as postcolonialism theory, which argues that this historical context, and especially the power relations involved, must be appropriately acknowledged (Loomba, 2015). Psychoanalytic theory therefore suggests that higher rates of BME detention may be the product of a drive to dominate BME people as a result of projected fears about them. Davids (2011) further described how these projections can happen imperceptibly, but, when they are realised, are then responded to with efforts to cover them up. This results in the perpetual defence against acknowledging racialisation and conceptualising BME people as human. Lowe (2008) summarised this psychoanalytic theory by suggesting that colonialism has left an enduring association of Black as bad and White as good in the contemporary conscious and unconscious. Within these theories, it is suggested that these psychoanalytic objects and projections exist in all people, both within the individual and the collective. Psychoanalytic theory may therefore reflect how explanations which implicate racism and racialisation are denied or dismissed, despite longstanding and widespread ethnic disparities (Cohen, 1993; 2002).

Systemic Theory. Theories of ethnic disparities are further theorised with specific reference to systems and structures across history and society. Laing and Cooper's (Laing and Esterson, 1964; Cooper, 1967) aforementioned theories of mental disorder describe the impact of wider social, political and familial systems. These are extended by an understanding of ethnicity in such systems (Krause, 2010; 2012). Systemic theories broadly argue that Western society and civilisation have been built and maintained through the systemic exploitation of BME people, including through institutionalisation in mental health services (Carmichael et al., 2003; DuBois, 2007). It is argued that BME people face ongoing structural oppression across all societal systems that have historically been intended to racialise and marginalise them (Feagin, 2004). Boyd-Franklin (Boyd-Franklin, 1989; Hines and Boyd-Franklin, 2005) presents a specific systemic theory which describes how BME people are disadvantaged and distressed by historical and contemporary discrimination against them through multiple systems including health, class and criminal justice. She theorises that this systemic oppression constitutes a trauma for BME people and therefore implicates these systems in understanding disorders (Boyd-Franklin and Shenouda, 1990; Franklin et al., 2006). Systemic theories may therefore explain higher rates of detention for BME groups as the result of structural ethnic inequalities causing psychological distress.

Systemic theories further argue that this distress is compounded by a neglect of BME perspectives in mental health systems. Boyd-Franklin (1989) outlines how systems of psychology and psychiatry have misdiagnosed BME differences as deficits and thus provided inappropriate responses, such as detention. This has also been conceptualised as systemic Whiteness, meaning that White perspectives are prioritised and dominate, in this case in areas such as clinical psychology (Garner 2007; Wood and Patel, 2017). This causes oppression and marginalisation for BME people by dismissing or denying BME perspectives on their own mental health. A 'Black/African Psychology' has been presented as an alternative to systemic Whiteness, representing the philosophy and psychology of BME groups from their own experiences (White, 1972; Nobles, 1980; Cokley and Garba, 2018). Black/African Psychology outlines a system of thought and action relying on Black/African principles of interconnectedness, collectivism and spirituality that are considered key to mental health (Parhman et al., 1999). These are distinguished from Western models, especially those that emphasise individual psychology. A similar theory has been proposed by Myers (2006; 2010) as 'Optimal Psychology' for people of African descent, compared to 'sub-optimal' Western approaches. Systemic theories may therefore add a further explanation for higher BME detention rates by explaining how BME people are marginalised by systemic Whiteness in the mental health systems available to care for them.

Psychosis Diagnosis. Barnett et al.'s (2019) review suggested that a diagnosis of psychosis was one evidenced explanation for higher rates of BME detention. The ICD-10 (WHO, 2019) outlines a block of schizophrenia disorders, which are described as "fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted" (F20-F29). These include acute and transient psychotic disorders, which are further described as "a heterogeneous group of disorders characterised by the acute onset of psychotic symptoms such as delusions, hallucinations, and perceptual disturbances, and by the severe disruption of ordinary behaviour" (F23). In a systematic review and meta-analysis of 28 studies, Halvorsud et al. (2019) reported higher rates of schizophrenia and psychotic disorders for BME groups in England, which reflects the findings of a similar systematic review and meta-analysis of 83 studies in England (Kirkbride et al., 2012). Both reviews reported correlations rather than causations and considerable heterogeneity between studies, but the findings remained when adjustments were made for quality. Gajwani et al., (2016) conducted a prospective analysis of detentions in one NHS trust and concluded that higher rates of BME detention were attributable to higher rates of psychosis diagnosis, rather than ethnicity per se. This warrants further understanding of why more BME people are diagnosed as such.

Some have theorised that schizophrenia and psychosis are racialised diagnoses, particularly due to their prominent use with BME groups during times of racial tensions (Metzl, 2010; Fernando, 2017). Foucault argued that such racialisation is another form of social control over ethnic groups (Foucault, 1983; Su Rasmussen, 2011). Fernando (2017) particularly highlighted how schizophrenia in BME groups is explained without much evidence, reflecting conclusions from Singh et al. (2007) and Barnett et al.'s (2019) reviews about BME detention rates. In particular, research has focussed on increasingly sophisticated biomedical theories with inconclusive results (Steen et al., 2006; Rietkirk et al., 2008; Pickard, 2011; Rogers and Pilgrim, 2014). Fernando (2017) argues that such persistent research into minute biomarkers reflects an attachment to Western biomedical theories to the exclusion of others. Boyd-Franklin and Shenouda (1990) instead present a systemic theory of schizophrenia in BME people that highlights historical and contemporary factors including class, racism and religion. This was supported by a content analysis of explanations for schizophrenia, which reported that BME people in England were more likely to have supernatural or social explanations than biological ones (McCabe and Priebe, 2004). Codjoe et al. (2013) found similar conceptualisations. However, these samples may not be representative and the authors acknowledge that these explanations were fluid and overlapping. Nevertheless, both studies suggested that BME perspectives of schizophrenia and psychosis may differ from biomedical Western approaches. This is exemplified by guidelines for psychosis and schizophrenia from the National Institute for Health and Care Excellence (NICE, 2014), which recommend contextualising these diagnoses with ethnic perspectives. Sharpley et al. (2001) ultimately conclude that a variety of hypotheses may explain the increased rates of diagnosis for BME groups in England. These include social disadvantage and racism, which is also one of Barnett et al.'s (2019) evidenced explanations for higher rates of BME detention.

Ethnic Disadvantage and Societal Racism. The independent review of the Act explicitly refers to "longstanding experiences of discrimination and deprivation" associated with detention, adding that there is "no doubt that structural factors which engender racism, stigma and stereotyping increase the risk of differential experiences in ethnic minority communities" (DHSC, 2018, p. 20). Government data reveals widespread disparities for BME people across education, employment, housing, health, community and criminal justice (Cabinet Office, 2018). These disparities directly overlap with the independent review's findings of factors associated with overall higher rates of detention (Walker et al., 2019). The statutory Equality and Human Rights Commission reports similar concerns, despite numerous government policies and legislation (EHRC, 2016). In addition, Pierce (1970) describes subtle acts of cumulative ‘microaggressions’ against BME people, which are not represented in published data. Nevertheless, it is argued that the disparities in what the government does publish reflect institutional racism (Sashidharan, 2001; Fernando, 2008; 2017). Institutional racism is here defined by the Stephen Lawrence Inquiry (Macpherson, 1999), which described the collective failure of an organisation to provide appropriate services to people because of their ethnicity. It involves attitudes and behaviours that disadvantage minority ethnic groups through prejudice, discrimination and racist stereotyping. Institutional racism and systemic ethnic inequalities in England have been especially highlighted in publications regarding the Windrush Scandal, the fire at Grenfell Tower and COVID-19 (Horton, 2017; Home Office, 2020; Platt and Warwick, 2020). This is in addition to government data documenting a recent rise in crimes against a person based on their race (Home Office, 2019). Outside of government, the Runnymede Trust, an independent thinktank, conducted semi-structured interviews with BAME groups who described widespread experiences of racism or ethnic disadvantage from societal institutions (Mompelat, 2019). The organisation highlighted how systemic racism has endured despite numerous intentions and initiatives (Lingayah et al., 2018).

The impact of racism is also associated with a diagnosis of psychosis, perhaps revealing a link between the two as explanations of higher BME detention rates. Karlsen et al. (2005) conducted a cross-sectional multivariate analysis of experiences of racism and mental health outcomes for 3,446 participants from ethnic minority groups in England. They reported a correlation between experiences of racism and psychosis in a nationally representative sample. The measures were not rigorous and experiences of racism were limited to the past year, but a similar link was found in a longitudinal survey of 4,000 BAME households (Wallace et al., 2019). This link may be explained by psychoanalytic theories of conflicts between Black and White objects, which leads to psychopathology (Fanon, 2008; Lowe, 2008). Conflicted parts of the self are described in some psychoanalytic theories as a feature of schizophrenia and some research findings have shown racial themes in hallucinations and delusions of BME people (Bion, 1954; Whaley and Hall, 2009). DuBois (2007) describes a similar theory of ‘double-consciousness’ which refers to “two warring ideals in one dark body” (p.8). Systemic theory also highlights how the historical context of BME people represents a trauma (Helms et al. 2012; Franklin et al., 2016; Sweeney et al. 2016). Some therefore advocate for explicit and specific diagnoses such as ‘race-based traumatic stress injury' that can incorporate the multiple and sophisticated ways that racism and disadvantage can affect BME groups (Carter, 2007). Conversely, a cognitive behavioural approach suggests that formulations of mental illness can be culturally adapted to include disadvantage and racism as component factors, particularly with respect to psychosis (Garety et al., 2001; Rathod et al., 2015). Overall, disadvantage and racism may be associated with mental health in multiple ways and are therefore explicitly discussed in professional guidelines (Bhui, 2002; British Psychological Society, 2017; Royal College of Psychiatrists, 2018). This suggests a possible framework of racism associated with mental disorders in BME people, thus resulting in higher rates of detention.

Risk and Police Involvement. Barnett et al. (2019) suggested that another explanation for rates of BME detention relates to perceptions of violent risk and police involvement. The independent review of the Act acknowledged significant police involvement with detention, which was also found to be more likely for BME people according to previous government reports (Independent Commission on Mental Health and Policing Report, 2013; Home Affairs Committee, 2015). The explanations given in these reports are rooted in a perception of BME people as violent risks, which results in the disproportionate use of force. The Sainsbury Centre for Mental Health (2002) found similarly prejudiced perceptions and practices from semi-structured interviews with service users and professionals. This is exemplified by independent inquiries and commissions which report institutional racism with respect to restraint and seclusion (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003; Crisp et al., 2016). Such practices may be especially harmful if experienced as re-traumatisation (Wynn, 2004; Sweeney et al. 2016). These findings represent a systemic need to address disparities in risk management practices and police involvement for BME people subject to detention (Cummins, 2015). The government has published guidance about risk-management under the Act, which includes a requirement for appropriate risk assessments and an avoidance of blanket bans on liberties such as the use of mobile phones and chargers, access to the outside world and participation in preferred activities (DH, 2014; DHSC, 2015a, s.8.5.) However, these documents do not define what risk is or outline explicit criteria for assessment (Glover-Thomas, 2011). Instead, general guidelines, not specific to detention, are provided by the government and professional bodies for the discretionary use of practitioners (Royal College of Psychiatrists, 2006; British Psychological Society, 2006; DH, 2009).

Undrill (2007) describes how this results in a core problem with risk assessments because organisations, individuals and patients do not share a standardised approach to risk. Fazel et al. (2012) demonstrate this difficulty in a systematic review and meta-analysis of risk assessment tools used across 24,847 patients. This concluded that the use of such risk assessments to determine detention could not be supported. In a narrative review, Spector (2001) tentatively reports degrees of racial bias in assessing violent risk for BME groups. Wright et al. (2002) similarly conducted a narrative review of research regarding ethnicity and dangerousness and found that BME groups were more likely to be reported as violent, though diagnosis was a confounding variable. Neither authors outlined their review methodology, so these conclusions are taken as descriptions rather than analyses. There does appear to be some association between risk and a diagnosis of psychosis for BME groups, perhaps reflecting why both are evidenced explanations for rates of BME detention in Barnett et al.'s (2019) review. Ghali et al. (2013) found that more BME people were subject to police involvement in mental health care for psychosis from a naturalistic cohort study of 1,024 individuals. Bhui et al. (2015) found a similar association in a two-year population-based survey of 481 patients experiencing a psychotic disorder. Both studies reported the limitations of incomplete and heterogenous data. Psychoanalytic theory suggests that risk is a projection of individual and societal fears onto mental health patients, who become objects of risks that require distance and control (Hilgartner, 1992; Yakeley, 2007; Felton, 2018). This builds on Foucault's theory, where risk is used to justify social control through restrictions on autonomy (Rose, 1999; Morgan and Felton, 2013). It also reflects Fanon's (2008) theory of BME groups being conceptualised as aggressive and threatening objects that require domination. Importantly, psychoanalytic theories explain how these racialised objects become internalised by BME people themselves (Hooks, 1992; Lowe, 2008). Indeed, some research suggests that BME family members instigated police involvement rather than engaging with mental health services when a family member experienced psychosis (Morgan et al., 2005a; 2005b). From these perspectives, it is suggested that higher rates of BME detention may be the result of perceptions of BME people as being more violent and requiring police involvement.

BME Engagement with GPs and Mental Health Services. Barnett et al. (2019) reported that engagement with GP services is another evidenced explanation for higher rates of BME detention. The independent review of the Act acknowledges that BME people are less likely to engage with GPs and talking therapy services. Cooper et al. (2013) analysed data from 23,917 participants of the National Psychiatric Morbidity Survey from 1993, 2000 and 2007 and found that BME groups were less likely to have contacted their GP regarding mental health in the past year. However, the study was limited by a low number of BME participants in a national sample, which affected power and the ability to control for confounding variables. Nevertheless, similar findings have been observed in government data from a national psychological therapies service and a local sample in secondary care (Baker, 2018; Mercer et al., 2018). The Race Equality Foundation (REF), an independent charitable organisation, published a literature review that outlined contemporary racial disparities across mental health services for BAME people, starting with access to GPs and including psychological therapies, detention under the Act and recovery (Bignall et al., 2019). Although a methodology for the review is not presented, the authors report that systemic racism and racialisation has led to mistrust and disparities in BME groups accessing mental health services.

Mistrust of services may be the result of BME people experiencing unequal treatment. A national survey of 13,787 participants reported that BME people were less likely to be receiving psychological treatments and more likely to be receiving medication (Sizmur and McCulloch, 2016). Das-Munshi et al. (2018) reported similar findings for schizophrenia disorders from survey data for 10,512 participants of the National Audit of Schizophrenia. Additionally, the government reports that BME people who do access its national therapy programme are less likely to improve and recover (Baker, 2018). These findings may be an under-representation, as the CQC (2020b) reports from a survey of 2,002 participants that BAME people are less likely to raise concerns about their care. The REF suggests that another factor affecting BAME use of mental health services is a lack of adapted provisions, despite national recommendations therein (NICE, 2014; Singh et al., 2015; Bignall et al., 2019). This is described as psychological and cultural accessibility and refers to the extent to which services accommodate BAME perspectives, expectations and needs without discrimination (Minas et al., 1996; Minas, 2007). A systemic theory of dominant Whiteness may explain this by highlighting a lack of Black/African Psychology in mental health systems. This extends to BAME representation in the workforce, as BME professionals are under-represented in NHS mental health services, including in clinical psychology and psychiatry (British Psychological Society, 2020; NHS England, 2020). However, there is limited research on the extent to which ethnic matching impacts on service use (Fernando, 2005; 2017; Karlsson, 2005; Cabral et al., 2011).

The REF also reports that stigma is an important factor affecting BAME disparities in use of services. Link et al. (2004) collated theories of stigma and subsequently describe a framework of components including: creation of labels, stereotyping of undesirable characteristics, separation of one group from another, emotional experiences of anger, shame and fear, loss of status, experience of discrimination and, finally, social, economic and political disempowerment (Goffman, 1963; Jones et al., 1984; Link and Phelan, 2001). Codjoe et al. (2019) suggest that, although stigma is described generally by people experiencing mental health difficulties, BME people face specific stigma as a result of faith-based beliefs about mental disorder. The REF describes stigma and service use specifically in Black African groups and refers to a study involving 26 interviews in faith-based communities (Mantovani et al., 2017). The authors reported that service use was mediated by stigmatic beliefs that mental illness represented a curse or moral failing and was associated with a risk of violence. Similar beliefs and avoidance were described in small sample studies with Black African service users and BAME women and (Kalathil, 2011; Tuffour, 2020). Leavey et al., (2016) theorised that when mental illness is thus perceived as a failing or a punishment, people are unlikely to seek medical help. Together, these findings suggest a number of factors which mediate BME experiences of mental health services.

Summary and Conclusions. Barnett et al.'s (2019) evidenced explanations of BME rates of detention appear to be interrelated. All but one overlap with the independent review's separate findings of factors associated with general rates of detention, not specific to BME groups (Walker et al., 2019). Engagement with services therefore appears to be more specific to BME groups. Overall, there has been a paucity of robust research involving BME experiences of mental health services (Raleigh et al., 2007). Moreover, research that does exist largely focusses on a wider BAME group. This difficulty is compounded by a view from services and policy makers that BAME people are 'hard to reach' (Begum, 2006; Kalathil, 2013). BAME patients have also been historically neglected by wider service user movements (Wallcraft et al., 2003). Nevertheless, some research has been conducted and this suggests a complex interplay between diagnosis, racism, risk and engagement. Keating and Robertson (2004) conducted interviews and focus groups with professionals, service users and carers. The authors described a vicious cycle of fear where BME people avoided engaging with mental health services due to experiences or fears of stigma, racism and control. Mental health services in turn feared BME people due to perceptions of dangerousness and also feared criticism of their interventions. As a result, BME people delayed seeking help from mental health services until they were in crisis and professionals were defended against acknowledging their limitations with BME groups. More recently, Schofield et al. (2019) conducted focus groups with people diagnosed with psychosis in London. They reported that disadvantage, inequality in experiences of services, a lack of community support and stigma were all described as explanations for higher rates of a psychosis diagnosis. King (2007) provides a survivor's account that refers to Foucault and Fanon and similarly incorporates the multiple contexts previously outlined, including racism, disadvantage and relationships with services and professionals. These accounts reflect all of Barnett et al.'s (2019) evidenced explanations for higher rates of BME detention.

With respect to the Act specifically, the independent review included a framework analysis of 45 stakeholders, including professionals, carers and BME patients. Though not published as a peer-reviewed study, the authors summarised that all stakeholders suggested that the Act was used differentially for service users from BME groups compared to White groups. Racism, police involvement, restrictive practice, limited access to therapy, workforce diversity, cultural competency and a lack of compliance with human rights were all reported as associated factors and described as an extension of BME experiences in general life. This may be considered from a number of theoretical perspectives, including Fanon's (2008) psychanalytic objects and projections and Tajfel's (1969) cognitive aspects of prejudice. They particularly demonstrate that a multitude of systems are involved, which reflects Boyd-Franklin's argument for a wider systemic understanding that can incorporate these (Boyd Franklin, 1989; Boyd-Franklin and Shenouda, 1990). The systematic reviews into experiences of detention by Katsakou and Priebe (2006), Seed et al. (2016) and Akther et al. (2019) do not robustly incorporate ethnicity as a factor of their research. The framework analysis included in the independent review also merges patient experiences with the perspectives of other stakeholders. Although the independent review includes a BME working group, further focus on patient experiences is needed with explicit reference to ethnicity. However, the body of research for BME experiences is somewhat limited. Instead, there are contemporary studies which explore BAME experiences overall. BME participants are included in such studies, so they may still provide a helpful foundation to build understanding.

Systematic Review

Experiences of mental health services by adult service users from a Black and Minority Ethnic (BAME) background in England and Wales

Overview

Research into the experiences of BAME people with mental health services has not yet been systematically reviewed. The aim of this review is therefore to synthesise studies which explore these experiences of adults from a BAME background with mental health services in England and Wales.

Design

The review used a qualitative design to explore BAME experiences. This was considered appropriate to the aim of the study because qualitative research is associated with exploring more descriptive data (Denzin and Lincoln, 2011; Creswell and Poth, 2018). The review followed PRISMA guidelines to ensure methodological rigour (Moher et al., 2009).

Methods

Search Terms. The SPICE framework (Booth, 2006) was used to create search terms by establishing, where possible, the setting, perspective, intervention, comparison and evaluation. In order to incorporate all literature that could relate to the research question, search terms were clustered and truncated using the Boolean operators of "OR" and "+" (Appendix A). No limiters or comparison terms were deemed necessary.

Search Strategy. Searches were carried out in March 2020 using EBSCOHost (including PsycINFO, MEDLINE, PsycARTICLES and CINAHL Complete) and Web of Science Core Collection. The separate groups of terms were searched individually, before being combined using the 'AND' Boolean operator (Appendix B).

Screening and Selection. Screening and selection was conducted in a stepped process according to PRISMA guidelines (Appendix C). Results were initially filtered by excluding: studies that were published before 2007 to be contemporaneous with the Act; articles that were not published in peer-reviewed journals; articles that were not in English; and articles that were duplicates. This was done using filtering tools within the databases and EndNote Online. Filtering then continued in stages, beginning with screening by titles, then abstracts and, finally, full-text. Once this screening process had been completed, the references of the finalised articles were then hand-searched for any additionally relevant literature (Armstrong et al., 2005).

The inclusion criteria for this screening process required that articles were primary research into the qualitative experiences of mental health services in England and Wales by adult service users from Black and Minority Ethnic (BAME) backgrounds. There were not enough studies to synthesise experiences solely for BME groups. Where research did not primarily or exclusively focus on these criteria, they were still included if appropriately distinguishable findings were part of the article.

The exclusion criteria for this screening process disregarded articles that were not primary research, such as editorials, unpublished theses or reviews. Articles within a setting other than adult mental health, such as child and adolescent or learning disability services, were also excluded due to the different medical and legal factors relating to these populations. Research that was quantitative was excluded as the focus of this research was on qualitative experience.

Quality Appraisal. Following completion of the screening and selection process, the quality of the 10 finalised articles was appraised with the Standard Quality Assessment Criteria for Qualitative Studies (Kmet, 2004). This assessment reviews the articles against 10 items which are scored between 0-2, depending on the extent to which the items have been satisfied. Finally, a composite score is calculated between 0-1 which serves as a measure of overall quality that can be compared against other articles. Quality appraisal of all articles was completed, not to exclude articles, but to aid in evaluating them (Daly et al., 2007).

Synthesis. The analysis of the findings from these articles was completed using Thomas and Harden’s (2008) method of thematic synthesis. This is an application of Thematic Analysis (Braun and Clark, 2006) for the purpose of systematically reviewing qualitative research. Thematic synthesis has three stages: line-by-line coding of data, developing descriptive themes and generating analytical themes. Analytical themes are distinguished from descriptive themes by the reviewer’s role in interpreting. Typically, descriptive themes are centred in the text of the articles, whereas analytical themes are developed beyond the articles by the reviewer, generating new overarching constructs. Any text in the articles that was reported as ‘Findings’ or ‘Results’ was defined as data that was eligible for synthesis. Where articles did not primarily or exclusively focus on the inclusion criteria, only text specifically relating to the research question and satisfying the inclusion criteria was used. All 10 articles were transcribed using Microsoft Word and synthesised using hand-written notes, beginning with a line-by-line analysis of the text to identify initial codes. This was done using an inductive approach. These were checked again with the text to ensure consistency and to begin developing descriptive themes. Relationships between codes were then considered in a process of composing codes into analytical themes. This in particular involved synthesising the reported findings, rather than attempting to re-analyse any raw data available from each article. Finally, the text of the articles was reviewed again to facilitate corroboration with the primary data and the subsequent interpreted themes.

Reflexivity. This synthesis is focused on researching the qualitative experiences of service users. It is being conducted by a Trainee Clinical Psychologist with experiences of both providing and receiving mental health services. It is possible that these experiences may inform the way that the data is analysed and it should therefore be interpreted critically in respect of this. Furthermore, the review has not been conducted in collaboration with service users, but is rather a synthesis of research with service users as participants.

Results

Search Results. In total, 590 results were generated by database searches. Following screening and selection, 10 articles met the criteria for inclusion and exclusion. Of these, 4 studies were not exclusively focused on the experiences of mental health services by adults from a BAME background. In these cases, the research may have used quantitative as well as qualitative methods or included professionals as well as service users. However, they each reported distinguished findings that satisfied the inclusion and exclusion criteria and were therefore included. Overall, qualitative experiences from 182 service users from BAME backgrounds were identified. The summary characteristics of the 10 articles, as described by the authors, are outlined in Appendix D.

Quality Appraisal. Appraisal scores for the 10 finalised articles ranged between 0.6 and 0.85 (Appendix E). The highest scoring domain was the studies' objectives and the lowest was reflexivity of the account, which is crucial to qualitative research because it discloses the extent to which researchers may have been biased (Haynes, 2012). Helpfully, Chtereva et al. (2017) gave a comprehensive reflexive account throughout the research. This included similarities and differences between the author and the sample, such as ethnicity and social privilege, as well as reference to a reflective journal and explicit discussion of the author’s ontological and epistemological positions. A purposive sampling strategy through community links was reported or inferred in most articles, which is generally appropriate for qualitative research, but may be especially suited to research with minority groups (Spring et al., 2003; Etikan et al., 2016). Two studies rewarded participants, for example with £25 in supermarket vouchers, to facilitate engagement (Memon et al., 2016). Focus groups and semi-structured interviews were used as the means of data collection across 9 studies, with one article reporting a case study. Both are considered appropriate for qualitative research and have been used to explore the experiences of BME people in England and Wales (Chappie, 1998; Culley et al., 2007; Gill et al., 2008). Questions for both methods were developed from literature reviews (Islam et al., 2015) or research teams (Wales et al., 2017) and were typically carried out by the authors or researchers themselves (Edge et al., 2008). Out of 10 articles, 7 reported variants of Thematic Analysis (Braun and Clark, 2006) as the means of data analysis. Other methods of analysis were Interpretive Phenomenological Analysis (Eatough and Smith, 2008) and a Framework Approach (Ritchie and Spencer, 2002). Some, but not all, disclosed the full process of the analysis. With respect to verification, some articles reported possible triangulation of their analysis to enhance validity through “convergence, complementarity and dissonance” (Erzerberger and Prein, 1997; Carter et al., 2014). Although reflexivity and transparency limited the quality of these articles, they were nevertheless considered appropriate to synthesise and analyse, albeit with some necessary restrictions on validity and reliability. Given that the articles included specific populations and asked about personal experiences, appraisal of their quality must be balanced fairly with both the pragmatic and conceptual challenges of such research. Helpfully, direct quotations from participants were included in all articles, affording some concept of the primary data. Therefore, despite the limitations of reflexivity and transparency, some quality endures and can offer insight.

Analysis and Synthesis. 25,694 words of data were transcribed from 10 articles. A thematic synthesis was conducted and 4 analytical themes were interpreted beyond the data collected. These were: ‘*the community constructs the concept’, ‘respecting experts by experiences’, ‘change to help’* and *‘one size fits none’*.

Theme One: 'The community constructs the concept'. This theme relates to the participants' conceptualisations regarding mental health and were interpreted as three sub-themes: explanations, interventions and mental professionals. These conceptualisations were described as pre-existing, having been developed over time, through family and friends or through the media. Firstly, articles reported idiosyncratic conceptualisations of mental health which varied from "no personal knowledge or experience" (Edge et al., 2008) to "multiple explanatory models" that were "competing and contrasting as well as interchangeable" (Islam et al., 2015). These conceptualisations were contextualised by the fact that "involvement with mental health services carried social stigma" (Wagstaff et al., 2018) and were either taboo to talk about or directly associated with weakness. Religion was also considered influential in giving a "structure and purpose and a framework within which to understand emerging symptoms" (Islam et al., 2015). Secondly, articles reported conceptualisations of both formal and informal interventions or service provisions. Informal interventions, such as spending time with friends, "provided a sense of emotional connection, shared values and inter-dependence" (Chtereva et al., 2017), whereas formal interventions from services were considered on a spectrum. Some articles reported that participants were generally "in favour" of service interventions (Almond and Lathlean, 2011), whereas others were reported as suspicious of "a money-making profession rather than serious medicine" (Wales et al., 2017). Finally, articles reported that participants had conceptualisations of a BAME "communication gap" (Gault et al., 2009) between professionals who were described as being unable to "recognise or respond to their needs" (Memon et al., 2016). This was centred on professionals being perceived as "Western" (Chtereva et al., 2017) and informed beliefs that professionals "pigeonholed" participants due to ethnic discrimination (Schofield et al., 2019). Professionals were also conceptualised in terms of trust, with articles especially reporting a concern about confidentiality, particularly if professionals "were from the same close-knit BME community" (Islam et al., 2015). All of these responses reflect the multiple conceptualisations that may relate to BAME people's experience of mental health services.

Theme Two: 'Respecting experts by experiences'. This theme relates to direct experiences with mental health services, rather than perspectives. Participants were considered experts in describing their own experiences instead of having others, such as carers or professionals, inferring them. These experiences were again interpreted into three sub-themes regarding experiences of mental health, professionals and interventions. Firstly, articles reported experiences of mental health that ranged from medical disorders where "the majority of participants wanted a “cure” (Islam et al., 2015) to “normalising attributions” of difficult life experiences (Edge et al., 2008). Moreover, these experiences were often discussed alongside the contexts and conceptualisations previously developed; in the same way, they were highly idiosyncratic. Schofield et al. (2019) summarise an “accumulation of stressors” linked to institutional racism which led to experiences of psychosis. Secondly, articles reported experiences of services and interventions that were sometimes positive but frequently critical. Some articles reported that interventions from services were experienced as “appropriate acceptable and perceived to be helpful” (Lovell et al., 2014) by participants. Others reported a “lack of choice” Wagstaff et al. (2018), “long waiting times” (Edge et al., 2008) and “gaps in the services” (Memon et al., 2016). Experiences of services were heavily influenced by cultural factors from resources being “only available in English” (Almond and Lathlean, 2011) to services where “cultural beliefs often competed and contrasted with medical explanations” (Islam et al., 2015). Finally, articles reported experiences with professionals. Infrequently, these were positive experiences of “empathy and understanding” (Lovell et al., 2014), however negative experiences were abundant. Professionals were experienced by participants as having an inability to “understand or sympathise with the realities and experiences of those from a BME background” (Memon et al., 2016). Even when participants were agreeable to formal interventions or services, articles reported an experience of professionals who stated that “formal treatment was not indicated” or who would “undermine the value of” such treatments (Edge et al., 2008). Articles also “described a sense of helplessness and passivity” (Memon et al., 2016) with respect to professionals perceived to have significant power and authority. These reports appeared to mediate the experience of mental health services by people from a BAME background.

Theme Three: ‘Change to help’. This theme relates to articles’ descriptions of barriers and facilitators to change, including conceptualisations or experiences that were qualified with the intention or lack thereof to engage with services. These were interpreted into three sub-themes of self-concept, practicalities and mental health provision. Firstly, articles described “an attitude which privileged personal agency and mastery over seeking help from others” (Edge et al., 2008) that stopped people from engaging with services. This was contextualised within the concepts of stigma and a lack of control associated with mental health and mental health services, meaning that “if people were concerned about stigma and shame they were more likely to delay their presentation to services” (Wales et al., 2017). Therefore, “personal choice was important” (Lovell et al., 2014) to participants in order to be in control of balancing their agency with help from others. Similarly, participants reported that stigma could be reduced by BAME communities themselves, for example, "if issues were portrayed either on Asian TV channels or in every day soap operas on television" (Wales et al., 2017). Secondly, articles reported a number of practical factors that mediated engagement with services, from "policies restricting their rights to work and healthcare" (Chtereva et al., 2017) to a "lack of funding for the associated costs" of informal support (Memon et al., 2016). Articles reported that participants therefore requested support and signposting for "domestic and financial issues" (Lovell et al., 2014). Finally, articles reported that mental health provisions should be targeted towards awareness, access, appropriateness and autonomy. A lack of education and awareness of mental health problems was an initial barrier to engagement, with participants requesting that "education was required firstly to raise awareness of [mental health problems] and secondly to highlight the seriousness and potential consequences of such disorders" (Wales et al., 2017). Articles also reported that accessing mental health services could be improved with flexibility, for example, by "being able to see people at home" (Lovell et al., 2014). Schofield et al. (2019) reported that people with negative symptoms of psychosis required more proactive services, or they risked "underdiagnoses and a failure to provide services". Providing culturally sensitive support with awareness about cultural beliefs, traditions, historical barriers and the need for a "relational approach in therapy was highlighted" (Chtereva et al., 2017) as key to facilitating engagement with mental health services. Similarly, a "positive interpersonal connection between service user and healthcare provider where the consultation was "a dialogue"" (Memon et al., 2016) was described as helping to address a power imbalance and give participants autonomy.

Theme Four: 'One size fits none'. This theme relates to the considerable extent to which reports of participants' experiences varied, sometimes in direct contradiction with each other. These were interpreted into four sub-themes of demographics, conceptualisations, preferences and internal inconsistencies. Firstly, differences between demographics were reported, particularly in the way that men differed from women prior to engaging with services. Men were described as "less likely to utilise helpful coping strategies" compared to women, who "tried to be more active" (Chtereva et al., 2017). Secondly, conceptualisations also differed amongst participants, for example, with respect to attitudes towards services and interventions. Some articles reported that participants described difficulty accessing services with "long waiting times" (Edge et al., 2008), compared to others that felt that "mental health services could best help them by leaving them alone" (Wagstaff et al., 2018). Thirdly, articles reported different preferences for service provisions, with some reports stating a preference for a "practitioner of their own ethnicity" (Lovell et al., 2014) but other reports stating that "it was not unusual for a [South Asian] patient to request to see a non-[South Asian] therapist" (Wales et al., 2017). Similarly, participants' preference for interventions was also conflicted, as some groups were "popular with those who attended", but "not all people felt able to engage in a group" (Lovell et al., 2014). Finally, articles reported differences within themselves as well as between themselves and others. With respect to medication, a "complexity of BAME experience" was reported (Gault et al., 2009) where participants felt a lack of control "regarding the prescription and ingestion of medication", but also recognised "how they benefitted from oral medication" (Wagstaff et al., 2018). In this way, experiences of mental health services and associated themes appeared variable between people from a BAME background.

Discussion

This synthesis reviewed experiences of mental health services by people from a BAME background and found four analytic themes. First and foremost, these themes reflect a diversity of experiences across a number of contexts. It is not possible to draw a unified or universal construct of these experiences and this should inform any discussion or interpretation of the findings. Though the review does not prove causation, it does provide insight into unique experiences that BAME groups have in relation to mental health services (O'Brien et al., 2009). Indeed, some specific findings were observed that relate to previous research into mental health and ethnicity. Firstly, the range of experiences reported reflect indications from the REF and previous research that factors mediating engagement with services are located in multiple contexts (Hankir et al., 2017; Bignall et al., 2019). These include racism and disadvantage, professional competency with BAME groups and community stigma. Secondly, it suggests that people from BAME groups utilise informal and non-medical sources of support to conceptualise and manage psychological wellbeing (Hatch and Thornicroft, 2012; Singh et al., 2015). Thirdly, it provides further context to the conceptualisation of ethnic identity with respect to mental health, with participants reporting that coming across members of their own communities could both help and hinder their engagement. Fourth, it provides some support for previous findings that report that people from BAME backgrounds do not feel autonomous or equal with respect to the interventions that they receive (Sizmur and McCulloch, 2016). Finally, at the very least, the review provides support for the suggestion that there is a disconnect between services and service users in mental health care. The review would not be able to support assertions about whether mental health services are therefore institutionally racist or not. Nevertheless, participants specifically reported a lack of provision for BAME mental health care.

Although the range of participants allowed the review insight into the experiences of BAME service users, it also highlights the considerable variation between participants, as well as each of their individual contexts. This is particularly highlighted by a lack of appropriate studies focusing exclusively on BME patients available for synthesis. These 10 articles alone included ethnic groups that would be classified as different even under the NHS' broad categories. As Wilkinson (2009) reflects, services should not make generalisations about 'culture', but provide "culturally competent, personalised support that addresses individual needs alongside a systematic approach to remove barriers to race equality in the service". These findings are also contextualised by their validity and reliability. The rich information interpreted by the synthesis remains limited due to a lack of reflexivity and transparency (Haynes, 2012). As a result, the data collection and synthesis may have been subjected to bias and therefore may not reflect the full nature of these experiences. Nevertheless, having some further insight into the standalone experiences of BAME people with mental health services is certainly one step towards prioritising patient perspectives and building equal collaboration with services and research. Future research could explore more detailed experiences of mental health services and people from BME backgrounds. This is particularly relevant to BME experiences under the Act.

Strengths and Limitations. This review synthesised the qualitative experiences of BAME people with the rigour of PRISMA guidelines. It included contemporary research that focused on BAME experiences to give an exclusive account from this perspective. As a result, the review presents a number of themes that contribute understanding about BME experiences, building on previous research. The review also highlights significant gaps in this research area and reflects the need for more reflexive and robust research in future. Although PRISMA guidelines were followed, the review was carried out by a single individual. This increases the potential for bias, especially in qualitative research. The review was also relatively general in its scope, exploring experiences for a wide range of participants in a variety of settings. Although this may help its generalisability, it may be difficult to interpret the review's findings for specific populations or contexts, notably BME adults detained under the Act.

Problem Statement

Adults from a BME background have consistently been over-represented in the rates of inpatient detention since the introduction of the first Mental Health Act (1959). Since then, a collection of publications from the government, academic research and patient organisations have reflected a chronic disparity. This has culminated in an independent review of the Act in a wider context of additional concerns including human rights conflicts. Despite such comprehensive documentation, a robust review of explanations for this increase has only recently been completed (Barnett et al., 2019). These explanations included diagnosis, racism, risk, police involvement and engagement with services. Such explanations are reflected in the historical and theoretical contexts relating to BME groups, as well as to detention in England and Wales overall. Although well-established, such statistical research reflects correlational relationships and, as a result, it is not clear how these multiple factors interact. Concurrently, there has been an increased social and legal impetus for patient involvement with respect to mental health services, including detention under the Act. Understanding lived experiences in addition to well-established statistical relationships may provide a better understanding of how and why BME groups are more likely to be detained under the Act. A number of systematic reviews have reflected both positive and negative experiences of detention overall. However, such research has not explicitly explored ethnicity. Moreover, where ethnicity is researched, it can be in terms of broad categorisations, which may not be fully representative of BME experiences. Thus, the experiences of adults from a BME background of detention under the Act remains under-researched.

Aims and Objectives

The present study will address the following aim:

- To explore the experiences of adults from a BME background who have been detained as inpatients under the Mental Health Act (1983; 2007).

CHAPTER TWO: METHOD

Chapter Overview

The current research used an exploratory, naturalistic, qualitative research design as part of a critical realist approach to explore experiences of adults subject to inpatient detention under the Act. This chapter explores this approach in further detail and includes the theoretical and philosophical approaches towards the current research and the resultant paradigm and procedure. Together, this provides the overall rationale for the methodology of the research as well as specific justification for the decisions made. In addition, the chapter includes a self-reflexive statement to represent the researcher’s beliefs, experiences and potential biases. The study concludes with how the research was carried out.

Philosophical Framework

Research is fundamentally underpinned by the philosophy of the researcher, typically discussed in terms of ontology and epistemology (Grix, 2019). Ontology is described as the study of reality and what is possible to know about it (Ormston et al., 2014). It reflects the way in which the researcher is orientated towards the conceptualisation of reality. Epistemology relates to what can be learned about reality and what this knowledge is based on (Ormston et al., 2014). Both ontological and epistemological assumptions are crucial to a robust methodology as they facilitate transparency and scrutiny with respect to the researcher (Spackman and Williams, 2001; Grix, 2019).

Ontology. Ontology may be considered the starting point of all research as it reflects what is believed by the researcher about the nature of what is being studied (Grix, 2019). This belief may be demonstrated by two broad ontological positions: realism and relativism (Ormston et al., 2014). Realism is described as a belief that reality exists independently of human consciousness or interpretation (Denzin and Lincoln, 2011; Patton, 2015). From this position, there is an objective, external reality that is observable and measurable, though variations of realism debate the extent to which this is achievable (Blaikie, 2007). Relativism instead proposes that reality is a relative concept that exists through human consciousness and interpretation (Denzin and Lincoln, 2011; Ormston et al., 2014). This approach broadly suggests that multiple relative realities are subjectively created by individuals, groups or contexts (Blaikie, 2007). A realist ontology is reflected in the significant body of statistical research regarding BME groups, which broadly suggests that some statistical realities are known and measurable. Notably, the over-representation of BME groups in detention rates reflects a known reality that exists as numerical data. There may be different explanations for this reality and different ways of measuring the data, but it has nevertheless existed in empirical research for decades. An relativist ontology may be demonstrated by the experiences of detention, insofar as research has consistently concluded that these are relative to individuals and contexts.

Epistemology. Following the ontological assumptions about the nature of reality, epistemology relates to the way in which knowledge about that reality is learned (Blaikie, 2007). Epistemology has similarly been represented by two broad positions: positivism and interpretivism (Ormston et al., 2014). A positivist epistemology suggests that knowledge about reality can be acquired through objective scientific research (Blaikie, 2007). This objectivism includes falsifying hypotheses through empirical methods used in the natural sciences, such as the five senses (Denzin and Lincoln, 2011; Ormston et al., 2014). It is therefore considered to reflect reliable, valid and generalisable knowledge that can be tested (Patton, 2015). The researcher is considered independent to the reality that they are researching and, as such, this reality remains unaffected by how the research is conducted. This is considered to be a ‘correspondence theory’ of reality, in that knowledge directly corresponds to objective observations of reality (Ormston et al., 2014). An interpretivist, or constructionist, epistemology argues that knowledge about reality is interpreted or constructed by people, including both the researcher and those being researched (Patton, 2015). This approach involves careful consideration of complex subjects that may not have a singular or universal understanding. Instead, a subjective understanding can be constructed or interpreted and this is usually mediated by individuals and contexts. These subjective conceptualisations therefore require a level of interpretation that is beyond the scientific methods from the natural sciences (Denzin and Lincoln, 2011; Ormston et al., 2014). What is considered valid, reliable and generalisable is more nuanced than positivist concepts of objectivity and falsifiability (Patton, 2015). This is considered to be a ‘coherence theory’ of reality, in that knowledge is learned through the coherence of subjective interpretations and constructions. A positivist epistemology reflects the way in which knowledge about BME detention rates is acquired. This has predominantly been through numerical data and statistical analysis, which is attempted with objectivity and independence from the researcher. Knowledge about over-representation for BME groups therefore directly corresponds to the observation of higher numbers of BME people detained under the Act. By contrast, an interpretivist epistemology relates to the way experiences of detention are learned about, which is to say, through the interpretation of accounts from people subject to detention. These experiences are constructed both by the participant and the researcher to develop a coherent account.

Methodology. Where epistemology relates to the way in which knowledge is learned, methodology here refers to the general approach to researching this, distinct from the specific techniques that will be carried out (Silverman, 1993). Methodologies are often described in terms of two approaches: quantitative and qualitative (Coolican, 2014). Quantitative methods traditionally relate to numerical data and are based on statistical relationships between variables that are quantifiable and measurable. In this respect, quantitative methods have often assumed objectivity and commonly reflect the realist and positivist positions previously outlined. This is demonstrated by the method of reporting BME detention rates. The number of people detained under the Act is quantifiable through clinical records. Ethnic groups, although diverse, have similarly been quantified into broad category variables to facilitate statistical analysis. Qualitative methods are contrastingly associated with exploring more descriptive data, such as experiences or beliefs which are not easily quantified (Denzin and Lincoln, 2011; Creswell and Poth, 2018). Such methods commonly assume a degree of subjectivity involving both the researcher and participants (Grix, 2019). In this respect, they may be more aligned to the interpretivist positions discussed. Although psychology developed as a discipline with qualitative methods, quantitative methods became considered to be more legitimate because of their realist and positivist notions of objective and scientific research (Ponterotto, 2010). However, qualitative approaches have more recently become increasingly legitimised in clinical psychology (Harper, 2017).

Self-Reflexive Statement. In addition to ontology, epistemology and methodology, Creswell and Poth (2018) propose a fourth philosophical assumption of axiology. This relates to the values and biases of the researcher, representing a relativist ontology and interpretivist epistemology insofar as the researcher is considered to have influence on the research. A similar concept of reflexivity has also been described as an in-depth reflection regarding bias (Ormston et al., 2014; Patton, 2015). Both concepts require the researcher to reflect on themselves and it is largely accepted that this cannot be separated from the processes of qualitative research (Taylor et al., 2015). This is considered especially important for conducting research with minority groups (Lincoln, 1995; Creswell and Poth, 2018). It is suggested that reflexivity can be prompted by questions regarding the researcher's biography, interests, experiences and values (Frost and Bailey-Rodriguez, 2019). This can further be positioned by considering class, citizenship, gender, age and race (Jacobson and Mustafa, 2019).

I identify as a 31-year-old male from a working-class British-Indian family. I have lived experiences of mental health problems, mental health services, racism and classism. I also have experiences of similar contexts from a professional perspective as a Trainee Clinical Psychologist: I have worked with people experiencing mental health problems; I have worked in mental health services, including where people are detained under the Act; and I have worked with people from minority communities with diverse experiences. I believe all of these professional and personal experiences have made me particularly aware of inequalities, both in mental health and wider society. They have developed into personal, professional and political values towards acknowledging and addressing such inequalities which have undoubtedly influenced my approach to the current research. In particular, they have endorsed my belief in the value of lived experiences to develop, provide and evaluate mental health provisions.

Although I am from a BAME background, I acknowledge that there is a significant difference between my experiences and those of BME people. This is not to minimise the racialised and racist experiences of British Indian people, but rather to contextualise BME people appropriately. British Indians and BME people have different historical and contemporary contexts that can overlap, but are also distinct, which reflects the difficulty of discrete conceptualisations and categorisations of ethnicity. The aforementioned government audit of racial disparities suggests marked differences in employment, housing, education and policing between the two ethnic groups. Indeed, there are significant differences within British Indian groups, as there are also within and between different BME and White groups. Similarly, though I have lived experiences of mental health problems, I have not experienced a schizophrenic disorder, nor have I been detained under the Act. This means that I approach the research with a degree of familiarity, but an acceptance that I cannot claim to know the same experience. I recognise that my professional biography has involved working in inpatient settings where people are detained under the Act. This has led to my awareness of systemic as well as individual factors relating to experiences of detention. I have felt a sense of frustration at how inpatient wards can operate, particularly with respect to power dynamics between staff and patients. This has been particularly unbalanced with respect to detention, where there has been a dismissive perception of disorder with respect to risk and liberty. I am therefore interested in the current research because it highlights the human impact of legislation and service provision. My professional biography also includes a depth of experience with systemic, cognitive and psychoanalytic models, which may influence the theories I approach the research with.

I think all of this is important with respect to an increasing demand for BME and service-user led research. Although I have attempted consultation and service-user involvement, I recognise that I have not taken all of the steps I would have liked to within the timeframe before beginning the research. This reflects an uncomfortable awareness of a conflict between my interest in the research area and my motivation to complete an assignment for a professional qualification. I also acknowledge that as a Trainee Clinical Psychologist, I have the power and opportunity to conduct this research, where others who may be better placed to have not. Moreover, I have had gainful employment from these services and a discipline that has a history of disempowerment and racism. In being transparent about these reflections, I hope to conduct research that can contribute to new knowledge as well as be available to appropriate scrutiny.

Research Paradigm

A research paradigm combines ontology, epistemology and methodology to provide a framework of the researcher's approach towards the research (Denzin and Lincoln, 2011). The current research takes a critical realist approach, which is described as a bridge between a realist ontology and an interpretivist epistemology (Grix, 2019). Critical realism emphasises the importance of a distinct ontology, which is presented as realist insofar as reality is considered to exist independently of human constructions (Bhaskar, 2016). However, it is interpretivist in its epistemology because it posits that our understanding of this reality is nevertheless a construction and relies on interpretation (Maxwell, 2012). Critical realism therefore allows for an objective reality to be researched while incorporating subjective understandings and experiences of that reality. A realist ontology is considered appropriate to the current research because it is argued that detention under the Act is a pressingly objective reality for those detained. An interpretivist epistemology is considered appropriate for the current research because the experiences of detention are subjective constructions or interpretations from participants and the researcher, rather than objective observations from the researcher alone. Finally, a qualitative methodology is considered appropriate to reflect these ontological and epistemological positions as it involves understanding people from their own frames of reference, beyond quantification (Taylor et al., 2015). This is considered particularly appropriate for exploratory research with ethnic minorities (Ponterotto, 2010). Qualitative research also allows for insights into service-user experiences that can complement quantitative research or compensate for its gaps in understanding (Braun and Clarke, 2014). All research paradigms may be considered subject to a degree of pragmatism, which highlights how researchers can often adapt an approach that best fits the research, even if it does not adhere to strict ontologies, epistemologies or methodologies (Ormston et al., 2014; Patton, 2015). Overall, all aspects of the research paradigm and procedure must be adapted to minority ethnic groups (Roosa et al., 2012; Bernal et al., 2014).

Data Collection Methods

Data can be collected by a number of methods, but these must be considered tools in service of the philosophical assumptions taken by the researcher towards the research aim (Grix, 2019). Lewis et al. (2014) first propose that the researcher should consider whether data collection is necessary, or whether a secondary analysis of existing data can be conducted. For the current research, it is argued that there are insufficient academic accounts of BME experiences of detention that can be analysed in service of the research aim, thus novel data is required. Collection of such data can be virtual or face-to-face (Lewis et al., 2014; Patton, 2015). The current research will use face-to-face methods, as these are considered better able to facilitate interpersonal rapport and this is crucial to the research aim and participants (Liamputtong, 2010; King, 2019). Face-to-face methods include interviews, focus groups and observations. Although observations allow for considerable depth in data collection, they require significant resources because the researcher has to be in the right place at the right time (Taylor et al., 2015; Grix, 2019). This is considered inappropriate for the current research as observing experiences of detention would require the researcher to have witnessed the whole process with the consent of not only the participant, but also the multiple people they engaged with (Coolican, 2014; Nicholls et al., 2014). It is also acknowledged that detention already involves a significant degree of observation.

Focus Groups. Focus groups involve a discussion by a number of people about a given subject and data is generated from the interaction (Coolican, 2014; Finch et al., 2014). This allows practical advantages, in that data from a number of participants may be collected simultaneously (Creswell and Poth, 2018). Focus groups are often contextualised by a degree of commonality between participants and are therefore particularly adept at exploring group norms or behaviour (Taylor et al., 2015). Focus groups have been used to explore ethnic minority experiences and can facilitate rich data on multiple levels (Ekblad and Bäärnhielm, 2002). However, the multiple interactions between participants may make it difficult to synthesise data and participants may also influence each other (Culley et al., 2007; Sánchez-Ayala, 2012). This reflects a degree of conflict between individual and collective experiences (Liamputtong, 2010). The current research aims to focus on a collection of individual experiences, especially because BME and BAME people have typically been grouped together in previous academic research.

Interviews. Interviews allow the generation and interpretation of experiences through a conversation between the researcher and participant (Yeo et al., 2014). Thus, they are dependent on both what the interviewer asks and what the participant answers, as well as both parties' interpretations therein (Denzin and Lincoln, 2011). Semi-structured interviews are the most commonly used method of qualitative interview (DiCicco-Bloom and Crabtree, 2006). These allow the researcher to have an intended framework of inquiry in mind, whilst also being able to follow the participant's direction (Patton, 2015). They enable reciprocity between the interviewer and the interviewee, allowing the interviewee to express themselves and the interviewer to follow-up (Kallio et al., 2016). This fits with the critical realist approach of the current research in establishing a focus on the reality of detention whilst allowing exploration of different interpretations of this. Such reciprocity is considered a standard of high-quality qualitative research, particularly with minority groups, where the researcher pays especial attention to their positions of power and privilege in relation to participants (Lincoln, 1995; Sánchez-Ayala, 2012). Semi-structured interviews are therefore considered most appropriate for the current research as they facilitate individual interpretations and allow flexibility, both of which are considered crucial to exploring minority groups experiences (Liamputtong, 2010).

Data Analysis Methods

Data analysis is a dynamic process whereby the researcher gains understanding of what has been studied (Creswell and Poth, 2018). It is described as challenging due to the scope of different approaches and processes that the researcher can take (Spencer et al., 2014). For semi-structured interviews, three approaches to data analysis are considered appropriate: Grounded Theory (GT), Interpretative Phenomenological Analysis (IPA) and Thematic Analysis (TA) (Coolican, 2014).

Grounded Theory. GT focusses on generating a theory through the analysis of data (Glaser and Strauss, 2017). It is a prolific and influential method that offers a systematic approach to analysing qualitative data, making it familiar to established quantitative principles (Patton, 2015; Charmaz and Henwood, 2017). Guidelines for GT outline a disciplined procedure therein and attempt to limit researcher bias in this way (Strauss and Corbin, 1998). The researcher is constantly comparing the data and testing emerging theory, with an often positivist notion that such a systematic and thorough approach would lead different researchers to similar analyses or theories (Charmaz, 2000; Bryant and Charmaz, 2007). GT's primary strength is that it generates theory through qualitative rigour and this is demonstrated by Seed et al.'s (2016) systematic review of experiences of detention. After analysing the data, the authors were able to conceptualise a theoretical framework for how detention is experienced. Despite the rigour of GT, there are still conflicts about the method and the analysis remains subject to some degree of interpretation and construction (Barbour, 2001, Charmaz, 2000). Nevertheless, GT has been used for research in minority groups and can identify important themes (Liamputtong, 2010; Sánchez-Ayala, 2012). The current research does not aim to establish a new theory or test an existing one. It is exploratory and aims to provide an account of experiences. Moreover, GT requires that participants are continually recruited until theoretical saturation is achieved (Glasser and Strauss, 2017). This is not considered in the current context because inpatient settings can have high turnovers and the research is time-limited.

Interpretative Phenomenological Analysis. IPA is a qualitative research approach that explores how an individual makes sense of their life experiences (Smith et al., 2009). IPA considers this experience to be key and takes a hermeneutic approach, which is to say that the participant is making sense of their experience and the researcher in turn is making sense of the participants' interpretations (Smith and Shinebourne, 2012). It uses a specific structured method of analysis focussed on uncovering meaning and conveying the experience of participants, rather than aiming towards the researcher's objective (Alase, 2017). As such, IPA is idiographic, meaning that it emphasises a particular level of individual detail (Smith et al., 2009; Eatough and Smith, 2017). It therefore focuses on single case studies or otherwise small samples of relatively homogenous groups that have something in common (Smith et al., 2009). IPA has been used to explore experiences for minority groups, but can lack standardisation and lead to somewhat ambiguous findings and conclusions (Brocki and Wearden, 2006). Nevertheless, phenomenology and IPA are both considered helpful in exploring BME experiences in detail, particularly with respect to psychotic experiences and how they are made sense of beyond a biomedical context (Morgan and Fearon, 2007; Smith et al., 2009). The current research is exploratory and broadly aims to describe and interpret experiences, rather than producing a particularly detailed meaning. Moreover, it is argued from previous research that experiences of the Act are not homogenous and that BME people represent a significantly heterogenous group. Therefore, IPA’s idiographic approach may be less suitable.

Thematic Analysis. TA is described as a diverse approach to analysis that can reflect a number of theories and philosophies and thus is rarely presented as a single or universal method (Terry et al., 2017). However, TA broadly relates to analysing data and interpreting patterns, or themes (Braun and Clark, 2006). TA has been considered susceptible to a lack of rigour because it can be done in so many ways and from so many theoretical or philosophical positions (Antaki et al., 2002). Because of this flexibility, it is important for the researcher using TA to be explicit about their ontological, epistemological and axiological approaches (Braun and Clark, 2006). This includes a distinction between an inductive approach, which is broadly guided by the data, or a deductive approach, which can be guided by theory or hypotheses (Blaikie, 2007). Overall, the subjectivity and transparency of the researcher is thus considered to be integral to the method (Terry et al., 2017). TA outlines a stepped process for data analysis, which facilitates its ease of use and popularity (Braun and Clarke, 2006; Terry et al., 2017). It is particularly recommended for use with interviews, in healthcare settings, and with minority groups (Braun and Clarke 2013; Braun and Clarke, 2014; Braun et al., 2015). TA is therefore considered most appropriate to the critical realist paradigm of the current research. Its pragmatic flexibility allows for the researcher to inductively explore themes relating to experiences of detention, without being bound to theory. Moreover, it facilitates a depth of individual experiences whilst simultaneously allowing heterogeneity between participants. It is acknowledged, however, that the appropriateness of TA for the current research is entirely dependent on the researcher’s explicit orientation to the approach and transparent execution of the analysis.

Consultation. The researcher sought consultation on the research paradigm from Dr. Colin King, a mental health survivor, practitioner, author and researcher (King, 2007). Dr. King suggested that the researcher be explicit about how BME people were defined in the research and the importance of qualitative research into lived experience. It was further suggested that the researcher should highlight the prominence of power and race in contextualising the research and suggested additional reading therein. The researcher also sought preliminary advice from academics with relevant expertise including Frank Keating, Professor of Social Work at Royal Holloway University, and Nimisha Patel, Professor of Clinical Psychology at University of East London. Prof. Keating agreed with the need for an interpretivist approach and a specific focus on BME experiences and suggested some further reading. Prof. Patel discussed the human rights perspective of detention and similarly agreed a need to explore BME experiences specifically. Both suggested careful consideration of ethics. The current research therefore incorporated contexts relating to power, race and human rights, including references to the reading materials recommended. BME groups were also explicitly defined and an interpretivist, qualitative paradigm exploring lived experiences was reaffirmed. Finally, the researcher established a thorough ethical framework for the study.

Ethical Considerations

The current research was conducted in compliance with the British Psychological Society’s Code of Human Research Ethics (BPS, 2014) for psychological research in the UK. This is supplemented by additional academic literature regarding research ethics, including for qualitative approaches and minority groups (Trimble and Fisher, 2006; King, 2019).

Informed Consent. Detention under the act is predicated on a lack of consent, so obtaining informed consent for research in this context is especially important. To facilitate this, a poster advertisement (Appendix F) was placed in the wards and participants were able to express an interest in the study by initiating contact with ward staff or the researcher. However, capacity to consent was ultimately determined by ward staff. Professionals can play an important role in research recruitment as gatekeepers, though this can both help and hinder recruitment with minority groups (Rugkåsa and Canvin, 2011; Bonevski et al., 2014). Interested participants were then able to discuss the research in more detail and review a Participant Information Sheet (PIS), which detailed the study further (Appendix G). Participants were given a minimum of 24 hours to consider the information before they could consent to take part. This involved a Consent Form (CF), which further informed participants of what the researcher was asking of them (Appendix H). Immediately prior to the interview, participants had a further opportunity to discuss information about the research and could also make inquiries after the interviews were completed. Participants were further informed that the research was separate to their detention and their decision to take part or not would not affect this. To emphasise separation from the ward, the researcher wore identification unaffiliated with the setting. Despite these procedures, informed consent is an imperfect process. In particular, these procedures can be argued to benefit the researcher's administrative and regulatory obligations more than participants' needs (Webster et al., 2014). Some therefore argue that true informed consent goes beyond these mechanistic processes and require stages of building relationships over time, particularly with respect to minority groups (Trimble and Fisher, 2006; Liamputtong, 2010). The practical limitations of the current research did not enable such extended relationships, however the researcher endeavoured to build as much familiarity and rapport as possible with frequent visits to the ward and open conversations about the research.

Right to Withdraw. Participants were informed of their right to withdraw as part of obtaining their informed consent (Coolican, 2014). It was made clear that this applied throughout the research process and would not affect their clinical context.

Confidentiality. Confidentiality may be a significant concern for minority groups engaging in research, not least due to concerns about whether researchers who are external to the group can be trusted (Liamputtong, 2010). However, this is highly dependent on the context and nature of the research and should not be used to assume that such groups are harder to reach or must be subject to disproportionate scrutiny for ethical engagement in research (Kalathil, 2013). In the current research, participants were provided with information regarding confidentiality both during the interview and with respect to the audio-recording of the interview. This included an explanation of how confidentiality may be breached in certain circumstances relating to safeguarding and risk management, which the researcher would inform them of if necessary. Participants were informed that this would result in the researcher contacting a responsible clinician on the inpatient ward who would follow local policies and procedures. Participants were asked to specifically consent to the confidentiality framework as part of the informed consent procedure.

Anonymity. Minority groups may feel that engaging with research can compromise their confidentiality and anonymity (Liamputtong, 2010). Qualitative data exploring experiences necessarily involves detailed accounts of participants lives which may allow others to identify them, however this can be somewhat managed through anonymisation of the data (King, 2019). Verbatim passages should especially be anonymised and participants were informed that this would be the case (White et al., 2014). As the current research took place in an inpatient ward, it is possible that participants were not fully anonymised to others in the ward. This was managed as best as possible by conducting the interviews in private rooms on the ward and informing participants about anonymity and access to further support from ward clinicians. Although anonymisation is a key ethical principle, for minority groups in particular, it is also important to consider that anonymising individuals in the research may facilitate the projection of individual experiences onto the wider minority group by others (Trimble and Fisher, 2006).

Data Management. The current research includes audio-recordings and written materials relating to participants. Participants were informed that these materials will be stored securely, either as hard copies in locked filing cabinets on University of Essex premises, or as electronic files which are password protected. Participants were also informed of the people that would have access to this data and how long it would be retained for in accordance with the Data Protection Act 2018.

Protection from Harm. It is suggested that all research involving minority communities could be considered sensitive (Trimble and Fisher, 2006). However, this again is dependent on specific research and should not in itself restrict ethical engagement in research for BME groups (Kalathil, 2013). Previous research suggests that participants discuss a number of positive and negative experiences of detention with varying degrees of sensitivity (Seed et al., 2016). The current research therefore expects that participants may discuss experiences that are sensitive and perhaps distressing. Participants in the current research were also surrounded by people that they may have talked about in the interview, which may have caused anxiety (Patton, 2015). However, as well as a potential for distress, participants may also find it cathartic to discuss their experiences (Webster et al., 2014). The researcher was careful to consider the potential for harm with possible advantages of taking part in the research, such as validation, self-awareness and empowering under-researched experiences (Hutchinson et al., 1994). Nevertheless, it is acknowledged that these notions of potential benefits for participants ostensibly serve the researcher’s interests. BME people subject to detention under the Act are considered to have less power than the researcher and the wider ward setting on a number of levels. There is therefore potential for exploitation, particularly in the context of wider socio-political power imbalances relating to issues including race, class and gender (Trimble and Fisher, 2006). The researcher was heavily influenced by this and attempted to maintain integrity and respect throughout the research process (Liamputtong, 2010). This included maintaining a reflexive journal and some consultation, however it is acknowledged that this was limited and does not guarantee ethical practice (Patton, 2015). Overall, there is considerable debate about the extent to which established research paradigms can cause potential harm through exploitation of minority groups (Thomas, 2009). It is therefore important that the researcher is reflexive with respect to their relationship to participants in minority groups (Creswell and Poth, 2018). Participants were made aware of the potential harms and benefits as part of obtaining informed consent. They were also reminded that they could stop or pause the interview at any time and had access to support in the ward beyond the interview. The researcher, as a third-year Trainee Clinical Psychologist, also had some knowledge, skills and experience in responding to distress as well as maintaining a respectful rapport (Meara and Day, 2003).

Debriefing. To ensure protection from harm, participants in the current research were given a debrief at the end of the interview (Patton, 2015). This allowed an opportunity for both the researcher and the participants to discuss any issues that arose as part of the interview and, in particular, for the researcher to remind the participant of relevant information and access to support (King, 2019). This was considered particularly important as participants would be returning to a context which they had just discussed in the interview.

Giving Advice. The current research involves discussions of experiences that are likely to be somewhat distressing, so the role of the researcher must have appropriate boundaries (King, 2019). Participants were informed that if they required further support or advice, they should contact a ward clinician in the first instance.

Financial Remuneration. The current research offered participants £10 in cash to give thanks for their participation in the research. Such offerings may unduly incentivise participants to consent and therefore it was ensured that the amount was not disproportionate to the research demands (King, 2019). Such remuneration can facilitate engagement with research, both generally and specifically with respect to socially disadvantaged groups (Liamputtong, 2010; Bonevski et al., 2014). It is suggested that remuneration can incentivise minority groups to engage with external researchers, but it can also reflect respect and appreciation for participants' efforts. Participants were informed of the financial remuneration as part of the process of obtaining consent, however it was not possible to anticipate whether this affected their decision.

Risk. The current research complied with local policies and procedures relating to risk on the ward. This included discussions with ward staff before and after the interviews and having access to an alarm system. The risk of distress to the researcher through exploring experiences of detention was also considered (Dickson-Swift et al., 2009). This was managed through research supervision.

Ethical Approval. The current research was submitted for ethical approval to an NHS Research Ethics Committee (REC) and received Health Research Authority (HRA) approval on 3rd June 2019 (Appendix I). The research was conducted in an NHS Trust, which granted access and ethical approval on 20th August 2019 (Appendix J). The University of Essex also granted ethical approval on 13th June 2019 (Appendix K). The researcher sought consultation on the REC and HRA submission form from Dr. Colin King, who suggested further reading about race and mental health.

Ethically Important Moments. In addition to the BPS code of ethics, Guillemin and Gillam (2004) further describe ethically important moments. These involve experiences that necessitate reflection and which therefore facilitate a more comprehensive relationship with ethical considerations in the actual practice of the research. An account of three such moments is therefore provided to contextualise the ethical considerations of the current research. The first moment relates to potential harm with respect to power imbalances from my initial visits to the ward and first interviews. I quickly became aware that I was perceived deferentially by some participants as a professional who could help them. Participants asked for both specific and general support and I, guiltily, had to maintain my defined role, including once during an interview. One participant asked me to document and report their individual experience with waived anonymity and it felt difficult to answer that their experience would be anonymised and synthesised with others'. This highlighted in sharp relief how much participants wanted to tell their stories and perhaps how few opportunities they may have to do so. This is not to say that my research was the remedy for this. Instead, it exemplifies how participants may consent to research because they have few other avenues to be heard and, moreover, how research can nevertheless co-opt such experiences into academic publications. The second moment relates to anonymity, protection from harm and risk. This was particularly complicated by the nature of the ward environment and relationships. My submission for ethical approval detailed that participants would be able to access support from ward staff in circumstances of distress and risk. However, in interviews, participants had described ward staff as unsupportive alongside negatively experienced risk-management procedures. As a result, it seemed paradoxical to ask participants to seek support from ward staff after they had just recounted how difficult these relationships were. In one instance, I witnessed a staff member speak about a participant pejoratively and raised this with a responsible clinician and my research supervisor. Finally, there were a number of moments where it seemed that participants were engaging in the research for the cash gesture of thanks. Although some participants said they were interested in the research regardless of the gesture, others were seemingly motivated by it. The amount was considered proportionate to the research task, though it may have been particularly influential in the context of the ward where access to funds appeared sparse. I had also attended a number of BAME events where speakers and attendees spoke about the importance of valuing contributions to research through financial remuneration. All of these moments caused me to reflect on the sometimes stark difference between theoretical ethics and ethics in practice.

Service Context. The current research was conducted in an NHS Trust in England with several adult acute inpatient wards, which has not been named to protect anonymity. The ward included adults who had been detained as well as those admitted without the use of the Act. The wards were staffed by a multi-disciplinary team of psychiatrists, clinical psychologists, nurses, occupational therapists and healthcare assistants as well as administrative and domestic staff.

Participant Inclusion Criteria. The current research relates to a specific group of participants, who were therefore recruited according to relevant inclusion criteria. Firstly, participants had to be detained under the Act in order to meet the primary aim of the research. Participants were therefore excluded if they were not detained under the Act. Secondly, participants had to be aged 18 and over and be detained in an adult mental health setting. Children and those detained in other settings, such as forensic or learning disability wards, were excluded due to additional medical, legal and ethical factors associated with these populations. Thirdly, participants had to self-identify as being from a BME background. This term was used in the information given to participants for them to decide if it was representative of them. Participants who did not self-identify as BME were excluded from the research. Fourth, participants had to be deemed by the ward clinicians as having the capacity to consent to the research. Participants who were deemed not to have capacity were therefore excluded. Fifth, participants were required to speak English, due to a lack of resources to provide interpretation services. Participants who were not able to speak English were therefore excluded. It is acknowledged that this can restrict access to research participation, especially for socially disadvantaged groups (Bonevski et al., 2014). Finally, participants could not be involved in any simultaneous research in order to limit confounding influences. Any participants that were involved in other studies would be excluded.

Sampling. The current research used a non-random purposive sampling method, which involves selectively recruiting participants who are likely to contribute specific experiences in line with the research aim (Creswell and Poth, 2018). This may be especially helpful for research with minority groups (Trimble and Fisher, 2006). The sampling was also determined by a degree of convenience, based on the availability of participants and the researcher within the research schedule (Coolican, 2014). In addition, ward staff mediated the sample in their role as gatekeepers to the research (Rugkåsa and Canvin, 2011). Appropriate sample size in qualitative research can be ambiguous compared to the statistical formulas used in quantitative research (Patton, 2015). It is largely dependent on the research aim or paradigm and is therefore widely subjective. In the case of TA, 6-15 participants are recommended for research as part of a professional doctorate (Terry et al., 2017). However, it is acknowledged that the number of participants does not necessarily reflect the quality of the data and there are additional variations in what number is considered appropriate for publishing research (Burmeister and Aitken, 2012; Terry et al., 2017). The current research therefore aimed to recruit between 6 and 15 participants to conduct an appropriate thematic analysis.

Data Collection. The current research considered a schedule of questions to guide the data collection in the interview, which was developed into an interview guide from previous research and consultation (Kallio et al., 2016) (Appendix L). These included questions about: the circumstances surrounding detention (Chambers et al., 2014); the experience of admission under detention (Loft and Lavender, 2016); experiences of compulsory treatment (Gault, 2009); demographic information (Hughes et al., 2009); and views on the appropriateness of detention (Katsakou et al., 2011). Interview guides are considered helpful because they allow the researcher to follow the overall aim of the research with a degree of consistency and structure (King and Hugh-Jones, 2019). However, this does not mean to say that the interviews were conducted identically, but rather that they were simply anchored by a basic framework (Arthur et al., 2014). The questions were simplistic and open-ended to facilitate participants' own interpretation and elaboration. The interview guide also included a narrative structure which was reflected in the chronological order of questioning (Coolican, 2014). Notably, participants were specifically asked about their experiences of detention with respect to ethnicity. Although demographic questions can be perceived with apathy or discomfort, some brief questions were included in the interview guide to situate the sample (Patton, 2015). These included questions about age, gender, length of detention, diagnosis and self-identified ethnicity. The interview guide was not subject to consultation with service users due to practical limitations, though it is acknowledged that this can considerably improve such research (Trivedi and Wykes, 2002; Kallio et al., 2016).

The interviews themselves broadly followed a framework for responsive interviewing which includes main questions, follow-up questions and probes (Rubin and Rubin, 2011). In particular, the interviews aimed to be interactive and generate a depth of meaning (Yeo et al., 2014). This was adapted, where possible, according to suggestions for research with minority groups, which included particular attention to the initial part of the interview, rapport building, making participants feel comfortable and using simple and open-ended questions before more complex inquiries (Moser and Korstjens, 2018). Moreover, use of inclusive language is considered especially important (Bonevski et al., 2014). It is also suggested that research with minority groups is facilitated by participants' satisfaction with the location of the interview and flexibility with appointments, however this was practically limited by the inpatient setting (Liamputtong, 2010; Bonevski et al., 2014). During the interview, follow-up questions and prompts are recommended to encourage dialogue with participants (Moser and Korstjens, 2018). However, overly lengthy data collection processes should be avoided if possible (Bernal et al., 2014). The end of the interview included a debrief which reminded participants of the research information and thanked them for their participation (Yeo et al., 2014). Finally, the researcher maintained a reflexive journal which incorporated the interview and reflected on it throughout.

Research Procedure. The research process began with arranging visits to the wards and liaising with ward staff. During these visits, the poster advertisements and PIS were distributed and discussed with ward staff to ensure that they were sufficiently aware of the study. These contained details including the aim of the study, what would be asked of participants and ethical considerations such as informed consent. The researcher also spent time on the wards to become familiar to participants and, over several visits, spoke to potential participants about the study and what it involved. The poster and PIS provided a telephone contact number for participants to contact if they had any questions about the study. Participants could also communicate with ward staff to express interest in the study. Both the written materials and the researcher's verbal communications highlighted that the researcher was separate to the ward staff and the Trust. Eligible participants who expressed an interest in the study were invited to discuss it in more detail with the researcher and were given copies of the PIS and CF to consider in the meantime. Finally, ward staff were liaised with to arrange a time that was convenient for the participants, the researcher and the ward.

The researcher then met with participants to discuss the PIS in detail, allowing for participants to ask any questions. When the researcher and participants were satisfied with the PIS, participants were given a minimum of 24 hours to decide if they would like to proceed. For those who did, an interview time was agreed with the participant and ward staff. Interviews were conducted from September 2019 until January 2020. Participants reviewed and signed the CF prior to the interview commencing. Interviews took place on the ward in private rooms. To manage risk, ward staff were notified of the interview taking place and the researcher wore a personal alarm. The duration of the interviews was expected to vary, though participants and ward staff were given an approximate length of one hour. The interview guide was followed and began with demographic questionnaires before exploring experiences of detention. The researcher used an audio-recording device throughout the exploratory questions in order to collect the data. Once these questions were concluded, the audio-recording was stopped. The researcher then completed a debrief with participants, which included inviting them to review the research findings and providing them with a £10 cash gesture of thanks.

Data Analysis

The data collected from the study included demographic information about participants, exploratory questions from the interview and the researcher's reflexive journal. All of these were used to conduct an analysis.

Data Transcription. The approach to transcribing the data was determined before the interviews commenced, according to the philosophical and theoretical assumptions of the research paradigm (Creswell and Poth, 2018). This included an intention to focus on participants' qualitative descriptions of their experiences as data to be interpreted. Transcription therefore involved writing a verbatim account of every verbal communication in the interviews, with line numbers and clear demarcation of the participants' and researcher's speech (Coolican, 2014) (Appendix M). Non-verbal communications were not included in the transcript, as the research paradigm focussed on interpreting the content of participants' verbal responses, rather than their behaviour. In any qualitative research, it is possible that participants will use language that the researcher does not understand and this also applies to minority groups (Trimble and Fisher, 2006). In these instances, the researcher sought clarification within the interview and this was included in the transcript. Transcription was completed within days of the interview by the researcher. This included transferring audio from the recording device to a computer and using word processing software. Parts of the interview that may have compromised anonymity were redacted, including information relating to geographical locations and identifiable people. The transcript documents also included the demographic information collected as part of the interview. Once completed, transcripts were proof-read by the researcher before being saved as final verbatim records of the interviews.

Thematic Analysis. TA has been outlined as a six-phased process with instructions on how to conduct each phase (Braun and Clark, 2006). Crucially, because TA can be flexibly adapted, the researcher conducted the analysis with explicit theoretical and philosophical assumptions as well as reflexivity. Therefore, the analysis took an inductive approach, allowing themes to emerge from the data without restraints of existing theory or methodologies (Thomas, 2006). However, it is acknowledged that the researcher has knowledge of previous research and theories and this may have influenced the analysis to some degree. Themes were developed through latent coding which relates to interpretation, rather than semantic coding, which is a description or summary of the data (Terry et al., 2017). The six phases of TA are: familiarising yourself with the data; generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. The researcher attended to these instructions alongside a published example (Maguire and Delahunt, 2017). Familiarity with the data and the generation of initial codes were achieved firstly through transcription and subsequently through reading the final transcripts repeatedly (Terry et al., 2017). Importantly, codes were generated with enough information to reflect the content and interpretation of the data, without requiring constant reference to the raw transcript (Braun and Clark, 2013) (Appendix N). Initial themes were then created by linking codes together and mapping themes and sub-themes based on patterns of meaning (Terry et al., 2017). Initial themes subsequently required further scrutiny and definition, to ensure that they worked well and appropriately reflected the data. This involved reading the transcripts with the themes in mind and developing provisional titles. Several thematic structures were developed and reconsidered through research supervision. Finally, the themes were drafted into a report of the analysis.

Quality Assurance. Qualitative research is often dismissed for lacking rigour compared to realist and positivist concepts in quantitative research (Cope, 2014). However, objectivity is not the aim of qualitative research; it is intentionally and necessarily more subjective, in service of breadth and depth in complex research areas (Taylor et al., 2015). Nevertheless, there is an explicit emphasis in qualitative research on rigorous frameworks to ensure quality (Frost and Bailey-Rodriguez, 2019). Quantitative data typically focusses on concepts of validity, reliability and generalisability, which may also be applied to qualitative research. In this context, validity relates to the appropriateness of the research paradigm and process, reliability relates to the extent to which the research is replicable, and generalisability relates to how widely the research findings can be applied (Leung, 2015). However, it also argued that qualitative research should replace positivist criteria of validity, reliability and generalisablity with credibility, transferability, dependability, confirmability and authenticity (Guba and Lincoln, 1994; Denzin and Lincoln, 2011).

Firstly, credibility refers to the extent to which the research findings appropriately reflect the respective realities of the participants, in this case as described in the interview (Lincoln and Guba, 1985; Lincoln et al., 2011). One crucial method for this is checking the research findings with participants. The current research offered this to participants who consented and, furthermore, ensured that the analysis was grounded in participants’ verbatim experiences (Ryan et al., 2007; Cope, 2014). However, it is acknowledged that the research paradigm does not facilitate one objective reality, especially because both the researcher’s and the participants’ interpretations are included. Credibility may also be achieved by prolonged engagement in the research setting, however this was not possible due to practical limitations. Secondly, dependability relates to how well the research may be audited by another researcher and broadly relates to transparency (Lincoln and Guba, 1985; Lincoln et al., 2011). This was facilitated by the researcher outlining a detailed research paradigm including theoretical and philosophical assumptions and reflexivity (Ryan et al., 2007; Cope, 2014). Thirdly, transferability reflects whether or not the research has applications outside of the study (Lincoln and Guba, 1985; Lincoln et al., 2011). It is acknowledged that qualitative research necessarily has limited generalisability, but this may be achieved by being explicit about the research so that others can judge the extent of its wider application (Ryan et al., 2007; Cope, 2014). This was again achieved in the current research by detailed reporting about the research context and participants. Fourth, confirmability addresses the objectivity of the researcher and involves a demonstration of how the analysis centred on participant responses rather than potential bias (Lincoln and Guba, 1985; Lincoln et al., 2011). This can be considered a function of the previous measures of quality, but is especially reflected in the researcher's self-reflexivity (Ryan et al., 2007; Cope, 2014). The current research therefore included self-reflexive statements in the method and discussion chapters, which represented the researcher's reflexive journal throughout the research process. In addition, the researcher sought consultation for the research findings as part of the analysis in service of confirmability. Finally, authenticity relates to how emotionally candid the researcher is, which is again a function of self-reflexivity and is demonstrated in the current research through reflexive statements (Guba and Lincoln, 1994; Ryan et al., 2007; Cope, 2014).

In addition to these general criteria for quality assurance in qualitative data, there are also specific measures for TA and research with minority groups. Because of its flexibility, TA can be vulnerable to a disconnect between the researcher's theoretical approach and their actual analysis (Terry et al., 2017). It is therefore suggested that, throughout the process of TA, quality is assessed against a 15-point checklist, which includes comprehensive codes, coherent themes and thorough analysis (Braun and Clarke, 2006) (Appendix O). This was used by the researcher to guide the six phases of TA. High-quality research with minority groups should also address and serve the purposes of the community it is carried out in (Lincoln, 1995). This includes a heightened self-awareness and reciprocity between the researcher and participants (Creswell and Poth, 2018). The current research attempted this through self-reflexivity and consultation, though it is acknowledged that this does not automatically confer quality. Overall, the researcher has primarily aimed to be transparent so that the current research may be accurately assessed for quality.

Dissemination. The research was considered for dissemination amongst participants, professionals and publications. Firstly, participants were invited to give their details if they wished to receive a report of the research following their involvement. Secondly, teams involved in the research were similarly invited to receive a report of the research and discuss the findings. This was somewhat limited by restrictions in place due to COVID-19. The research was also due to be presented at conferences, but these opportunities were also limited due to the pandemic. Nevertheless, the research will be drafted for academic publication where it can be further disseminated.

CHAPTER THREE: FINDINGS

Chapter Overview

This chapter reports the results of the present study. Firstly, the demographic characteristics of the participants are presented. Secondly, the themes and sub-themes interpreted from the thematic analysis are outlined. These themes will then be elaborated on using verbatim extracts taken from the transcripts of interviews with the participants. In accordance with the responsibility to protect the anonymity of participants, identifiable information has been redacted.

Study Sample

A total of 20 people expressed an interest in taking part in the study. Of these, 7 participants (3 male and 4 female) changed their minds after a 24-hour period and 1 (male) withdrew after giving consent. The reasons given included concerns about confidentiality and involvement of the NHS Trust, particularly with respect to being audio-recorded. Practical availability was also a barrier, amidst other demands and interests on the ward.

A final 12 people were recruited into the research. Information about the sample characteristics was self-reported by participants in a pre-interview questionnaire (Appendix L). The sample consisted of 8 females and 4 males aged between 20 and 57 years old. The mean age was 35 years (with a standard deviation of 11.43). Of 12 participants, 10 different descriptors of ethnicity were given. The number of days of detention across participants varied from 3 to 120. When asked for a brief description of the reason for detention, 6 participants gave an answer relating to a diagnosis of psychosis, while 4 participants reported that they did not know. The sample is situated in Table 1.

Interviews

The interviews lasted between 12 and 48 minutes. The mean interview time was 29 minutes and 32 seconds.

Table 1. Demographics of the Sample

No.	Age	Gender	Ethnicity	Length of Detention (Days)	Reason for Detention
1	42	Male	Black British/African Origin	5	Acute Stress Disorder
2	38	Female	Black Other	7	Paranoid Schizophrenia
3	41	Female	Black African	30	Split Personality
4	39	Female	African Jamaican Mexican American German	10	Don't Know
5	29	Female	British African	21	Psychosis
6	52	Female	Jamaican	3	Don't Know
7	57	Female	Black British	14	Don't Know
8	24	Male	Mixed Race – English/Zulu	47	Don't Know
9	20	Male	Black British	30	Psychosis
10	28	Female	Black British	21 days	Schizophrenia
11	19	Female	Caribbean and African	30 days	Psychosis
12	36	Male	Black African	120 days	Psychosis

Thematic Analysis

From the 12 interviews, 4 themes were interpreted, including 15 sub-themes. The themes and sub-themes are presented in Table 2.

Table 2. Themes and Sub-Themes

Theme	Sub-Theme
Help is decided by others, not tailored to me	Family betrayed me to get ‘help’ from the police I’m here because I didn’t get help when I asked Restraint is not help for psychological distress I’m being detained, but I don’t know why They’ll enforce what they think
I am not a person; I am a Black patient	I was detained because I was Black You get resigned to the inhumanity of racism Black culture causes problems too
Mistreated or neglected instead of cared for	I’m an animal in prison, not a patient in hospital Staff have no time to care Everything has to be signed off Left inside alone and outside of the loop Detention becomes a powerful deterrent
Sectioning can be a space for sanctuary and support	Time away from stress and harm You can get some support and sustenance

Theme One: Help is decided by others, not tailored to me. The process of being detained was described by participants as divorced from their agency or needs. Though a need for help was acknowledged, participants describe being denied access to the support that they wanted and forced into help as it was defined by others. The first sub-theme, *‘family betrayed me to get ‘help’ from the police’*, reflects experiences of participants feeling that their family’s fears overrode their personal perspectives and led to police involvement. The second sub-theme, *‘I’m here because I didn’t get help when I asked’* represents experiences of participants at their most vulnerable seeking help and receiving unhelpful responses. The third sub-theme, *‘restraint is not help for psychological distress’*, highlights the discordant experiences participants had of their mental health detention involving restraint. The fourth sub-theme, *‘I’m being detained, but I don’t know why’* demonstrates the disconcerting impact on participants of being detained in a way that is decided by others and not tailored to them. The fifth sub-theme, ‘*they’ll enforce what they think’* relates to participants’ experiences of being subject to the views and actions of others, which were often incongruent with their own.

‘Family betrayed me to get ‘help’ from the police’. When describing the circumstances of their detention, many participants reported incidents involving their family members, the police, or both. These experiences were characterised by family members that were described as disproportionately alarmed and by the police being called upon as result. Participants found neither of these experiences helpful and described being detained in such a manner as being subject to a loss of control. Participant 5 explains how her family contacted the police following an argument, which she felt was an overreaction. She describes feeling angry and humiliated and as though a line had been crossed. Participant 1 adds a sense of the whirlwind speed at which a similar process happened to him.

> “I just felt weird. Why’re they calling the police on their own daughter, their own wife?… I’m not mental or anything, I just stamped my foot because they’re humiliating me and that, they’re not meant to do that. That’s why I stamped my foot and I got angry”
> (Participant 5)

> “My dad looked scared, I could tell, cause his eyes was just transfixed. And my mum panicked, thought I was gonna attack my dad, why am I gonna do that? And, she

> called the police, within three and a half minutes the police were there. So that's how I became here for the second time"
> (Participant 1)

When being detained, participants find themselves in an incongruous context where agents of law and order are involved in their family and healthcare. As such, managing behaviour perceived to be risky becomes conflated with providing clinical support. Participant 6 demonstrates this when she recalls being antagonised by police officers in an ambulance. She states that this was at the behest of her mother, with whom she had an acrimonious relationship with.

> "then all of a sudden, they [police] handcuff me, in the ambulance. And I said, like "What's going on?". "Oh you not well", she [Mum] says, "You're not well". I said, "Mum what you talking about… the police were really antagonising me, there were three of them in front of me and they just kept calling me names and saying how horrible I was to my mum"
> (Participant 6)

Even when police involvement is understood, it nevertheless creates confusion and distress because the police are not associated with mental health difficulties. Participants find themselves interpreting police involvement as an indication of criminal behaviour rather than support. Participant 9 says that it was necessary for the police to be involved, but describes being detained as being arrested. His experience also reflects how help can be decided by a lack of preferred options, defaulting to police involvement. This was echoed by Participant 12, who felt as though if he was not detained, the police would decide he should go to prison.

> "Well, my mum wanted me to talk to people. I didn't wanna talk to no counsellors. So the police had to get involved for my own health and safety… It was kind of, um, not a nice experience at all 'cause I never been arrested before. However they didn't arrest me, they just took me to this place."
> (Participant 9)

> "Okay, er, basically, I was talking to myself on the streets, 'cause I was hearing voices. But, like, they [police] thought, like, obvi-, obviously that's not, er, it's not

> good behaviour for citizens to be carrying out in the, in, in public. So I had to be detained to calm myself down… it was either prison or mental home. And they [police] decided mental home."
> (Participant 12)

'I'm here because I didn't get help when I asked'. When describing the circumstances of their detention, some participants spoke of feeling like life was not worth living and said that they had thoughts of ending their lives. When this was reported to services, participants described not having their needs met and reported that their distress escalated subsequently. Responses from services were felt to be particularly inappropriate due to the level of distress participants were experiencing at these times. The sub-theme demonstrates how help is determined by others, not by the participants themselves. Participant 2 describes a protracted experience of seeking support a number of times and receiving conflicting responses. Participant 7 adds that she spoke to her GP about feeling depressed and did not get help, which led to her feeling more suicidal.

> "Basically I felt suicidal, um, so I called, um, A&E, um, and I told them that I felt suicidal and they said that I should get myself to A&E straight away… Um, so I went into A&E… um, the second time I went to A&E, I went the day before, and they gave me sleeping tablets and sent me home. Um, this time, they said they're going to section me under Section 3."
> (Participant 2)

> "So when, months ago when I approached my GP and I said to him that I was feeling depressed, I should have got help then. Rather than when it becomes too late, so that's where I feel I've been let down. 'Cause I verbalise it, when I'm feeling something, I don't hide stuff, I let it [out] 'cause you know how I'm feeling. And I went to my GP probably about six months ago and told him that I'm literally depressed. So, I think, at that time, I feel he should have taken it more seriously"
> (Participant 7)

When detention is a response to suicidality or family distress, the experience of detention itself can result in additional distress. The processes involved in detention, such as observations, can be experienced as distressing and further affect the mental health of those subject to them. This may compound participants' experience of receiving ill-suited support at the hands of others at a time of great need. Thus, the potential emerges for a vicious cycle where peoples' initial distress is exacerbated by detention and leads to responses which are used as grounds for further detention. This is demonstrated by Participant 7, who describes being on a lesser section (it is not clear which, perhaps a Section 4) and finding the processes involved distressing. She reports that her responses to being sectioned led her to be put on a further Section 2.

> "I was suicidal. And I felt, felt like, I was suicidal. I was, um, monitored under a lesser section initially. But because I was being, um, er, like restrained and um followed everywhere... I started to like breakout and, um, try and get off the ward and be quite disruptive. I admit to that. Um, with that happening, I was then given a Section 2."
> (Participant 7)

Although detention may physically prevent somebody from a risk of suicide, it can neglect to address crucial circumstances that lead to such distress. Where a person feels that life is not worth living, detention may be experienced as an inadequate response if it does not provide the appropriate support for these difficulties. The result is a maddening situation of being denied the support to live by one service and being detained for wanting to die by another. Participant 3 explains how her socio-economic circumstances led her to deciding that life was not worth living. She was living in a field and being sanctioned for failing to secure work. When describing the process of her detention, she explains that she asked for support for these circumstances and was not given the responses she needed.

> "If you're forcing me to live, give me the means, or get me a job and get me a decent place to wake up in the morning from, from there. And how do I apply for a job and everything living in the field?… Waking up in the morning, every day I cry that I'm alive because I'm just always think, urm, er, I need to die, I need to die. I just have, I don't wanna wake up, I don't wanna wake up… Maybe I could have lived if you've given me the responses."
> (Participant 3)

'Restraint is not help for psychological distress'. The use of restraint was reported by participants as part of the process of their detention. In these cases, participants describe chemical and physical restraint being used against them, causing distress and representing the experience of being subject to others' decisions when being detained. This is a paradox of the detention experience, where participants find themselves being helped for psychological distress through chemical and physical restraint. A focus on risk management ostensibly provides a rationale for others to decide that this is the help that is required. Participant 11 states that she was restrained for non-compliance when being initially detained. She conceptualises a rationale for the restraint, but nevertheless describes the physical discomfort she endures.

> "So when I was being detained there was more than ten to fifteen people trying to control me because I wasn't conforming… they're quite handsy, they're very, like, they will grip you up to make sure you're not gonna hurt anyone when you're being restrained, it's not nice."
> (Participant 11)

Participant 7 similarly reports an understanding of why restraint was used in response to her behaviour. However, she also describes how the process of being both chemically and physically restrained started her experience of being subjected to the decisions of others.

> "Yeah so, um, I was very, very disruptive. Now, that's not my normal behaviour. I was, um, put on the floor, given an injection, um, taken back to my bed."
> (Participant 7)

Although the use of restraint may be understood by participants, experiences of excessive force reveal the extent of the harm caused when such measures are used to detain people. Participant 4 voices the inner monologue of mental health professionals using both physical and chemical restraint, which she explains was to ensure that she was completely overpowered. Participant 6 recalls being restrained by the police and finding that her attempts to draw attention to the pain that she was suffering went ignored.

> **“**And then, this time we [professionals] have to get ten in the room, we wanna triple her [medication] this time so she can’t fucking do nothing to us… you got twenty men just jump on you. I had twenty men jump on me.”
> (Participant 4)

> “They restrain you. You know, in a most awkward position, your hands are like that and I kept telling them, the bar [of the handcuff] here is hurting. And he kept wrenching it and I was screaming.”
> (Participant 6)

‘I’m being detained, but I don’t know why’. The impact of detention being decided by others and not tailored to individuals is that those who are detained can feel confused, angry and frightened about what is happening. It can be unclear why it is happening, what it is going to involve and who is accountable for taking such action. Participants describe all such experiences alongside the associated emotional impact of not knowing and not having their needs responded to. Participant 9 outlines his initial confusion at the whole process of being detained, leaving him feeling as if he had done something wrong to be in such a position. Participant 10 shared this feeling of being left wondering why it was happening.

> “I was just thinking, what’s happening? What’s going on? Because I haven’t done nothing wrong and I literally that’s all really, so I was thinking, what’s going on?”
> (Participant 9)

> “I was, um, extremely upset because it just felt like, why, and what difference is it gonna make if I’m on section?”
> (Participant 10)

This disorientating experience of detention also creates a considerable amount of fear. Participant 8 describes how not knowing what was happening led him to feel frightened. He said that he believed his life was in danger while he was being detained, highlighting just how distressing an experience detention can be.

> “I was scared for my life, I thought I was here to be murdered. I thought they brought me here just to kill me. Or just to make me worse.”
> (Participant 8)

Anger was also reported as a response to the process of being detained without knowing what is happening. Participant 3 explains how not having access to information about her sectioning left her feeling frustrated and exacerbated her distress. This reveals a sense that the detention is happening to participants, rather than with them, and demonstrates the way in which this leaves participants excluded from their own care.

> *“*It can escalate, being in a situation like that, being sectioned without information... I want to know the reasons of my sectioning and my diagnosis and who did it. I, that was all that I wanted. I wanted to know what, why am I, why has that person sectioned me and I still haven’t had the answer. I need to know who diagnosed me, what my diagnosis w-why am I sectioned?”
> (Participant 3)

Similarly, participants can be given information that is meaningless to them. This can cause disorientation when participants do not feel that what is happening relates to what they are experiencing. Participant 5 was aware that she was sectioned, but was unsure what this meant. Participant 7 adds how things only become clear later.

> “I’m Section 17, I don’t know what that means. Maybe I might be here for a long period of time.”
> (Participant 5)

> “So you’re sentenced to section, you don’t realise what it entails. It’s only when you’re in that place, being sectioned, that you see the true reality of it all.”
> (Participant 7)

‘They’ll enforce what they think’. Experiences of detention were frequently associated with others’ presumptions, labels or other thoughts being put onto participants. This reflected a lack of autonomy that participants described as well as a sense that it was futile and frustrating to try and be heard. Instead, participants described either being excluded from

decision-making processes entirely, or otherwise experiencing that the views of professionals overrode their own. This led to serious consequences for participants' feelings of safety and power. Participant 2 describes being left out of the decision-making process and being sectioned afterwards.

> "They'll say we'll have a discussion. They have their discussion and they say, they look at the records and then they say let's section her. And they choose a section and section you."
> (Participant 2)

The decisions made by others were described by participants as based on assumptions or conceptualisations of professionals. These were not shared by participants and it was felt that this reflected a lack of understanding by professionals about participants' own views and experiences. Participant 10 describes how decisions were made about her because clinicians did not know her well, and therefore assumed risks of absconding or harm to others.

> "I had a ward round with my doctor but he didn't know me. It's the first time I've been in his care. And he put me on a section 5(2), because he thought that I was gonna run away from the hospital."
> (Participant 10)

> "Because, um, well to me it feels like it's a punishment because I did not abuse anybody, I did not get into trouble on the outside in the community, so for them to section me, um, just because they thought I was going to run, um, was, um, a bit of a discrimination really… presuming that I'm gonna do something without, um, any, um, evidence that, that I will do that or any opportunity for me to do that."
> (Participant 10)

In addition to risks, participants described different conceptualisations of mental health problems from professionals that did not feel congruent with theirs. Participant 3 describes how difference is deemed abnormal and pathological. Participant 8 describes how the diagnosis he was given did not reflect his life experiences, which were more significant.

> “The person who’s not normal or who’s weird or who’s different is mentally ill.”
> (Participant 3)

> “They just labelled me as, as schizophrenia or something like that. But really it’s marijuana which, and my difficult life, which I’ve had in the past. It just came together, it just made this trauma.”
> (Participant 8)

The effects of such conceptualisations or decisions being enforced were significant. Participant 4 describes having a particular medication regime enforced, despite her strong protestations. She explains how this leaves her without a voice and afraid for her life. Participant 7 further describes how she was left feeling like it was pointless to resist and like she had to accept a section being imposed on her.

> “And my doctor here now is giving me the same drug. Why would he give me the same drug? Why would they give me the same drug? I don’t know (sobs). I’m terrified, it’s the truth, I can’t speak. I don’t have a voice. I can’t say anything, I can’t tell him that “I’m not happy with that, you’ll have to find something else”. It won’t do anything, he’s given me that, that’s what I’m still in here to get and I’m frightened that I’m gonna die.”
> (Participant 4)

> “At first I said no, but then as time went on, that was imposed on me so it wasn’t an option anymore… it felt difficult, but it gets to a point where you can’t fight anymore. So you just start accepting.”
> (Participant 7)

Theme Two: I am not a person; I am a Black patient. The second theme brings together participants’ reports of how their ethnicity was involved in their experience of detention. It reflects an overall perception from participants that their experience was never just of being a patient. Instead, their ethnicity was linked to various aspects of their detention, described as an additional difficulty to the experience of being detained. The first sub-theme, *‘I was detained because I was Black’*, includes participants’ explanation of their detention being directly and indirectly linked to their ethnicity. The second sub-theme, *‘you get* *resigned to the inhumanity of racism'*, reflects participants' descriptions of racism while under detention and their response to it. The third sub-theme, *'Black culture causes problems too'*, outlines participants' reports of differences within and between BME communities that have adverse effects.

'I was detained because I was Black'. Participants reported both direct and indirect relationships between their ethnicity and the reason that they were detained. Ethnicity and racial prejudice was discussed across a spectrum of experiences. It was associated with the context leading to detention, the factors influencing the decision to detain and the true target of detention overall as a mechanism of control. Participant 6 explains her belief that detention is used as a means to sedate and remove Black people from society. The experiences she has had have led her to conclude that Black people, especially Black men, are detained for socio-political reasons and she further suggests that death in mental health custody is a result of this.

> "That's a racial thing. The less, the least of us on the street, the better. Especially the men. That's what I think. I think, I think they want it. I think they get us in, drug us up, some of us never come back. I've been in seven times, drugged up and I'm still here. Compus mentus. That's what I think, it's racial."
> (Participant 6)

It is not clear from the description who "they" are, which may reflect a sense that this experience is not limited to an individual system or circumstance, but rather a more universal experience of being Black. Participant 4 does identify specific people, referring to professionals as a grouped "they". She explains how she is treated differently as a Black person by being left out of the decision to detain her. She describes how others feel able to judge her experiences from hearsay, which she later clarifies as medical professionals' previous experiences and records of her.

> "Being black, black people get torn apart. Black people get torn apart. Or they listen to the grapevine, which is just hearsay by people and then that's it… You have to go to the person yourself and find out yourself. You can't just through hearsay can you? Doesn't really work, does it?... They've [medical professionals] been living in the

> past… [talking about previous experiences of me] from way back when, “she was doing this and she was, we did this to her, we’re gonna do it to her again”.”
> (Participant 4)

Experiences of racism are not limited to the ward during detention. There are links between experiences of racism and psychological distress, and this distress can subsequently be what leads to detention. Participant 8 describes how experiences of racism in employment led him to traumatic distress, which resulted in his detention.

> “I was being fired from job to job…That drove me to a trauma. You know, like I was not working properly. I just, yeah, [being fired] just brought racism into me. You know, it made me feel like oh, everyone’s racist.”
> (Participant 8)

‘You get resigned to the inhumanity of racism’. Racism experienced whilst under detention was described as being representative of racism experienced in general life. Participants describe racial abuse and stereotypes that are held in wider society and are reproduced during detention. As a result, participants report being somewhat desensitised or disempowered by these experiences. The racism described is centred on Black people being inhuman, with references to either subhuman or superhuman stereotypes. Participants 6 and 7 both report experiencing verbal racial abuse during their detention. They describe how this is what they experience in day-to-day life, so there is little expectation that it should be different during detention. Neither participant differentiates who the abuse is from, perhaps further reflecting a widespread experience.

> “There’s a few foes, few racists in there calling me nigger, monkey and whatever, but, I get that every day anyway so it don’t really bother me anymore.”
> (Participant 6)

> “Yeah, so I do get, um, name calling sometimes. I hear the odd word like nigger and all that. But that could be outside in the real world, so I just totally ignore that.”
> (Participant 7)

This may reflect the pervasive and chronic experience of racism in wider society, demonstrating that it has become commonplace to experience racial abuse, even when vulnerable. However, it may also reflect how detention could be representative of wider systems of racism that Black people experience. While it is not clear who the perpetrators are, the fact that participants have little expectation of being protected against such abuse during detention is revealing. It perhaps suggests that their conceptualisation of detention is one that is congruous with a wider racist system. Participant 2 builds on how racism in wider society leads to racial stereotypes that punctuated her care during detention. She explains how an assumption that black people are inhumanly strong leads to physical abuse and suggests that this is neglected by the police when reported.

> "I mean we all know, there's no point kidding ourselves, this is generally a racist country. Um, from my experience of fifteen years of having a mental illness. Being black, you are treated as if you're superhuman, you've got superhuman powers. Um, I've had, you know, I've had someone break my nail backwards, um, and it bled, I called the police, they were supposed to come in to see about it. Um, yeah, you know, you just get treated differently because you're black. They assume because you're black that you're stronger, um, you know, you can take it."
> (Participant 2)

As Participant 2 demonstrates, some participants do report feeling distressed by their experience of racism, but also feeling disempowered from reporting it or overpowered from resisting it. Participant 4 agrees, describing a racialised perspective of Black people which led to attempts to sedate, tame and control her.

> "Sometimes it can be racism. Sometimes it can be they, you're hard to be controlled, so they will Acuphase [antipsychotic medication] you, they will sedate you so you, you, you can't, you can't defend yourself even verbally. They shut your brain down… [a professional said] that's what we have to do, we have to tame her that way. And then, this time we have to get ten in the room, we wanna triple her [medication] this time so she can't fucking do nothing to us."
> (Participant 4)

Such experiences extend across the experience of detention, again suggesting that a sense of racism that is widespread. Indeed, Participants 2 and 4 further report experiences of being treated differently based on their ethnicity in other aspects of their detention. Participant 2 describes inequalities in her physical health that she feels would not happen if she were White. She later adds experiences of differences between BME groups with relation to food. Participant 4 describes a perception that other minority ethnic groups are treated differently, stating that they may receive a level of care that Black people do not have access to.

> "I'm incontinent, so I've been constantly asking for incontinence pads, but, they're not given to me. But if I'd been elderly and White, they probably would have been given to me."
> (Participant 2)

> "My only thing is, there's food for Caribbean people, but there's not food for African people. But African people can eat Caribbean food anyway, but that was just something that I thought of."
> (Participant 2)

> "A Black person come in, and would just sit a whole meditation and you monitor them without medication as it's against our religion and we would start to get forced and held down and all sorts of things. But an Indian will come in and an Indian will be praying five or six times a day and have special requirements and they're always met. What is, what is that?"
> (Participant 4)

'Black culture causes problems too'. When discussing the relationship between ethnicity and detention, some participants felt it was important to recognise that Black culture and different Black communities can be the source of difficulties that lead to detention. This ranges from cultural differences in socialisation in different Black communities to cultural clashes on the ward during detention. Participant 1 describes his belief that Caribbean culture can facilitate a socialisation to detention. He differentiates himself as an African man and speaks about the differences he perceived growing up with Caribbean men.

> "Cause Caribbean men in general, their dads, they're normally known for running away from situations, right? But if a Caribbean boy has been brought up by his mum, it means the boy is gonna be ruthless, right?... Say for instance, their dad has been detained, or their uncle has been detained, they see it as a way of life, as [thinking] I'm not tough unless I get in trouble."
> (Participant 1)

Some differences are less clear and are hypothesised. Participant 11 describes a propensity for ethnic minority women to be involved in fights, which she attributes to an abundance of energy. This, she identifies as being distinct from calmer White people.

> "I think there's, it's just too much energy. Not trying to be funny, but it's, it's like that in here. Like, the White people, they're quite calm, they keep themself to their self. But when there's a fight, there's a fight between minorities."
> (Participant 11)

Experiences of differences between Black people is also experienced by participants from staff members. These experiences dispel an assumption that Black members of staff provide better care for Black people under detention. Participant 2 puts this bluntly.

> "They have few white staff, but it's mainly African staff, and then that's not to say that because it's African staff you get better treatment. Um, sometimes they do empathise with you, other times they'll make your life more difficult."
> (Participant 2)

The differences between staff and patients in terms of ethnicity is described as cultural and leads to clashes in care. Participant 10 suggests that she has more adverse experiences with Black staff members than White staff members. She draws a distinction between Black people who are born in Britain and those who are not.

> "Cause I'm Black British and not black African, like from Africa, I don't get along with most of the Black staff in the hospital, unless they're Black British too… They don't understand me, they, they disrespect me, because I don't follow their culture,

> their tradition, and I don’t know their language so they look at me as I’m dumb… I get discriminated by the Black staff even more than, the Asian, or the white staff.”
> (Participant 10)

Participant 1 similarly implicates a language barrier as a key difference. He describes how language can be used by some Black members of staff to exclude him from discussions. He suggests that the reason for using different languages is to conceal inappropriate discussions.

> “When I go over there and I can hear them [staff] speak [in another language], I can translate quickly in English and then they’re shocked. Now they know that when they speak, they need to be careful what they say.”
> (Participant 1)

Stigma is also described as part of the experience of being detained by participants. The stigma of being detained is described as being prevalent in the Black community, although it is not clear where this originates from. Participants report feeling anxious about this when thinking about being discharged from detention. Participants 6 and 7 describe their perception of what people in the Black community say about those that have mental health problems or who have been detained. It is described as another obstacle that participants have to face when they are detained.

> “The stigma. Once people, especially Black people, they have mental health problems, they shun you. [They say] “Oh she’s mad, look at her, oh she’s in mental health, oh look at her”. It’s a real big taboo in the Black community.”
> (Participant 6)

> “Going into the big world, that’s gonna be another issue. ‘Cause to be that girl sectioned, [they say] “She was sectioned, she’s mad”. I’m not mad… I think in regards to being Black and, um, being Black and being sectioned, I think there’s less understanding in our community.”
> (Participant 7)

Theme Three: Mistreated or neglected instead of cared for. The experience of detention was associated by all participants as being at odds with their normal lives and their fundamental rights. This theme relates to participants describing detention as being something that should not be happening in the way that it is because it is divorced from both normality and justice. The first sub-theme, *'I'm an animal in prison, not a patient in hospital'*, brings together the frequent comparisons participants made between feeling like an animal or being in prison when under detention. The second sub-theme, '*staff have no time to care'*, relates to participants' descriptions of staff being neglectful. It includes benevolent perceptions of hardworking staff not having adequate resources, as well as experiences where participants felt staff were directly uncaring. The third sub-theme, '*everything has to be signed off*', reflects the experiences participants had of being subject to policies and practices on the ward, which were felt to be frustratingly disproportionate. The fourth sub-theme, *'left inside alone and outside of the loop'*, represents participants' feelings of isolation on the ward during detention. It includes descriptions of being secluded from important people or from processes inside and outside of the hospital. The fifth sub-theme, '*detention becomes a powerful deterrent'*, relates to participants' description of detention as a deterrent for future admissions. It includes how their current experiences have shaped a motivation to never have to return, either through their own realisation or through warnings from others.

I'm an animal in prison, not a patient in hospital. The concept of being detained for healthcare or safety was roundly rejected by most participants. Instead, they drew attention to the paradoxical experience of distress that was directly caused by detention itself. This was alternately referred to as being treated like an animal or feeling imprisoned. These two comparisons were widespread across the experience of detention. A lack of freedom was referenced as a key experience that made participants feel as though they were animals. Participant 7 describes the process of restraint and observations in this light and Participant 11 relates the comparison to being restricted from access to the outdoors.

> "But because I was being, um, er, like restrained and, um, followed everywhere, I just felt like I was at, like a animal or, I didn't have, like, any freedom."
> (Participant 7)

> "I felt like I was being treated like an animal. I wasn't allowed to go outside, I wasn't allowed to have fresh air. The only fresh air you get is from the cracked windows and it only opens so much."
> (Participant 10)

References to prison were both general and specific. Participant 8 summarises his whole experience of being detained as like being in prison, whereas others spoke of being deprived of basic necessities and preferences. Participant 6 represents the frustration of many that smoking is heavily restricted, arguing that it can be the only remaining comfort for those who are detained.

> "My sectioning here feels like a prison cell. Yeah, I think I will leave it like that. It feels like I'm trapped in prison."
> (Participant 8)

> "I feel like I'm more in prison than I am in a mental institution. I do, it feels like a prison… There shouldn't be restrictions on smoking, not in a mental institution or prison 'cause that's the only thing they've got."
> (Participant 6)

Although smoking was frequently mentioned, access to other basic necessities was highlighted as a reason for why detention was akin to prison. Participant 10 talks about having to use the same items every day, which conflicts with her sense of womanhood. Participant 11 reports that she was deprived of a medical product, which left her feeling as though she was in prison receiving rations.

> "[It was] absolutely awful. Awful because I'm in the same clothes. I wash my clothes, put the same clothes back on. Wash my hair, put the same shampoo, like, I'm a, I'm a woman, I like to have different smells, I like to have different shoes, I like to have different make-up."
> (Participant 10)

> "For example, I have medical cream for my skin… I would have to shower, put on my clothes, I'm all dry, and then I get like a little tiny sample of my cream and it's not

> enough for my whole body so it doesn’t make sense. So I, in that sense, I felt like I was in a prison the whole time.”
> (Participant 11)

The feeling of being in prison was also characterised by an emphasis on coercion and good behaviour, rather than improved health. Participants talked about a need to be compliant in order to access support or be discharged. In these cases, participants do not refer to care or wellbeing, but instead describe experiences of coercion. Participant 3 talks about being coerced to comply in order to access legal support, whereas Participant 11 describes coercion towards good behaviour in order to be discharged from detention. Such behaviours include being helpful to the staff.

> “This is how these people treat you, you have to, you have to comply otherwise you are not going to get a call from the solicitor.”
> (Participant 3)

> “I just followed the rules ‘cause I knew that if I just be good and then eventually I won’t be sectioned… [being good involves] being friendly with staff, talking more, interacting, helping out if they need help.”
> (Participant 11)

Experiences of medication during detention draw together experiences of coercion and a lack freedom that were associated with references to prison and animal treatment. Participant 4 twice relates medication to being treated as an animal. First, she describes how the medication regime leaves her feeling as though she was part of a commercial animal testing lab. She subsequently summarises her experience of detention as being treated like an animal due to the medication she is given. Participant 7 adds that medication is administered with threats rather than appropriate information and collaboration. This reflects the experiences of coercion alongside threats of ongoing imprisonment.

> “They use medicine as, to people that, like we’re guinea pigs. It’s like marketing of madness.”
> (Participant 4)

> "I'm not an animal, and they treat me as though I'm an animal. They gonna give me this Clopixol [antipsychotic medication]."
> (Participant 4)

> "The medicines that you get given. I don't think that you're properly advised or consulted or told about medications. You just get them…If you decide not to have your medicines, then you're constantly told, "Oh look, you won't get out. You won't get out if you don't take all your medications"."
> (Participant 7)

'Staff have no time to care'. Although the lawful concept of detention may be detailed in policies and procedures, the operationalisation of care whilst under detention is experienced as lacking. Participants highlight how staff are unable or unwilling to carry out their duty of care, even when participants feel that the desire to care is there. Some participants were careful to say that they were not critical of staff and sympathised with their workload. Participant 1 describes his appraisal of the functioning of the workforce and Participant 6 acknowledges the volume of demands on staff.

> "But, if I'm being honest with you, I noticed a lot of inefficiencies in terms of the workforce, and this is not a criticism, it's just an observation."
> (Participant 1)

> "The day staff, I think they're too stressed, 'cause everyone wants to go in their rooms, everyone wants to smoke, and it is a lot of work."
> (Participant 6)

Other participants were also sympathetic to staff demands, but nevertheless highlighted the adverse interactions that were a result of this. Participant 2 gives two accounts of how overworked the staff are and describes how she can have both positive experiences of care and negative experiences of aggression. Participant 10 echoes the latter experience, explaining that understaffing can result in members of staff being unpleasant.

> "I find staff really helpful… They're really caring. They're, they're really stretched, they do their best."
>
> (Participant 2)

> "I find the staff to be overstretched, um, to be quite aggressive… I find their attitude quite abrupt."
>
> (Participant 2)

> "Majority of the time the staff is short staff or they're busy, so they really rude to me."
>
> (Participant 10)

The level of care received by participants appeared to be determined by the availability of staff. Access to person-centred support was not routinely experienced by patients as a result of this. Participant 4 describes being turned away by staff when attempting to develop a care plan. She later describes how even small interactions with staff can have a significant emotional impact. Participant 5 describes how she can only enjoy an activity on the ward at restricted times due to the availability of staff, rather than according to her need.

> "I feel as though, if I'm talking to the staff, they just ignore, [and say] just go away, just go away. They never got time to actually give me a care plan that is a meaningful care plan."
>
> (Participant 4)

> "I wake up and I ask straight away, Can I have a cup of coffee, please? [They say] "Ahhh, coming". I get sick to the stomach of being, I'm, I'm sick to the stomach of them."
>
> (Participant 4)

> "You only get to come in here and do arts and crafts at a certain time, when staff is available. Not all staff is available all the time."
>
> (Participant 5)

'Everything has to be signed off'. Due to the policies and practicalities of the ward, there were a number of limits on participants' autonomy including access to outside areas and, in particular, the ability to smoke. Such activities required participants to have to make requests for what they perceived to be basic things. These requests were subsequently met with delays, compromises or dismissal. Participants described the significant effort involved in making requests and having them responded to. There was a particular sense that such requests were small, but nevertheless had to go through a number of measures to be approved and effected. Participant 7 describes how this is a core feature of detention. Participant 3 talked about how many requests are deferred to a formal meeting, rather than having an immediate response. Participant 5 explains how she was informed that she would be getting leave, but nevertheless has to wait for a doctor to formally approve it.

> "I mean you've lost your freedom, you have to ask to go out, you got to... everything, you just lose everything. So you do realise the extent of the section, so… that is something you don't realise if you're not sectioned."
> (Participant 7)

> "You, you, you're not even-, on admission you should be told about the solicitor. It should be the first thing. But, you, I, I had to ask for it and I had to wait for the ward meeting, everything, ward meeting."
> (Participant 3)

> "And then they give me the chance to go on leave for like three to five hours a day once or twice a week, but that hasn't started so I'm waiting for the doctor to give me an answer… They just said you have to just be patient. It's the doctor that decides whether it's Section 17, section that."
> (Participant 5)

Participants described the injustice of such decision-making processes and the subsequent decisions they lead to. Requiring approval for leave in particular was described as unfair. Participant 8 spoke about a sense of feeling like his rights were not being respected when leave was not approved. Participant 2 spoke of feeling like she was treated differently to others with respect to leave. Participant 10 adds how such meetings involved decisions which felt dismissive of important requests.

> "When I'm asking for, like, "Can you please, may you please sign me out?"… even though they know I've got leave, they still want more for me when, when they know that I've got rights. Just like every human being on earth. Every single human being on this earth has rights."
> (Participant 8)

> "But bringing someone in under section is a little unfair. I have other patients who are working, they go out to work and come back. There are other patients that are informal, can go and come as they please. Maybe they were Section 2 when they got here, but it just seems a little unfair."
> (Participant 2)

> "I've asked you for leave to go and send money to my daughter and, and, get Christmas presents for my son and for my family, and you're telling me you're gonna change my leave into escorted leave [instead of unescorted leave, which is less restrictive]."
> (Participant 10)

It was particularly acknowledged that the need to have everything approved was a facet of policies and procedures that participants felt were disproportionate, or not tailored to them. Participant 6 describes how important smoking is to patients, but how the processes involved make it incredibly difficult to actually do. She later highlights how the policy feels general rather than tailored to individual patients.

> "I know the laws have changed and you can't smoke inside, but we have a garden out the back, we can congregate there, have an ashtray, put water in it to make sure it doesn't get burnt… Listen, people are desperate to smoke, you think people are gonna set fire to anything? Alright, I can understand why, health and safety, but, have designated people then, that have lighters. Everyone's scrambling for the little bit of t-, littlest bit of tobacco, it's ridiculous."
> (Participant 6)

> "Alright if they can't hold their lighters, fine, but don't hold the lighters and the cigarettes like we're five year old children. [They say] "Here's one for you and we've got the lighter, you're not having it". I can understand the implications of some people who are more severely mentally ill than others. But for the ones I've seen out there, they just wanna smoke a cigarette, they ain't got time to burn down no building."
> (Participant 6)

'Left inside alone and outside of the loop'. The experience of being detained featured a degree of isolation from others that participants reported as challenging. This included being away from family and friends on the outside as well as being excluded from their own care whilst inside the ward. As a result, participants describe being stripped of important connection and autonomy as a result of their detention. Participants 9 and 10 talk about being scared and angry because they were away from their family and friends.

> "It was a scary experience, I didn't like it at all 'cause obviously I've been away from my friends and family for a month and a half. So it's not a really nice experience at all."
> (Participant 9)

> "I'm really cheesed off (laughs), I mean really cheesed off because I just wanna get out of here, I wanna see my kids, wanna see my family, wanna see my boyfriend."
> (Participant 10)

Isolation during detention can relate to economic matters as well as personal relationships. Participant 1 adds that his army of employees are slacking in his absence because, as their "general", he is not able to monitor them.

> "'Cause their general's not there, they're beginning to take the mick, right?"
> (Participant 1)

As well as isolation from the outside world, participants describe being left out of important processes happening within the ward. Participant 8 describes being left out of his own ward round, unable to contribute and feeling unhappy as a result.

> "'Cause first in my ward round, they didn't even allow me in my ward round. How would you feel about that? You'd be unhappy right?... Who wants their destiny to be decided without them there."
> (Participant 8)

'*Detention becomes a powerful deterrent'*. The impact of these experiences of detention, as being abnormal or unjust, results in participants feeling strongly motivated to never experience it again. This motivation is driven by fear of having the same experience again and this perhaps reflects the extent to which participants were distressed by their detention. Participant 2 talks about a friend who said that she would rather end her life than be detained again. She appeared to empathise with this position, describing the experience of detention as a trauma.

> "It's quite traumatic, um, yeah, so one of my friends actually said to me, if she was readmitted she would kill herself, because it's just such a, you know, soul destroying experience."
> (Participant 2)

The fear of detention can also mean that participants feel coerced into action, desperate to avoid repeat experiences. Participant 10 explains that her experience of detention frightens her into compliance with her medication. She repeats an emphasis on good behaviour rather than wellbeing, suggesting that the experience of detention is focussed on the former.

> "I know that it's gonna scare me to come back here. Um, I don't think I'm gonna come back here, I will take my medication… I will behave myself, um, even more, 'cause I really don't wanna come back here. It's just so daunting and so depressing."
> (Participant 10)

Even when experiences of being detained are considered helpful, this may serve as a deterrent for people to return to their lives and be discharged from detention. Participant 5 describes a number of anxieties about being outside of the ward and wonders whether she may be better remaining detained.

> "I don't know how to get to places on my own. I don't know, like, I don't drive, do I? I don't know how to follow navigation. I don't know how to guide myself to different places. Maybe it's better for me to stay indoors."
> – Participant 5

Theme Four: Sectioning can be a space for sanctuary and support. Some positive experiences of being detained were described by participants, including being able to do things that they needed to or avoid things that were causing them difficulty. Detention is thus described as being helpful in parts. These experiences were not often related to clinical support or healthcare, but rather to the secondary benefits of being detained. The first sub-theme, *'time away from stress and harm'*, represents participants' experiences of being able to recuperate whilst under a detention and be protected from some sources of distress. The second sub-theme, *'you can get some support and sustenance'*, relates to experiences of detention where participants have described receiving support that has felt helpful to their needs.

'Time away from stress and harm'. Detention as an inpatient necessarily involves the removal of a person from their existing environment. Participants describe this as helpful on a number of levels, from respite to safety. Detention is welcomed in this way as providing space for opportunities and experiences that may otherwise have not been possible. Participant 4 describes how being detained as an inpatient kept her safe from threats outside of the ward. Participant 6 agrees that detention gave her time away from an acrimonious relationship with her mother.

> "I use the hospital as a safety net for myself, away from danger. I used to utilise drugs, I don't utilise drugs anymore. But drug dealers are why I use mental health, to get away from drug dealers, so I don't die. I give my benefit money, most of my benefit money I give to the dealers so they don't hurt me."
> (Participant 4)

> “Peace of mind and not having to worry about her [mum] twenty-four seven [is a helpful part of detention]. Concentrating on me, just being me, having fun, laughing, smiling, crying if I want.”
> (Participant 6)

Being detained as an inpatient does not only provide safety from harm. Participants also explained how the respite created opportunities for enjoyable activities as well. Participant 12 explains how the space allowed for all manner of activities and suggests that these can be helpful for wellbeing. Participant 6 similarly describes being able to have some time and space, however quickly qualifies this with the limitations on smoking.

> “It’s just a place you can put your mind together. If it’s songs that you wanna write, write your songs. If it’s letters you wanna write letters, write your letters. If it’s calls you wanna make, it gives you a point to, to take life easier on yourself”
> (Participant 12)

> “It’s been okay here, I’ve been able to get my head together. Been reading. The only thing is the cigarette breaks, they’re just, too restrictive. Sometimes I just need to blow off steam and I, I can’t.”
> (Participant 6)

For others, the experience of being removed from usual life through detention creates an opportunity to reflect and refresh because they are away from previous stressors. In this case detention is described as providing a new perspective and energy towards discharge, particularly with respect to independence. Participant 9 articulates how being detained gave him the space to come to know the direction he wanted to take upon discharge. Participant 11 adds a sense of agency that she gained from detention.

> “It was like a little wake up call for me to wake up and let me know exactly what I want to do in life. And it’s actually helped me progress in life. It’s helped me become more of a man as well, myself… just being my own person, like, being my own man and being my own person and stuff.”
> (Participant 9)

> "Being sectioned has taught me to be a lot more independent, I think. Um, at home I would usually rely on my parents to do things for me."
> (Participant 11)

'You can get some support and sustenance'. Experiences of detention included some ways in which it was described as helpful. Some participants talked about the various forms of support that they received while detained. This support was not explicitly linked to the stated aims of detention, but nevertheless reflected experiences of being helped. Participant 7 describes the beneficial experience of being around others who had similar experiences to her, resulting in her feeling less alone in suicidal thoughts. Participant 2 shares a similar notion of being able to relate to others on the ward. She speaks to examples of others who she can aspire to be like, as well as examples of distress that she would like to prevent. Participant 9 also recognised support from staff.

> "You can be around other people who are going through the same stuff as you, so you don't feel, you don't feel awkward about saying, "Oh I felt like killing myself" or "I had these thoughts yesterday". So you got people who's going through the same experience."
> (Participant 7)

> "It's also like kind of a blessing because I see in the extremes, I see the really unwell people and the really well people and I think… hopefully I can get well. But if I don't, I could become really unwell."
> (Participant 2)

> "Literally, it's helped me a lot and the nurses have helped me a lot as well."
> (Participant 9)

Support was also described in a more basic sense, particularly in relation to food. Many participants commented on the food provided being a positive side to the experience of detention. Participant 12 describes a sanctuary related to the provision of food. Participant 10 agrees, but later adds that this reflects how detention is limited to physical wellbeing. Participants 10 and 6 similarly qualify the provision of food as a small positive against wider negatives.

> “I’m going to a sanctuary, like here, and people are gonna get me dessert, ice cream, starters, fruit”.
> (Participant 12)

> “The food (laughs). I can tell you three times a day, food. Breakfast, lunch, dinner. Oh and supper… Instead of recovering, it is eating, sleeping and pooping and basically, just getting the body well, but the spirit, the mind and soul is not healed. In fact, actually more damaged.”
> (Participant 10)

> “It feels like a prison with very good food. The food’s good.”
> (Participant 6)

> “On the flip side, there’s things like halal meals, I know they serve kosher meals. And they serve Caribbean meals, which go down really well, because… you know what it’s like, when we look at English food, we’re like. So yeah, so it’s nice that they provide, you know, food for BME people, that’s a step in the right direction.”
> (Participant 2)

Another form of social support may be in the form of welfare. Being detained can renew focus on a person’s social circumstances and trigger appropriate action. Participant 8 described how being detained led to a number of social welfare improvements that left him feeling positive about the future.

> “It’s like a second chance, I have my debts fixed, I have my benefits, my housing. So that I can have stability and be stable within, within my own space.”
> (Participant 8)

CHAPTER FOUR: DISCUSSION

Chapter Overview

This chapter will discuss the findings of the current research and how these might apply to wider contexts. Firstly, the main findings will be discussed in relation to previous research and theory. Secondly, the findings will be contextualised by an overview of the strengths and limitations of the current research. Thirdly, the implications of the current research will be discussed in relation to clinical, policy and research contexts and this will be accompanied by corresponding recommendations. Finally, the researcher will summarise feedback about the findings and provide a reflexive account.

Main Findings

Research Aim. The current research aimed to explore the experiences of adults from a BME background detained as inpatients under the Mental Health Act (1983; 2007). Twelve participants gave interviews where they spoke candidly about their personal experiences. A thematic analysis interpreted four main themes with fifteen sub-themes relating to such experiences. These findings broadly support previous research which details a complex mixture of experiences of detention overall. Akther et al. (2019) outlined experiences of detention that incorporated poor communication, restrictions and restraints, comparisons to prison, neglect, dehumanisation and an emphasis on the importance of staff relationships. All of these experiences correspond to themes in the current research, with some identical descriptions, such as detention being like prison. This suggests that there may be some universal or common experiences of detention that are somewhat independent of ethnicity. However, there were also explicit references to ethnicity by participants, reflecting rich and varied experiences in addition to previous research such as Akther et al.'s (2019). These reflect factors highlighted by the Race Equality Foundation (REF; Bignall et al., 2019) as well as Barnett et al.'s (2019) review findings which highlight how racism, police involvement and access and engagement with services are prominent factors in BME detention. The current research directly echoes this by contributing experiences of racist abuse, ethnic differences in treatment, police involvement in the detention process, limited access to services and differences in engagement. Together, themes from the current research support findings from previous research into general experiences of detention, while adding critical understanding of specific experiences for BME people.

Racism and Racialisation. The current research primarily indicates that BME people experienced detention as racist and racialised, which is distinct from findings in previous research exploring experiences of detention in the general population (Seed et al., 2016; Akther et al., 2019). This is first and foremost exemplified by the experience of direct and overt racist abuse that participants described. The language that participants reported, including “nigger” and “monkey”, reflect the descriptions of aggression, dehumanisation and animalisation in Fanon’s (2008) psychoanalytic theory. This is in line with Klein’s (1946) theory of projective identification, which described how people project parts of themselves into others which they identify as bad or unacceptable. Fanon (2008) described how identifications with inferiority and animalism are projected into BME people and they therefore become feared objects, which Fanon termed ‘phobogenic’. Fanon described how this fear leads to an aggressive drive to dominate and denigrate BME people, which may explain higher rates of BME detention. Although Fanon wrote about the historical context of colonialism, Lowe (2008) described how these colonial objects have endured in a contemporary context. This is perhaps manifested in the current findings through experiences in which BME report being abusively identified as inhuman or animalistic. It is also acknowledged in psychoanalytic theory that such racialisation can happen at an imperceptible level, in addition to the overt abuse described (Davids, 2011).

Of particular concern is the concurrent perception from participants that these experiences of racism during detention are reflections of wider experiences of racism in society. These are described as chronic and countrywide and, as a result, participants reported feeling desensitised to them. Accordingly, systemic theories suggest that BME experiences must be considered in a wider context, particularly with respect to racism and racialisation. As DuBois (2007) argued, Western civilisation is founded on multiple systems that racialise and exploit BME people, including institutions. Feagin (2004) adds that such systemic racism is often denied and instead conceptualised as minor, temporary or isolated examples of racism. However, the current findings suggest that participants indeed have a systemic experience. This is perhaps best reflected in official published data that reports widespread disparities for BME people across education, employment, housing, health, community and criminal justice (Cabinet Office, 2018). It is also represented in research by the REF, which reported lived experience of enduring racism across societal systems (Lingayah et al., 2018; Mompelat, 2019). Boyd-Franklin specifically discusses how systemic racism constitutes trauma for BME people and describes how their mental health is the product of wider social, cultural, historical, familial, political and economic systems (Franklin et al., 2016). This also reflects previous theories of detention in the general population which highlight the role of socio-political and familial contexts (Laing and Esterson, 1964; Cooper, 1967; Carmichael, 2015). Previous research in the UK has supported these ideas by providing a link between experiences of racism and mental health problems (Karlsen et al., 2005; Wallace et al., 2019). This corresponds with Barnett et al.'s (2019) review of evidenced explanations for BME detention, which referred to the role of societal racism.

Although there is some debate about whether racism is the cause of higher rates of detention for BME people, there was certainly a perception from participants that this plays a significant part (Singh and Burns, 2006; McKenzie and Bhui, 2007). It was specifically thought that detention was a mechanism to tame BME people and remove them from society in the sub-theme, '*I was detained because I was Black*'. This reflects theories by Fanon (2008) and Foucault (1965; 2006) that describe detention as a means of control. Fanon in particular wrote about a drive to control BME people, manifested through colonisation, which is perhaps reflected in the current findings by participants' perception of detention. DuBois (2007) similarly outlined a historical and contemporary motivation to institutionalise BME people. These findings can only reflect an interpretation and it is not possible to prove that conscious racism motivates higher rates of detention for BME people. However, psychoanalytic theory suggests that racism can be quite unconscious and, moreover, what conscious awareness there is can often be denied to defend against the discomfort of racism (Cohen, 1993; 2002; Davids, 2011). Some argue that the widespread disparities in ethnicity are enough to suggest institutional racism (Sashidharan, 2001; Fernando, 2008; 2017). Systemic theory may again be used to explain some causal impact of societal racism, particularly for a participant that described racism in unemployment leading to a label of schizophrenia. Boyd-Franklin highlights how racism in employment can affect mental health, but she also discusses how BME experiences can be mislabelled by Western models (Boyd-Franklin and Shenouda, 1990). This may suggest that detention for this participant in particular was perceived to be caused by societal racism through unemployment, as well as clinical Whiteness through Western misdiagnosis of racial trauma (Parham et al., 1999; Wood and Patel, 2017). This has been suggested in previous research in the UK which reports experiences of racist stressors accumulating to cause psychosis and an inability of professionals to understand or sympathise with the realities of BAME people (Memon et al., 2016; Schofield et al., 2019). Similar research found that cultural beliefs often competed and contrasted with medical explanations (Islam et al., 2015). These findings sit in a wider context of traditional psychiatric diagnoses being inappropriate, as discussed by Laing and Cooper (Laing and Esterson, 1964; Cooper, 1967; Carmichael, 2015).

As well as these experiences, which are described as racism, participants also describe additional experiences of different treatment for different ethnic groups. These are not explicitly described as racist experiences, but are nevertheless noticed as differences based on ethnic group identity. Participants described: being refused incontinence pads that a White person would have been given; not being allowed to practice their religion, which an Indian person would have been able to; and not having African food, despite Caribbean food being available. Tajfel (1969; 1981) refers to this in a cognitive theory of prejudice, highlighting how people are stereotyped according to their group identity, rather than being seen as individuals. As a result, they are responded to based on prejudicial stereotypes of the group. This may explain participants' experiences of different treatment with respect to their individual needs compared to their perceptions of other ethnic groups. Moreover, this seems to extend beyond Fanon's (2008) specific conceptualisations of BME people and instead includes participants' experiences of White, BAME and BME people. Participants discussed how White, Indian and Black Caribbean people received preferential treatment and suggested that this was due to their ethnic group status. This adds an additional layer to participants' racialised experiences and reflects the homogeneity highlighted in previous research with BAME and BME groups (Barnett et al., 2019).

BME Culture and Communities. Participants highlighted specific aspects of BME culture that may be associated with detention, including Black Caribbean men brought up to be ruthless and BME women having too much energy. These conceptualisations echo Fanon's (2008) descriptions of racialised objects as aggressive and, in particular, having somewhat inherent traits. This is theorised psychoanalytically as an internal projection of these objects by BME people themselves (Hooks, 1992; Hook, 2004). From this perspective, BME people consciously and unconsciously identify with an objectification of White as good and Black as bad, which has extended from historical colonisation through to more contemporary contexts (Fanon, 2008; Lowe, 2008). Hooks (1992) in particular writes about how BME women and men can internalise racialised conceptualisations of themselves, which builds on Fanon's (2008) writing also. These conceptualisations include sexualised women and aggressive men, with descriptions that may be considered somewhat similar to the notions of energy and ruthlessness described in the current findings. However, this association is again not possible to prove and it is possible that the participants have these conceptualisations for other reasons. Participants also spoke about a stigma in BME culture and communities around mental health and detention, which is described as being a taboo with little understanding. This reflects findings from the REF about the role this stigma plays for BME people when conceptualising mental health (Bignall et al., 2019). However, participants did not specifically detail what this stigma was, whereas previous research has suggested it is faith-based (Mantovani et al., 2017; Codjoe et al., 2019). It is also acknowledged that Akther et al.'s (2019) review found that mental health stigma was experienced as part of detention by the general population. However, previous research into experiences of mental health services for BAME people suggests that stigma is a specific issue in these communities and could be addressed within them (Wales et al., 2017; Wagstaff et al., 2018).

The role of BME families was also discussed by participants, in particular with respect to police involvement. Participants' experiences seem to reflect previous research which suggests that the police have prominent involvement in detention for BME people (Cooper et al., 2013). However, the current research does not explicitly support explanations from previous research that this is the direct result of prejudice from the police (Sainsbury Centre for Mental Health, 2002). Instead, participants seemed to describe how police involvement was largely instigated by family members, rather than the police themselves. This has been highlighted in some previous research (Morgan et al., 2005a; 2005b). A sense of betrayal was described in this vein, where police officers were called by family members who were concerned, or during familial conflicts. These findings may therefore complicate recent amendments to the Act which have increased the capacity for a family member to be involved in the decision to detain. Rogers and Pilgrim (2014) add particular caution to the inclusion of family members, arguing that, whilst this can be helpful, it can also contribute to problems for the individual. Conversely, Boyd Franklin's systemic theory and Black/African Psychology theory both emphasise the importance of including family contexts in BME mental health care (Parhman et al., 1999; Hines and Boyd-Franklin, 2005; Franklin et al., 2006). Discussing mental health services overall, McPherson and Oute (2020) describe a gap between evidence and policy with respect to involving family members, especially distinguishing collaborative family work from giving sole family members responsibility.

Human Rights to Liberty and Autonomy. The current findings support previous research into experiences of detention which describe a lack of liberty and autonomy (Seed et al., 2016; Akther et al., 2019). Participants reported feeling like imprisoned animals due to the lack of freedom with respect to leave, activities and treatment. Akther et al.'s (2019) review into experiences of detention in the general population reported an identical comparison with prison. It further concluded a theme that discussed dehumanisation through a lack of autonomy. Participants in the current research routinely described a number of grievances that left them with a similar sense of dehumanisation and imprisonment. This included access to mobile phones and chargers, access to outside space, permission to leave the ward, access to cosmetic and hygienic products and the ability to smoke. These experiences were accompanied by descriptions of regimented processes that were considered disproportionate and unnecessary. Moreover, each of these requests required repeated approvals, meaning that any autonomy to access activities and items was subjected to scrutiny and surveillance. Widespread restrictions on such activities and items appear to contradict the government's guidance to avoid blanket risk management processes (DH, 2014; DHSC, 2015a, s.8.5.). In addition to being deprived of these items and activities, participants also described the process of restraint involved in restricting their liberty and autonomy. Participants described painful experiences of restraint, sometimes including large numbers of staff and the use of chemical as well as physical procedures. This is framed by previous research which explores how restraint can be a re-traumatisation (Wynn, 2004; Sweeney et al. 2016). All of these experiences draw direct comparison with EHCR and UN concerns about human rights and detention. The ECHR (1953) allows detention but emphasises protection from inhumane treatment and respect for autonomy. The UN demands that people are not deprived of their liberty unlawfully and describes how detention can constitute torture through involuntary treatment (UN-CRPD; 2006; Human Rights Council, 2020). Although the terms torture and inhumane are not used explicitly by participants, these accounts were interpreted as such. The findings further reflect similar concerns from service users about the independent review of the Act falling short of human rights compliance (NSUN, 2020). Previous research and a regulatory report further highlight how professionals can be uncertain about whether human rights are safeguarded (Fistein et al., 2016; Dixon et al., 2019; CQC, 2020a). This is of particular concern due to the prominence of this theme in the current findings. Notably, the findings show that human rights abuses through detention are not exclusive to developing countries, but are also observed in the UK (UN-CRPD, 2017). The current findings may therefore be used to understand a wider context of detention and human rights.

Autonomy and liberty were particularly compromised by participants' experiences of exclusion, both inside and outside of the ward. Participants described having little autonomy over their care by being excluded from the decision-making processes involved. This included decisions about being sectioned, granting leave and the use of medication. Information was described as lacking and requests were deferred, leading to a perception from participants that decisions were taken without their consent or participation. This was especially true of decisions about detention, which participants described as confusing or punishing. Akther et al. (2019) describe a similar theme where information was not always available and participants experienced a lack of involvement. In the current research, participants described a perception that these decisions were motivated by presumptions about them, including that they would be at risk of running away. With respect to medication in particular, participants described not having a voice in the decision and giving up trying to fight this. Participants also described being excluded as a result of detention, missing out on personal and professional opportunities outside of the ward. The examples given by participants included being unable to manage wayward employees and missing family activities such as Christmas shopping. Participants were especially frustrated by a lack of leave from the ward when such opportunities arose, leading to feelings of frustration, separation and isolation. Again, participants described being excluded or disregarded from these decisions and one participant explicitly discussed this in terms of their human rights. This adds further scrutiny to the concerns raised by the UN, EHCR and NSUN (EHCR, 1953; UN-CRPD, 2006; NSUN, 2020).

The impact of such experiences with autonomy and liberty may be explained by theories of detention as an institutional mechanism of social control (Foucault, 1965; 2004; 2006). This is described in detail by Goffman (1961) who referred to ‘total institutions’ which create a custodial rather than caring environment. Through blanket restrictions on liberty and autonomy, these institutions produce all-consuming conditions for inpatients where they become separated from the outside world. They are subsequently subject to formal administration as an indistinguishable collective, rather than as individuals. Participants in the current research certainly describe elements of this with respect to feeling cut off from others and being subject to blanket rules despite their individual needs and perspectives. Barton’s (1959) description of institutional neurosis also appears similar, with descriptions of isolation, regimentation, disrespect from staff and separation from loved ones and the outside world. This is perhaps best demonstrated by the experience of detention as a deterrent. Participants largely described feeling afraid of being detained again, with one reference to the experience being traumatic. This arguably is a cause for concern for legislation and services that ostensibly aim to care for vulnerable people. Although ethnicity is not mentioned explicitly with respect to these experiences of autonomy or liberty, a link may still be drawn. This is especially relevant to risk management processes such as restraint, because previous reports indicate institutional racism therein (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003; Crisp et al., 2016). Moreover, previous research into BAME experiences of mental health services highlights the importance of personal choice and control for these groups and includes experiences of helplessness and passivity due to a lack of autonomy (Lovell et al., 2014; Memon et al., 2016; Wagstaff et al., 2018). Finally, given that BME people are more likely to be detained, it follows that they may be more susceptible to the potential human rights concerns described. Systemic theories argue that this is the intention of socio-political systems that have been constructed to marginalise and dominate BME people (Feagin, 2004; DuBois, 2007). These theories argue that Western civilisation is historically and contemporarily based on this structural institutionalisation of BME people. This perhaps relates back to the experiences of racism and racialisation that participants described, including a perceived motivation to tame and control BME people through detention and chemical and physical restraint.

Access and Engagement. The current findings provide further insight into access and engagement with mental health services. This was highlighted as a particular area that affects BME detention rates in the independent review and was also the central focus of the REF report (Bignall et al., 2019). The current findings contribute participant experiences of access and engagement both before and during detention. Firstly, participants describe seeking support and being denied in the sub-theme, '*I'm here because I didn't get help when I asked'*. This related to a number of services including Accident and Emergency, a GP and social welfare. Although participants do not specify that this denial of support was linked to ethnicity, some links may still be drawn from previous research. This includes experiences of BAME people asking for support and not receiving it, leading to a vicious cycle where they avoid seeking support as a result of expecting such responses (Keating and Robertson, 2004; Bignall et al., 2019). Moreover, previous research into BAME experiences of mental health services suggests that proactive services are crucial, especially with respect to psychosis, where BME people can be subject to under-diagnosis and a failure to provide services (Schofield et al., 2019). The current findings may also be explained by Boyd-Franklin's systemic theory (Boyd Franklin, 1989; Boyd-Franklin and Shenouda, 1990). This highlighted how BME mental health care necessarily involves a number of systems, in this case primary care, emergency services and social welfare. This supports previous research into experiences of BAME people in mental health services that included requests for social support (Lovell et al., 2014).

The current findings also support previous research into experiences of detention that highlight the significance of staff relationships in engagement (Seed et al., 2016; Akther et al., 2019). Seed et al. (2016) conceptualise this as a central factor in their theoretical framework of experiences of detention in the general population. Akther et al. (2019) also emphasised the importance of staff relationships, which were largely considered kind and respectful despite high demands, but which also included neglectful, disrespectful and coercive experiences. Participants in the current research made similar descriptions in the sub-theme, '*staff have no time to care'*. This acknowledged that staff could be helpful and caring, and were probably trying their best. However, it also described staff as stressed and overworked, with little time or resources to care for patients, sometimes resulting in disrespectful or aggressive experiences. Participants therefore reported a sense of being neglected by staff and having their requests and needs repeatedly denied or deferred. This reflects independent analyses and reports that demonstrate occupational shortages and decreased resources, which are associated with a deterioration in inpatient care (King's Fund, 2015; 2017; Crisp et al., 2016; Rolewicz and Palmer, 2019; CQC, 2020a). This is of particular concern given the suggested link between stressed staff and compromised human rights practices (Kinderman and Butler, 2006).

Participants further highlighted the significance of ethnicity with respect to staff relationships. This reflects previous research into BAME experiences of mental health services that reported a perception of professionals pigeonholing participants due to ethnic discrimination (Schofield et al., 2019). The current findings indicated that, while BME staff may be considered better able to relate to BME patients, this is not a foregone conclusion. In particular, participants described how staff with a shared ethnicity as them, as well as BME staff of a different ethnicity to them, were experienced as difficult or disrespectful. One participant described this distinction as being about migration status, with themselves being British-born and BME staff being migrants. This reflects the significant homogeneity in BME research highlighted by Barnett et al.'s (2019) review. It also supports previous research which paints an uncertain picture of how beneficial it may be to ethnically match staff to patients (Fernando 2005; 2017; Karlsson, 2005; Lovell et al., 2014; Cabral et al., 2011). Overall, these findings suggest that having a broadly representative BME workforce is not enough to ensure quality of care for BME patients. This may relate back to the discussion of theories regarding perceptions within BME cultures and communities.

Access and engagement during detention has already been discussed in the context of autonomy and deprivation of liberty and through staff relationships. However, the current findings also indicate additional factors which affect access and engagement during detention. Notably, participants rarely discussed access to or engagement with formal treatment, particularly psychological interventions. Instead, participants in the current research discussed negative experiences of forced medication and positive experiences of engaging with peer relationships on the ward over shared experiences. This reflects previous research into BAME experiences of mental health services which highlighted the importance of informal interventions, such as relationships with peers and shared experiences (Chtereva et al., 2017). It may also reflect previous findings of disparities in access to psychological interventions for BME people, who are instead more likely to be offered medication (Sizmur and McCulloch, 2016; Baker, 2018; Das-Munshi et al., 2018). Black/African Psychology (Parhman et al., 1999) and Optimal Psychology (Myers, 2006; 2010) theories both suggest that Western perspectives can neglect the especial emphasis that BME people put on connectedness. This is in addition to Fanon’s (2008) and DuBois’ (2007) discussion of a motivation to tame BME people, which may be manifested in the current findings through the prominence of medication and restraint and the lack of reference to therapeutic engagement. The sub-theme, ‘*restraint is not help for psychological distress*’, exemplifies this with participants highlighting a distressing discrepancy between their experiences and the interventions that they receive.

Participants also spoke of being engaged by access to respite from stressors in their lives, accompanied by basic necessities such as regular meals. This echoes themes of sanctuary from previous research into experiences of detention in the general population (Seed et al., 2016; Akther et al., 2019). These findings perhaps indicate that the aims of detention to treat mental disorder and protect individuals from harming themselves or others may be somewhat misplaced. In fact, participants seemed to experience a benefit through protection from others and made no explicit link to appropriate treatment for mental disorder. These findings may be explained by previous theories about an over-emphasis on risk in mental health care and in the Act specifically (Hilgartner, 1992; Glover-Thomas, 2011; Felton, 2018). This builds on Foucault’s theory, where risk is used to justify social control rather than address actual social vulnerability or inequality (Rose, 1999; Morgan and Felton, 2013). Systemic theory may further explain these experiences through the conceptualisation of BME mental healthcare across multiple systems (Boyd Franklin, 1989; Boyd-Franklin and Shenouda, 1990). This broadly suggests that focusing on mental disorder and risk management, as the Act does, may be culturally narrow and therefore inappropriate for BME people.

Summary of Main Findings. Higher rates of inpatient detention for adults from a BME background have rarely been considered to have a singular or universal understanding. The current research reflects this with a range of themes that incorporates multiple facets from previous research and a combination of theoretical concepts. Notably, the findings reflect how detention for BME people spans multiple systems that are perhaps best explained by a systemic theory. Boyd-Franklin (1989) especially articulates this in her demonstration of how BME mental health must be approached through engagement with social, cultural, historical, familial, political and economic systems. These systems may also incorporate cognitive or psychoanalytic conceptualisations of BME people that are implicated in their experiences of detention (Tajfel, 1969; 1981; Fanon, 2008). With respect to explanations, the themes provide some support for Barnett et al.'s (2019) review which described police involvement, racism and engagement with services as key factors. There are also parallels with the REF report of similar factors, as well as previous research into general experiences of detention (Akther et al., 2019; Bignall et al., 2019). The current research also supports the independent review in acknowledging that "longstanding experiences of discrimination and deprivation [and] …structural factors which engender racism, stigma and stereotyping increase the risk of differential experiences in ethnic minority communities" (DHSC, 2018, p. 20). The findings add to concerns raised by service user and human rights organisations that the Act and independent review fall short of human rights recommendations (UN-CRPD, 2017; NSUN, 2020). Overall, the themes in the current research highlight the richness of lived experiences and emphasise the importance of such research with respect to BME people. Experiences of detention for BME groups cannot solely be considered through dominant positivist and Western models. As Myers (2006; 2010) outlines, these are 'sub-optimal' psychological approaches for BME people. The themes therefore endorse intentions and initiatives to prioritise BME perspectives and lived experiences (NSUN, 2018).

Strengths and Limitations

BME Experiences of Detention Under the Act. The current research is unique in exploring the experiences of adults from a BME background detained as inpatients under the Act. Previous academic research into mental health in the UK has generally been more broad, featuring experiences of detention overall or wider samples of BAME people, sometimes mixed with carers and professionals (Sainsbury Centre for Mental Health, 2002; Akther et al., 2019; Barnett et al., 2019; DHSC, 2018). There have been some publications that do specifically explore BME experiences and include detention, however these have largely been produced by organisations outside of UK academia (NSUN, 2018; Bignall et al., 2019). The current research was founded on such publications and therefore demonstrates how UK academia has perhaps neglected the knowledge, skills and experiences of BME mental health research outside of these circles. This is discussed with respect to academic research into mental health in the UK having a lack of BME perspectives, notably in clinical psychology (Wood and Patel, 2017). Similarly, the current research adds rich qualitative data about lived experiences, rather than dominant quantifications and correlations. In particular, the current research highlights the lived experiences of BME people, who can be neglected in wider service user movements (Wallcraft et al., 2003). Despite these strengths, the current research does not presume to represent a comprehensive or definitive account of BME experiences of detention. Instead, it serves as a preliminary exploration from one perspective and context. This naturally has limitations, but the findings nevertheless contribute to understanding and highlight further avenues for research in this area.

Study Sample. One of the primary findings of the current research relates to the characteristics of those who participated, as well as those who did not. It is noted that some participants who were interested in the study had prohibitive concerns about confidentiality. Although this may be a concern for any participant, it has been suggested that minority groups in particular may be particularly concerned about confidentiality, perhaps due to a mistrust of systems (Hines and Boyd-Franklin, 2005; Liamputtong, 2010). The current research attempted to mediate this by offering flexibility in conducting the interviews, but the necessity of audio-recording meant that some interested participants declined to participate, fearing involvement from the NHS Trust. The sample also had a majority of female participants. Ostensibly, this was because staff on the female wards were more proactive with recruitment, however there is also potential for bias from staff members recruiting for such research, including with respect to gender (Rugkåsa and Canvin, 2011). Moreover, some qualitative research indicated that BAME women were more likely to be active in their care, which may have extended to their participation in the current research (Chtereva et al., 2017). To try and mitigate this, the researcher offered as large a time-frame as possible to recruit and conduct the interviews, which included evenings and weekends. The age range of participants is considered appropriately broad. Participants identified themselves as BME, but gave varying descriptions of their specific ethnicities. Although these largely map onto the NHS categorisation of broad ethnic groups, it is clear that they would require some interpretation to fit into the specific NHS ethnic groups. One participant's description of herself as African, Jamaican, Mexican, American and German in particular reflects previous research that highlights how diverse ethnicity can be (Phinney, 1990; Bhopal, 2004; Burton et al., 2008). Even more diverse is the range of reasons given by participants for their detention. It is particularly stark that a number of participants did not know the reason for their detention and the ones that did gave a diagnosis as the primary factor. Given that a disorder in itself is not grounds for detention under the Act, this calls into question whether the criteria set out by the legislation appropriately reflects patient experiences. This is particularly relevant considering previous research which concludes that BME people in the UK have fluid and contrasting conceptualisations of mental disorder (McCabe and Priebe, 2004; Codjoe et al., 2013; Islam et al., 2015). No participant, in this initial stage, spoke of the Act's criteria of being at risk to themselves or others and having a mental disorder that they felt required detention and appropriate treatment. The length of detention varied mostly within the range of a month, with one significant outlier. This perhaps reflects the fact that there are a range of ways to be detained. The demographic questions in the current research did not ask for the specific section participants were detained under, which may have created a heterogenous sample of detained participants. In particular, BME participants may be more likely to be subject to detention via specific police powers (Independent Commission on Mental Health and Policing Report, 2013; Home Affairs Committee, 2015). Nevertheless, the sample arguably still reflects a BME group and allows the current research to exclusively explore their experiences. Moreover, it supports previous arguments in dispelling certain myths about BME people being hard to engage, although it is recognised that adaptations to research are required (Begum, 2006; Trimble and Fisher, 2006; Liamputtong, 2010; Kalathil, 2013).

Research Paradigm. A critical realist approach was considered to be a strength of the current research in comparison to previous research into BME groups and detention rates. This has predominantly focussed on numerical data and statistical analysis, with large-scale meta-analyses and routinely published NHS figures (Barnett et al., 2019; NHS Digital, 2019a). By contrast, experiences of detention for BME groups have received less academic attention and the NHS does not publish reports relating to this. Although the review of the Act spoke to experiences of detention and included some qualitative research pertaining to this, research from recent history has predominantly been quantitative (Ponterotto, 2010). Such an emphasis on a positivist epistemology in psychological research has been criticised for reducing human experiences and, moreover, leading to policies which prioritise technocratic objectivity at the expense of meaningful social improvement (Fischer, 1998; Darlaston-Jones, 2007). This is perhaps best represented by the fact that BME people have remained objectively over-represented in detention statistics for decades, despite abundant positivist research highlighting this. A positivist epistemology with respect to policy has therefore been considered unethical for universal application (Amy, 1984). By contrast, an interpretivist epistemology in the current research incorporated the experiences of BME people detained under the Act beyond numerical data and its statistical corollaries. Existing research has already demonstrated a wider range of subjective interpretations relating to experiences of detention than positivist research has suggested (Akther et al., 2019). Thus, applying an interpretivist approach to these experiences for people from a BME background provided further subjective understanding.

In particular, where quantitative methodologies have revealed relationships between variables, the qualitative approach used in the current research has allowed insight into lived experiences. This may be best demonstrated by the difference between quantitative and qualitative data regarding racism. Barnett et al. (2019) quantitatively highlight that racism is a variable that corresponds to higher rates of BME detention. The current research additionally reveals the verbal racist abuse that participants experienced, the perception that detention is a form of systemic racism and nuanced differences in perceived treatment between different ethnic groups. Notably, participants described being somewhat desensitised by these experiences of racism, perhaps indicating that they would not have reported them without the depth of a qualitative approach. Where there has been qualitative research into the experiences of detention, this has not incorporated a proportionate focus on BME people. Therefore, the current research has been able to add insight into the lived experiences of those least featured in qualitative research regarding detention, despite them being the most subject to it. This includes the qualitative exploration of an apparent gap between the aims of legislation and policy and the lived experiences of those subject to it. Despite the Act discussing risk, mental disorder and treatment, these themes were not emphasised by participants in the current research. Instead, they spoke of detention being a traumatic experience which involved racism, restraint, a lack of autonomy and isolation.

There are further approaches to research paradigms beyond the ontologies, epistemologies and methodologies explored in the current research. Critical race theory is a philosophical research framework that emphasises the context of racism and power throughout ontology, epistemology, methodology and axiology. It broadly aims to present experiences of racism, eradicate racism and address the intersectionality of racism with other inequalities such as gender and class (Lynn et al., 2002; Creswell and Poth, 2018). Postcolonial psychology similarly emphasises the importance of a research framework positioned by the historical context of colonialism (Macleod et al., 2017). The current research was a preliminary exploration of BME experiences, rather than an explicit critique that intentionally focusses on a philosophical framework of race, power and social action. This distinction broadly favours an interpretivist approach rather than critical theory (Ponteretto, 2010). The current research therefore sat principally within a critical realist paradigm. It accepted an objective reality of detention under the Act, but aimed to explore experiences of it for adults from a BME background, as opposed to analysing quantitative data about them. It rejected an objective experience of detention and, rather, aimed to explore multiple subjective interpretations regarding that experience. Still, Western philosophies such as critical realism may be considered inappropriate for research with minority groups, especially without appropriate adaptations (Bernal et al., 2014). A research paradigm informed by the philosophical positions of critical race theory or postcolonial psychology may have been a more appropriate approach to take. Nevertheless, the themes described by critical race theory and postcolonial psychology, including racism, power and class, were still implicitly and explicitly relevant to the current research and featured prominently. Although the research was informed by the three dominant approaches in clinical psychology, adaptations of these theories from BME perspectives were emphasised. It is acknowledged that other disciplines, such as sociology, also have comprehensive and critical theories of racism which may have been helpful to consider (Golash-Boza, 2016).

Interview Length. Qualitative research guides suggest a typical timeframe of an hour for interviews, and this was what was suggested to participants and ward staff in the PIS (Patton, 2015). By comparison, the interviews in the current research were relatively short. There may be a number of explanations for this, which all must be considered assumptions rather than evidence. Firstly, it is possible that the length of the interview reflected shortcomings of the interview guide and the researcher. The researcher attempted to mediate this by seeking consultation on the interview guide and asking participants, as part of the interview, if there were any additional prompts or questions that they felt would be helpful. It is acknowledged that the researcher was external in many ways to participants and this may have influenced the extent to which participants wanted to engage, both positively and negatively (Denzin, 2003). Secondly, it may have been that participants felt that their experiences were sufficiently captured in the timeframe given and did not want to elaborate. Thirdly, participants may have felt distressed by the interview, or by their acute mental health presentation, and spending a longer time discussing these experiences may have been too taxing. These factors may have been compounded by a fourth explanation, where participants' time was limited and other activities were prioritised such as leave from the ward and visitors. The researcher anecdotally identifies with this explanation in particular and recalls participants eager to conclude the interview to do something else. The researcher did explain verbally and in writing that the interview was expected to take an hour of participants' time and flexible appointments were offered to accommodate this. Overall, it is plausible that a combination of these factors may explain the length of the interviews.

Implications and Recommendations

Clinical. The current research reflects a number of informative experiences regarding BME people in an acute clinical setting. Firstly, the current research implies that detention for BME people is experienced as racialised and racist. This includes outright racist abuse as well as experiences of more subtle acts, or microaggressions. The current research therefore recommends that this is acknowledged and addressed at the level of clinical delivery. This could perhaps be facilitated by embedding BME people who have experienced detention into clinical systems of leadership and delivery. In addition to wider policies to be discussed, individuals and teams involved in the clinical care of BME people under detention might also reflect on their cognitive, systemic and psychoanalytic conceptualisations of race and racialisation. Secondly, the current research must highlight the implications of participants' descriptions of clinical treatment, or lack thereof. The findings suggest that participants have largely negative experiences of medication being enforced on them and little experience of other interventions, positive or otherwise. The findings of the current research may therefore imply that psychological treatments are not present or not significant in participants' experiences of detention. This is especially concerning because clinical guidelines recommend a choice of medication in conjunction with psychological interventions for acute episodes of psychosis (NICE, 2014). The current research therefore redoubles these clinical recommendations for meaningful psychological interventions, as well as for medication that participants have choice over. Thirdly, participants made clear reference to an environment with restrictions akin to a prison. This incorporated a physical lack of access to the outside world as well as restrictive risk-management practices that limited autonomy. This supports findings from previous research as well as concerns raised about the quality of inpatient wards (King's Fund, 2015; 2017; Crisp et al., 2016; Akther et al., 2019; CQC, 2020a). In a context that aims to provide protection and care for vulnerable people, such a restricted environment appears to have clinical implications of additional distress. The current research therefore builds on recommendations highlighted by independent analyses for improved inpatient environments (King's Fund, 2015; 2017; Crisp et al., 2016). Fourth, the current research implies that staffing levels are crucial to BME experiences of care, and these currently appear to be overstretched. This perhaps reflects a national occupational shortage in mental health professionals (Rolewicz and Palmer, 2019). Nevertheless, the current research recommends that the number of clinical staff involved in care during detention is increased. Finally, the current research highlights the need for inclusive and collaborative relationships between professionals, patients, families and communities. This has been especially highlighted by previous research (Seed et al., 2016). The current findings imply that these relationships can be neglectful, disrespectful and exclusionary during detention and this may be especially iatrogenic from a BME perspective that prioritises connectedness (Parhman et al., 1999; Myers, 2006; 2010). The current research therefore recommends clinical responsibility to specifically ensure that BME patients are included in discussions about their care, are aware of the reasons for their detention, have access to support, are protected from isolation and, above all, are treated with respect. The current research further demonstrates how this cannot just be achieved by aiming to have a broadly representative BME workforce. These recommendations are arguably present in the independent review as well as overall guidelines for clinical practice (Baggot, 2005; NMC, 2015; Royal College of Psychiatrists, 2016; British Psychological Society, 2017; NHS England, 2017). However, the current research suggests that there is still a gap between these guidelines and lived experiences.

Legislation and Policy. In addition to the actual legislation of the Act, there are a number of policies and initiatives to ensure that inpatient detention fulfils its aims of providing protection and treatment. However, the current research implies that there is a considerable disconnect between such policies and the lived experiences of BME patients. The aforementioned clinical recommendations are not novel and this arguably reflects a degree of failure in the implementation of policies to acknowledge and address BME experiences of detention. The Act is accompanied by a Code of Practice and a Reference

Guide published by the Department of Health and Social Care (DHSC, 2015a; 2015b). In addition, there have been specific policies attempting to address BME detention, including the Delivering Race Equality Programme and the Race Equality Action Plan (Wilson, 2010). Finally, there are a number of professional guidelines and organisational policies that recommend or require patient involvement (Baggot, 2005; NMC, 2015; Royal College of Psychiatrists, 2016; British Psychological Society, 2017; NHS England, 2017). Together, these policies all make versions of the aforementioned clinical recommendations, including with respect to BME experiences. Despite this, chronic ethnic disparities continue and, as the CQC states, "there is little evidence that this situation is improving or that there is a system-wide commitment to effect change" (CQC, 2020a, p.5). A notable omission from many such policies and recommendations are robust regulatory systems that relate to patient experiences. The current research therefore recommends that such policies become accountable to lived experiences, which should be used to develop an evidence base that prioritises parity of esteem for qualitative research alongside traditional quantitative research (McPherson et al., 2020). This is particularly relevant to the independent review of the Act. Although it outlines recommendations and principles that arguably reflect the current research's findings, these are not too dissimilar from previous recommendations and findings about understanding and respecting a broad umbrella of diversity. As Fernando (2017) articulates, these repeated initiatives and intentions can often saturate the conversation around BME mental health, without meaningful action to accompany it. Crucially, the independent review has not been endorsed by NSUN (2020), which represents a significant service user population. This exemplifies the ongoing conflict between legislation or policy and those that are subject to it. Although this has largely been discussed from a human rights perspective with respect to deprivation of liberty, it arguably relates to BME people specifically. The main implication of the current research is that BME people have a uniquely racialised experience of detention, linked to research highlighting the historical and contemporary contexts of systemic racism (Feagin, 2004; DuBois, 2007; Fanon, 2008). It therefore endorses the review's acknowledgement of systemic racism and recommendations for comprehensive and meaningful engagement with lived experiences from BME communities. Encouragingly, the independent review did include some engagement as part of its methodology, but it remains to be seen how this is monitored and responded to going forward.

Further Research. The current research was exploratory and captured preliminary themes relating to BME experiences of detention. While it highlighted the need for such research, it is by no means a comprehensive account and further research is much needed. Firstly, building on Barnett et al.’s (2019) findings, future research may explore the heterogenous BME population in more detail. Most research in this vein groups BAME and BME people together and there is an emerging case for understanding experiences in more specific samples. Barnett et al. (2019) point to unique findings for Black Caribbean people and this is mirrored by the government’s reporting of specific systemic disparities for this ethnic group (Race Disparity Unit, 2020c). Other areas of heterogeneity may also be explored, including experiences of different sections and intersectional experiences with gender and migration. The current research explored experiences of detention contemporaneously, so further research could also explore experiences of detention longitudinally. Most research into experiences of detention overall are cross-sectional and largely focus on past accounts. Conversely, the independent review considers advanced directives for people to help make future decisions around detention. Further research could therefore integrate experiences before, during and after detention to get a fuller picture. Secondly, further research could explore specific areas of experiences of detention for BME people in more detail. Barnett et al.’s (2019) evidenced explanations for higher rates of BME detention in particular could be used to ask BME people specifically about experiences therein. Although the current research reports some of these, it may be worthwhile to explicitly explore how BME people experience the involvement of police in relation to detention, or the influence of ethnic disadvantage on detention. This could in turn influence policy across the different systems which impact BME mental health. Thirdly, further research should explore alternatives to detention and experiences of them. Although community treatment orders have been acknowledged in this vein, including in the independent review (DHSC, 2018), the current research points to more radical alternatives that are based on protection from others, respite from stressors and social welfare. Finally, and most importantly, future research should focus on developing a breadth and depth of studies that prioritise lived experience and service user involvement. The current research demonstrably benefits from this and uses it to contribute to further understanding of BME detention rates. Despite the scope of service user movements, patient involvement remains conflicted between the credibility of lived experiences and traditional professional dominance (Rush, 2004; Campbell, 2005; Rose and Lucas, 2007). Future research must therefore contribute to the meaningful involvement of service users, rather than limiting them to being subjects under the researcher’s gaze (Fulford and Howse, 1993). It is therefore suggested that service users themselves could and should be involved in research as researchers (Beresford, 2005; Russo and Beresford, 2015). Indeed, Rose (2014) argues that it is ethically imperative that the subjects of research should have a role in its conduct. On this basis, patients are ‘experts-by-experience’ who offer an ecological validity to evidence-based research (Faulkner and Thomas, 2002; Noorani, 2013). This expertise can balance out the dominance of professional and academic perspectives and there are increasingly robust methodologies to enable this (Gillard, 2010; Patterson et al., 2014).

Feedback and Reflexivity

Feedback from Participants and Consultation. Three participants consented to being contacted for their feedback regarding the findings. Following completion of the analysis, one of these participants responded to the invitation to review a summary of the findings. This participant said that they agreed with two themes: ‘*help is decided by others, not tailored to me’* and *‘I am not a person; I am a Black patient’.* The participant did not comment on any other parts of the analysis. A summary of the findings was also sent to a BME professional with lived experience for consultation. It was suggested that all of the findings could be related to racial trauma rather than the singular theme *‘I am not a person; I am a Black patient’*. Racial trauma was not interpreted by the researcher as part of every theme, but rather when it was explicitly discussed by participants. However, it is acknowledged that racial trauma necessarily contextualises the discussion. It was further suggested that the analysis could be more focused on the specific language used by participants rather than the interpretation of the researcher. The researcher therefore reviewed the analysis and aimed to make further links to the language used by participants. This is a facet of credibility in qualitative research (Lincoln and Guba, 1985; Lincoln et al., 2011). The consultant also commented on the difficulty of giving feedback without access to the whole study, which perhaps reflects a need for more extensive consultation and service-user involvement in such research.

Reflexivity. As the researcher, I maintained a reflective research journal throughout the course of conducting the research. This was in service of exploring my approaches to the research at a level of detail that would allow me to be as reflexive as possible. Reflexive journals are common in qualitative research for this reason, generally helping the researcher to document their presence in the research (Etherington, 2004). I also attempted to hold in mind that all research must service the community in which it is carried out, with particular reflexivity for minority groups (Lincoln, 1995; Creswell and Poth, 2018). Although the journal included my activities in the research process, it also included spontaneous moments that triggered reflection (Guillemin and Gillam, 2004). I use this reflexive journal to inform my reflections on the current research.

One of the most frequent themes in my journal related to how little I knew about BME perspectives and experiences. I began my research process with a general interest in inequalities in clinical psychology and this narrowed to rates of BME detention because it is arguably one of the starkest inequalities in mental health. This initial narrowing was led by existing academic research, or lack thereof, which meant that my understanding of BME experiences and perspectives was limited in a way that I was not even aware of. During the process of conducting the research, and especially from attending events and seeking consultation, I was faced with my privilege of ignorance and learnt much more about these perspective and experiences. This has uncomfortably made me recognise that there is more breadth and depth that might have been captured. Specifically, I wonder whether I could have used a critical race theory paradigm and approached my research with more philosophical assumptions of historical and contemporary racialisation and power. I now believe this approach is well suited to such research. Perhaps I could have also used methods of collection and analysis that asked more specific and sophisticated questions about racialised experiences, rather than the open-ended exploratory questions that I chose. Mostly, I wonder if I could have co-produced the research with individuals and organisations with lived experience and expertise in the field. My reflections here acknowledge my privilege as a Trainee Clinical Psychologist with the support and resources to conduct research and which, at least in part, benefits me with progression in my career. I do not believe that I exploited participants in this vein, but I certainly feel like I could have done more to understand BME perspectives and experiences. I particularly felt ashamed to not know the extent of inequalities outside of my own minority group membership. This all led to a doubt that I hold even now about whether it was wholly appropriate for me to conduct this research and whether I did a good enough job. Themes of fraudulence and imposter syndrome occurred repeatedly in my journal.

I also reflected extensively on my feelings during the interviews, and the stark power imbalance between me and participants. This was compounded by reminders of my time as a member of staff on inpatient wards and the power that I had then. I left three interviews in particular with a painful sense of the distress and disempowerment some participants described and a discomfort at the systemic forces that contribute to this. Despite the wording of the Act and associated policies, my experience of the current research was that detention is far from being a caring clinical experience. The interviews were dominated with participants talking about racism, neglect, mistreatment and deprivations of autonomy and liberty. From my work experience, I could empathise with how every part of the day can be dependent on staff and how every freedom has to be requested and granted. I was particularly discomforted by the experience of witnessing first-hand how members of staff could be disparaging towards patients. As a psychologist, with the power and responsibility to deliver interventions, I was also concerned by the lack of reference by participants to psychological interventions as part of their experience of detention. I thought about what this might mean for my profession, to potentially have such little impact during acute periods of mental health care. I admit to researching evaluations of psychological interventions on inpatient wards to console myself that some useful work is being done. These reflections also emphasised the power I have to represent these experiences in a way that has impact. From reading my journal, I felt an imperative to publish my research and use it to engage as many people as I can to reflect on experiences of BME people, experiences of detention and the combined experiences of detention for BME people.

In addition to these broad themes, I also had a number of smaller reflections in my journal that may reflect my values and biases. Firstly, I noted my initial impressions of the inpatient wards where I interviewed and how they were not particularly pleasant places to be. I reflected on how this must impact both the staff and patients. Not only were the wards somewhat chaotic, but they were also physically unwelcoming. I also noted how much my initial codes and themes changed over the analysis, reflecting the subjective nature of qualitative research. I had a completely different theme structure in my first attempt and made several further alterations to the names of themes and their order. My journal has many references to how frustrating it was that codes could be included into more than one theme and how non-linear the process of thematic analysis is. Finally, I reflected on my use of theory in the research and how difficult it was to identify robust links to BME theories that could explain experiences of detention from dominant and established sources. I nevertheless sought theories that were from a BME perspective and specifically addressed the BME experience, rather than overall theories from other disciplines, such a social psychology. This perhaps meant that I was biased towards particular psychological theories. I think this ultimately reflects how complex the experience of detention is for BME people and perhaps how traditional theories in clinical psychology must be adapted and integrated to understand such complexity. Taken together, these reflections reveal that I am potentially biased against inpatient detention and hold beliefs that it is not currently experienced as very positive or helpful. This may have informed my analysis, but I would argue that the findings relating to negative experiences may be inferred from the verbatim quotes included, without my interpretation. My reflections also reveal my ignorance, which also may have caused bias in the conception and conduct of this research.

I must also acknowledge a great deal of anger, fear and sadness about systemic inequalities currently being discussed across the world with respect to racism. This painfully highlights how widespread and fatal these inequalities can be and how, too often, policies and procedures are used to whitewash a lack of action. This may bias my scrutiny of the independent review of the Act, especially in the context of the many proceeding reviews and initiatives that have gone before it and yet still failed to enact real change.

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APPENDICES

Appendix A

Grouped Search Terms Using the SPICE Framework

1. Setting:
   “England” OR “Wales”
2. Perspective:
   “Black*” OR “Asian” OR “Mixed” OR “Minorit*” OR “Ethnic*”
3. Intervention:
   “mental health service*”
4. Evaluation:
   “experience*” OR “qualitative”

Appendix B

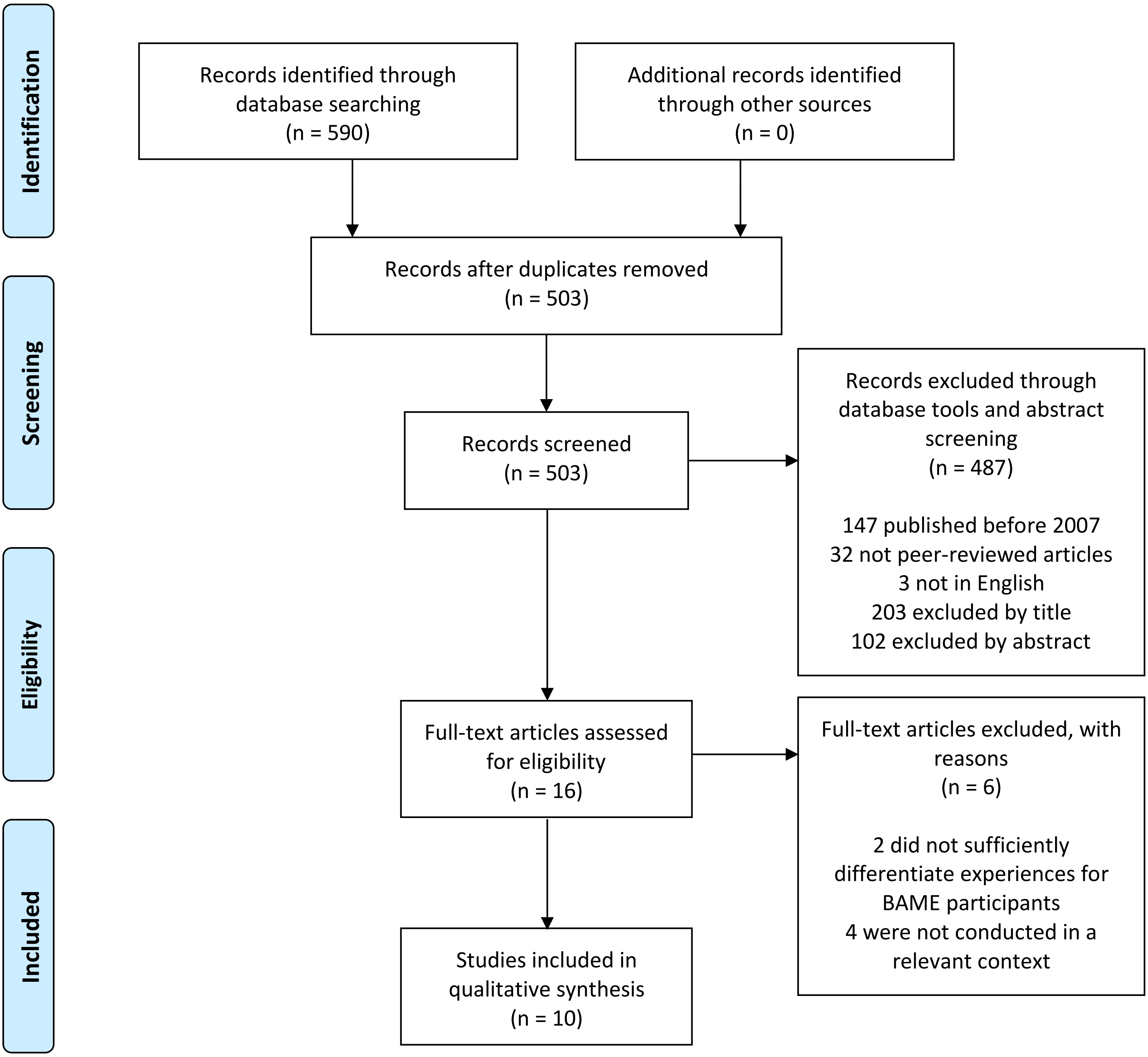
Search Term Groups and Results

Search Term Groups	**Results**
1	802,243
2	3,216,784
3	287,275
3	4,604,235
(1) AND (2) AND (3) AND (4)	590

Appendix C

PRISMA 2009 Flow Diagram of Screening and Selection

PRISMA 2009 Flow Diagram



Appendix D

Summary Characteristics of Included Articles

Study Author(s)	Service Context	Sample	Ethnicity	Method	Analysis
Almond and Lathlean (2011)	Postnatal Depression	9	Bangladeshi	Case Study	Thematic Content Data Analysis
Chtereva et al. (2017)	Mental Health Services	16	Central and Eastern European	Semi-Structured Interviews	Inductive Thematic Analysis
Edge et al. (2008)	Perinatal Depression	12	Black Caribbean	In-Depth Interviews	Thematic Analysis – Constant Comparative Approach
Gault et al. (2009)	Medication	10	Asian, Black African, Black Caribbean	Semi-Structured Interviews	Grounded Theory
Islam et al. (2015)	Early Intervention in Psychosis Services	24	Asian/Asian British – Pakistani, Asian/Asian British – Bengali, Black/Black British – African, Black/Black British – Caribbean, Black/Black British – Mixed White and Black Caribbean and Arab	Focus Groups	Thematic Approach and Framework Analysis

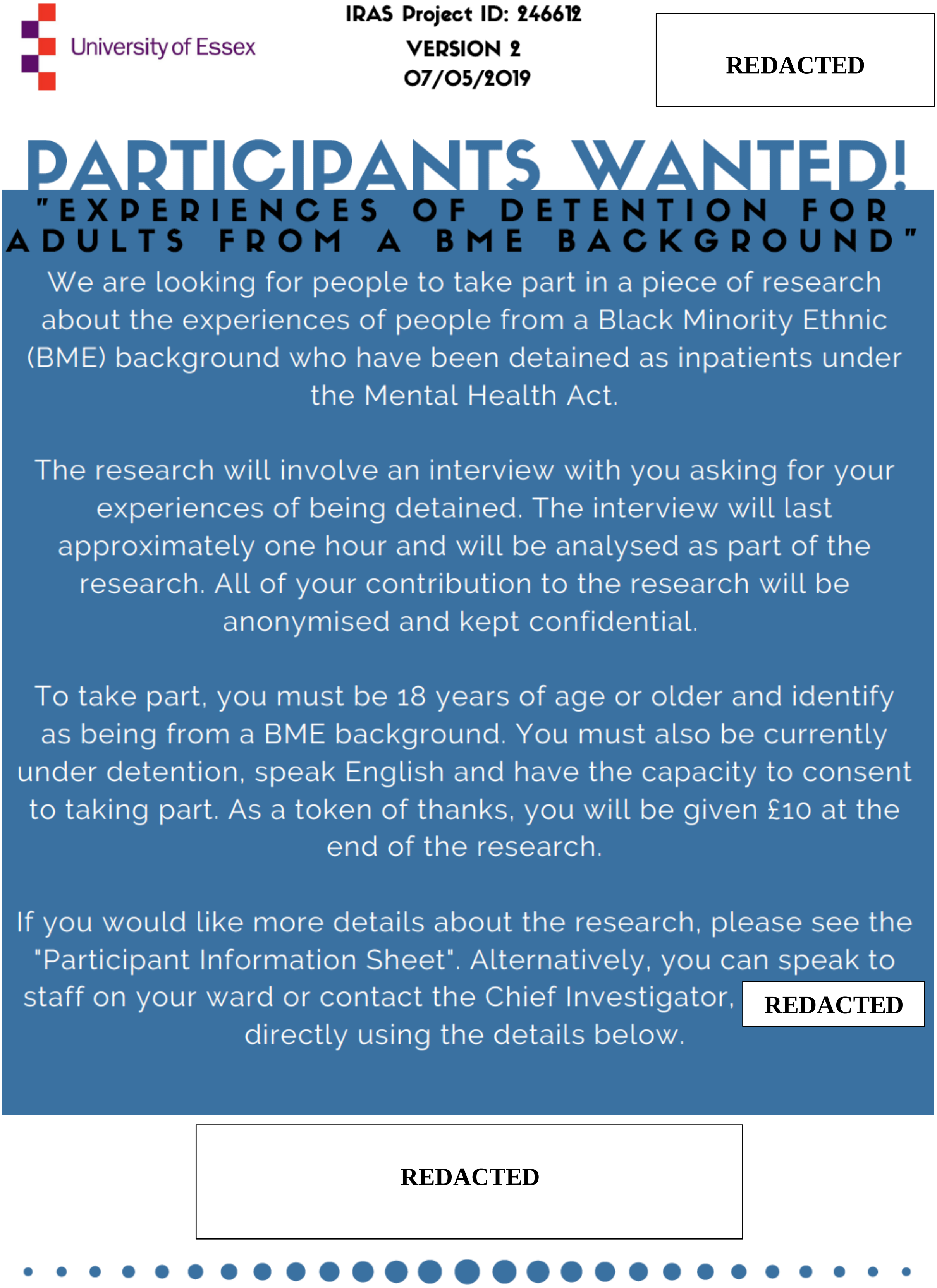
Lovell et al. (2014)	Primary Care Wellbeing Intervention	15	Pakistani, Bangladeshi, Indian and Somali	Interviews	Framework Approach
Memon et al. (2016)	Mental Health Services	26	Asian/Asian British, Black/Black British and Mixed	Focus Groups	Thematic Analysis
Schofield et al. (2019)	Mental Health Services	35	Black African and Black Caribbean	Focus Groups	Thematic Analysis
Wagstaff et al. (2018)	Mental Health Services	7	Black	Semi-Structured Interviews	Interpretative Phenomenological Analysis
Wales et al., (2017)	Eating Disorders	28	South Asian	Focus Groups	Thematic Analysis

Appendix E
Quality Appraisal Scores

	Study Authors									
Quality Appraisal Criteria	Almond and Lathlean (2011)	Chtereva et al. (2017)	Edge et al. (2008)	Gault et al. (2009)	Islam et al., (2015)	Lovell et al. (2014)	Memon et al. (2016)	Schofield et al. (2019)	Wagstaff et al. (2018)	Wales et al., (2017)
Question / objective sufficiently described?	2	2	2	2	2	2	2	2	2	2
Study design evident and appropriate?	2	2	1	2	1	1	1	1	1	1
Context for the study clear?	2	2	2	2	2	2	2	2	1	2
Connection to a theoretical framework/wider body of knowledge?	1	2	2	1	2	1	2	2	1	2
Sampling strategy described, relevant and justified?	1	2	2	1	1	1	1	2	1	1
Data collection methods clearly described and systematic?	1	2	1	1	2	2	1	1	1	2

Data analysis clearly described and systematic?	2	1	1	2	2	2	2	1	2	1
Use of verification procedure(s) to establish credibility?	0	0	0	2	2	1	2	1	0	1
Conclusions supported by the results?	2	2	2	2	2	1	2	2	2	2
Reflexivity of the account?	1	2	0	0	0	0	0	0	1	0
Summary Score (Final score divided by total possible score)	0.65	0.85	0.65	0.75	0.8	0.65	0.7	0.7	0.6	0.7

Appendix F
Poster Advertisement



University of Essex

IRAS Project ID: 246612
VERSION 2
07/05/2019

REDACTED

PARTICIPANTS WANTED!

"EXPERIENCES OF DETENTION FOR ADULTS FROM A BME BACKGROUND"

We are looking for people to take part in a piece of research about the experiences of people from a Black Minority Ethnic (BME) background who have been detained as inpatients under the Mental Health Act.

The research will involve an interview with you asking for your experiences of being detained. The interview will last approximately one hour and will be analysed as part of the research. All of your contribution to the research will be anonymised and kept confidential.

To take part, you must be 18 years of age or older and identify as being from a BME background. You must also be currently under detention, speak English and have the capacity to consent to taking part. As a token of thanks, you will be given £10 at the end of the research.

If you would like more details about the research, please see the "Participant Information Sheet". Alternatively, you can speak to staff on your ward or contact the Chief Investigator, REDACTED directly using the details below.

REDACTED

Appendix G
Participant Information Sheet

REDACTED

PARTICIPANT INFORMATION SHEET

Experiences of adults from a Black Minority Ethnic (BME) background who have been detained as inpatients under the Mental Health Act (1983)

Overview

You are being invited to take part in a piece of research about the experiences of people from a Black Minority Ethnic (BME) background who have been detained as inpatients under the amended Mental Health Act (1983). Before you decide whether you would like to take part, it is important to make sure that you understand why the research is being done and what it will involve. This information sheet can be used as a guide to explain the research and should be discussed with Jay Solanki, the Chief Investigator. You can also ask the Chief Investigator questions about the research or talk to others about the study if you would like to. If anything is unclear, please ask and let the Chief Investigator know.

This piece of research has been ethically reviewed and approved by the **[REDACTED]**

About the Researcher

[REDACTED] **[REDACTED]**

About the Research

What is the purpose of this research?
Official statistics report that more people from a BME background are detained or "sectioned" as inpatients under the Mental Health Act (1983) than any other ethnic group. This has been consistent over a number of years and can have a significant impact on the wellbeing of people who experience detention. Although some research has explored these

experiences generally, none has yet focussed on the experiences of people from a BME background. It is therefore important to understand these experiences in the context of the disproportionate number of people from this group who are detained. This research is being carried out as part of the Chief Investigator's doctorate in Clinical Psychology.

Why have I been invited to take part?
This research is interested in the experiences of adults from a BME background who have been detained as inpatients under the Mental Health Act (1983). Therefore, the Chief Investigator is inviting people to take part who may have such experiences. The research will involve adults aged 18 and above who identify as being from a BME background and who have been detained or "sectioned" under the Mental Health Act (1983).

Do I have to take part?
Taking part in this research is completely voluntary and you are under no obligation to participate. The decision is up to you and you should not feel pressured to be involved. If you decide to take part, you will be asked to sign a consent form, but you can change your mind at any point and withdraw without having to give a reason and without any impact on your care.

What will happen if I decide to take part?
You will be contacted by the Chief Investigator to have an initial conversation about the research. 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 would like to take part. If you do decide to take part, you will be asked to sign a consent form.

What will I have to do?
The research will involve the Chief Investigator conducting an interview with you based on your experiences of being detained under the Mental Health Act (1983). This will be at a time that is convenient to you in a private room within **[REDACTED]**. You will be asked to complete a short demographic questionnaire (age, gender, etc) before being interviewed for 45-60 minutes about your experiences of detention. You will be able to take breaks during the interviews if required. These interviews will be recorded using an audio-recorder and transcribed by the Chief Investigator. Following the interview, there will be some time to debrief with the Chief Investigator. After the research has been written, you may be invited to discuss it again with the Chief Investigator if you would like to.

Will taking part cost me anything?
No, the study will only require some of your time.

What are the possible advantages of taking part?
Taking part in this research will help build an understanding of what it is like to be detained under the Mental Health Act (1983) for people from a BME background. It is important to understand these experiences because people from this group are detained significantly more than any other ethnic group. As well as building understanding, talking about your experience may be helpful opportunity for you to discuss a significant experience that may be cathartic or empowering. You will also be given £10 to thank you for your time.

What are the possible disadvantages of taking part?

Detention is a significant experience that may be difficult to talk about and it is therefore possible that you may experience some emotional distress when being interviewed. The Chief Investigator will be mindful of this during the interview and has experience working with people who are experiencing emotional distress. You will have the opportunity at the end of the interview to discuss any concerns and you will be able to withdraw from the research at any time without having to give a reason if you would like to. Data that has already been collected may be kept if you withdraw from the study. This is explained further in the "Confidentiality and Data Protection" section below.

Confidentiality and Data Protection

Will the research be anonymous?
Yes. All of your contribution to the research will be anonymised. This means that any personal information that you give will be taken out or replaced after the interview has been concluded. Where personal quotes are used, every effort will be made to anonymise these quotes as much as possible. However, full anonymity may not be guaranteed. For example, direct quotes from your interview may be used in writing up the research, but you will not be identified as having said them. Instead, this will be reported as "Participant Number 5". If you would like to, you will be able to discuss the research with health professionals involved in your care (for example, nurses). In this case, staff will be aware that you may be taking part in the study. However, you can contact the Chief Investigator directly to express your interest without having to let anyone know.

Will the research be confidential?
Yes. All of your contribution to the research will be kept confidential. This means that only the Chief Investigator will have full access to your personal information and will store it securely. There are two limits to this confidentiality. Firstly, the research may be reviewed by the University of Essex, **[REDACTED]**, or other authorities for monitoring and auditing purposes. This may include a review of some personal information. Secondly, if the Chief Investigator had any concerns about your safety, or the safety of others, information may be shared with relevant professionals.

How will my information be stored?
All of your contribution to the research will be stored either in a locked filing cabinet at the University of Essex or on a secure and encrypted electronic file on a University of Essex computer. Only the Chief Investigator will have full access to this contribution, with the Research Supervisor(s) named above having access to anonymised files. The University of Essex is the sponsor for this study based in the United Kingdom. It will be using information from you in order to undertake this study and will act as the data controller for this study. This means that it is responsible for looking after your information and using it properly. The University of Essex will keep identifiable information about you for five years after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting the Chief Investigator.

How long will my information be stored for?

Your confidential and anonymised contribution to the research may be kept for up to five years. This is to allow time for the research to be written into a report and reviewed. This is in accordance with the Data Protection Act 2018.

Questions and Complaints

What do I do if I have a question?
If you have any questions, or would like to take part, you can contact **[REDACTED]**, the Chief Investigator, using the details at the beginning of this sheet. You can also tear off one of the paper slips attached to this sheet and place it in the box provided on your ward. If you would like to, you may also speak to healthcare professionals around you who have also been given details of this research.

What happens if something goes wrong?
This research does not involve any medical intervention. You will only be asked to discuss your experiences of being detained and it is not expected that this interview will impact your health. If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

Minor Complaints
If you have a minor complaint, please contact **[REDACTED]**in the first instance on **[REDACTED]** or at **[REDACTED]**

If the issue is not resolved, please contact the Research Supervisor(s), **[REDACTED]** and **[REDACTED]**

Formal Complaints

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact the Research Governance and Planning Manager, University of Essex, Wivenhoe Park, Colchester, CO4 3SQ, United Kingdom, by emailing: sarahm@essex.ac.uk or by telephoning 01206 873561.

Independent Advice
If you would like independent advice about taking part in research please contact:
Patient Advice and Liaison Service (PALS), **[REDACTED]**

Thank You

If you would like to take part in the research, please tear away this part of the form and post it in the collection box located on the ward. The collection box will be monitored by the Chief Investigator, however it will be located on the ward and staff may have access to it. If you would prefer, you may give the slip to the Chief Investigator directly during their visits to the ward.

Consent to Contact

Name:____________________________________ Date:______________________

I give my consent for **[REDACTED]**, Chief Investigator, to contact me/XXXX ward, about the proposed research.

Appendix H

Participant Consent Form

REDACTED

PARTICIPANT CONSENT FORM

Title of Project: Experiences of adults from a Black Minority Ethnic (BME) background who have been detained as inpatients under the Mental Health Act (1983)

Participant Identification Number for this trial:

Name of Chief Investigator: [REDACTED]

Please initial box

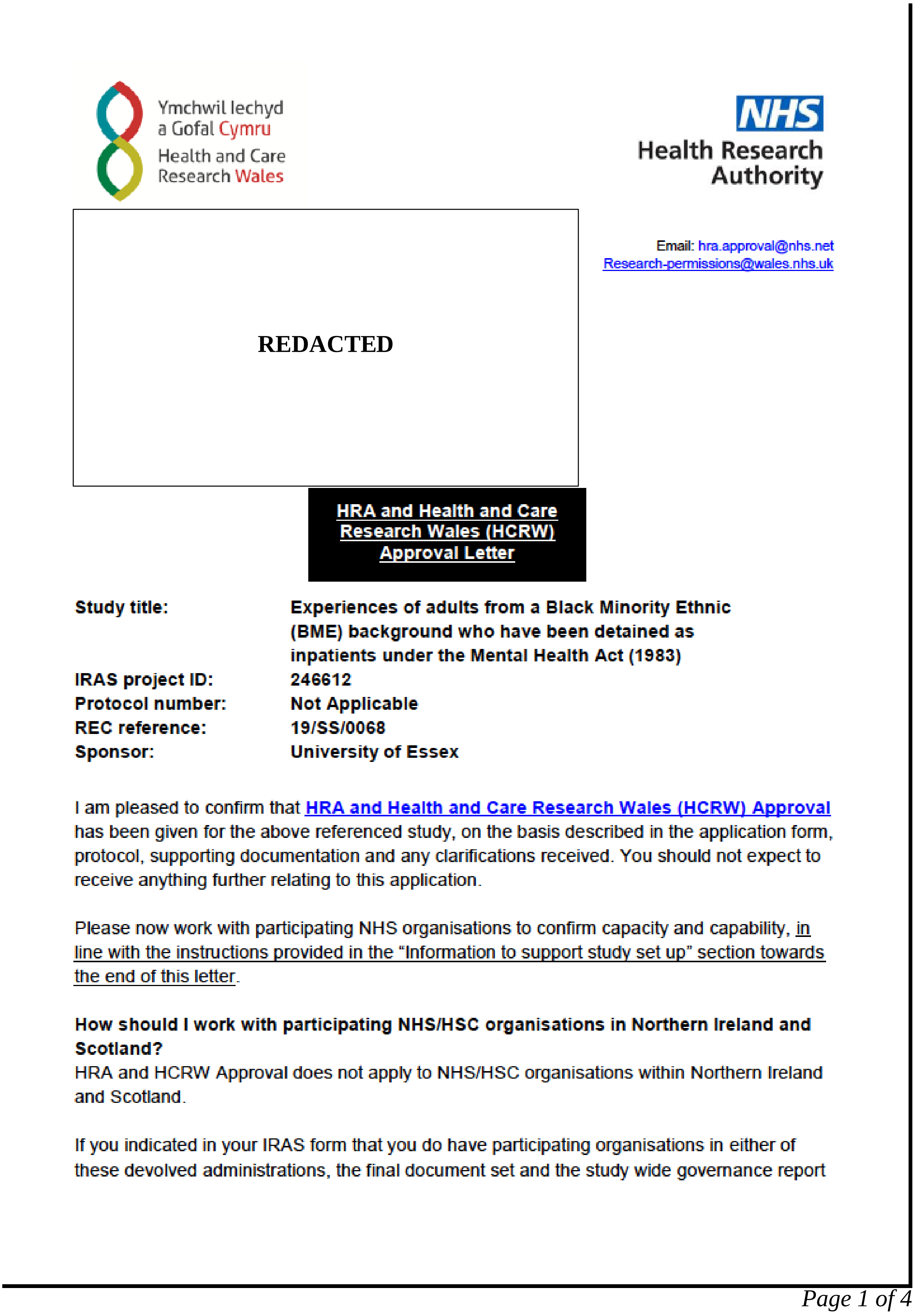
1. I confirm that I have read the information sheet dated MM/DD/YYYY (version ___) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that data collected during the study may be looked at by individuals from the University of Essex, North East London NHS Trust, or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. ☐
4. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
5. I consent to direct quotes being used from the recording of my interview. ☐
6. I agree to be contacted later on to be offered the opportunity to attend a feedback meeting about the findings of the study. ☐

7. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix I

HRA Approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

REDACTED

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

Study title: **Experiences of adults from a Black Minority Ethnic (BME) background who have been detained as inpatients under the Mental Health Act (1983)**
IRAS project ID: **246612**
Protocol number: **Not Applicable**
REC reference: **19/SS/0068**
Sponsor: **University of Essex**

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 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.

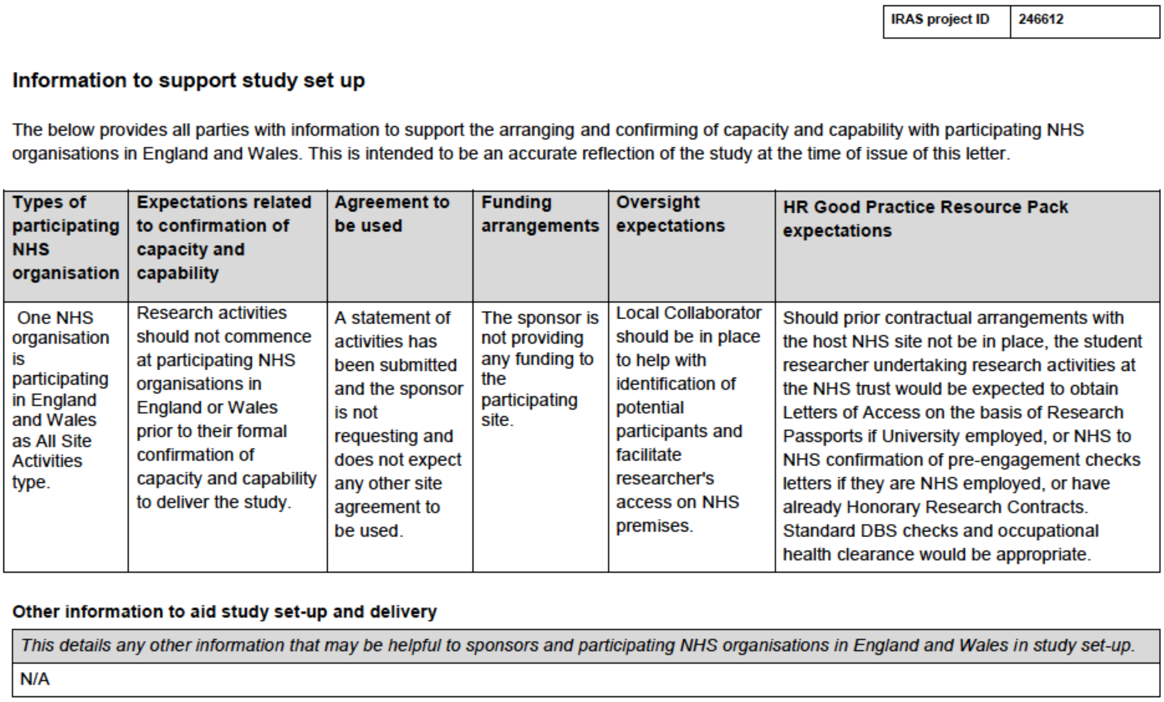
Your IRAS project ID is **246612**. Please quote this on all correspondence.

Yours sincerely,

Emma Stoica
Approvals Manager

Email: hra.approval@nhs.net

Copy to: Ms Sarah Manning-Press



IRAS project ID	246612

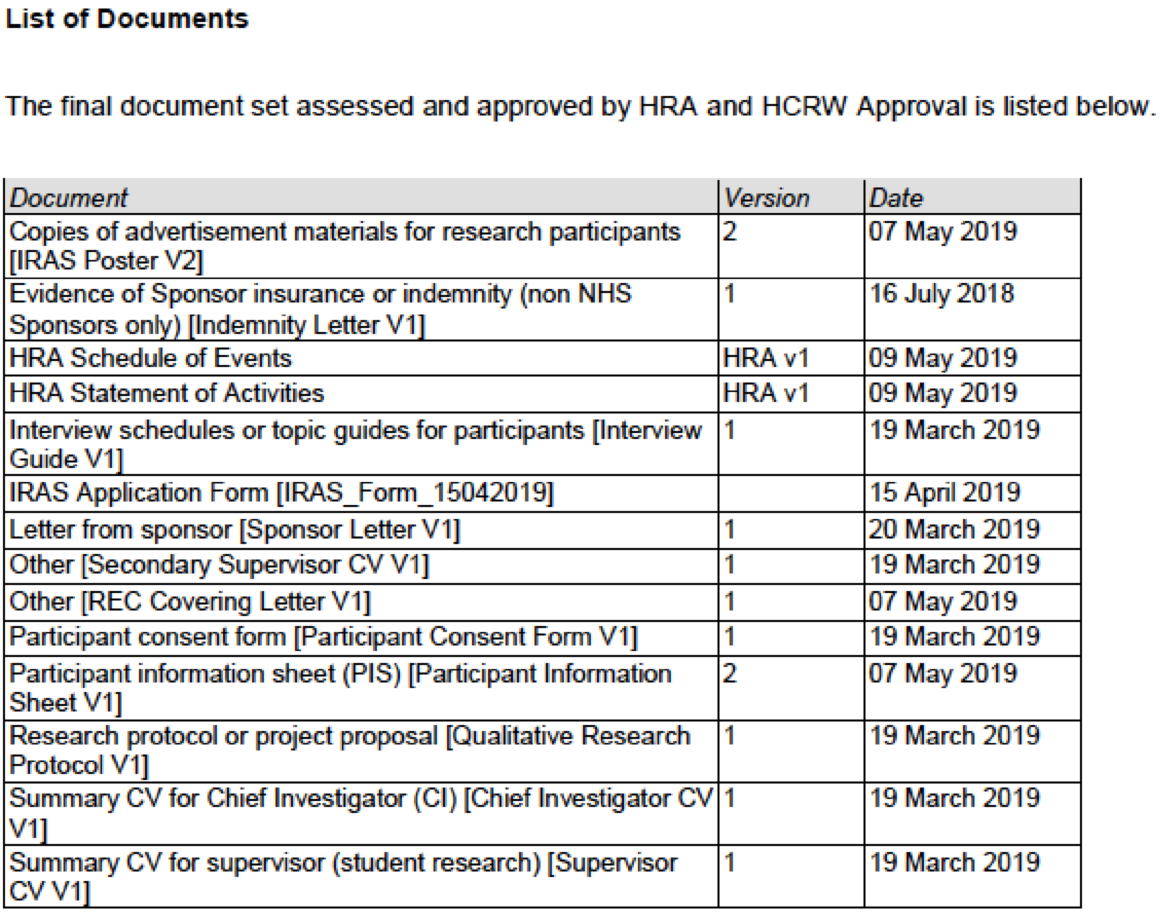
Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
One NHS organisation is participating in England and Wales as All Site Activities type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	The sponsor is not providing any funding to the participating site.	Local Collaborator should be in place to help with identification of potential participants and facilitate researcher's access on NHS premises.	Should prior contractual arrangements with the host NHS site not be in place, the student researcher undertaking research activities at the NHS trust would be expected to obtain Letters of Access on the basis of Research Passports if University employed, or NHS to NHS confirmation of pre-engagement checks letters if they are NHS employed, or have already Honorary Research Contracts. Standard DBS checks and occupational health clearance would be appropriate.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
N/A



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [IRAS Poster V2]	2	07 May 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Letter V1]	1	16 July 2018
HRA Schedule of Events	HRA v1	09 May 2019
HRA Statement of Activities	HRA v1	09 May 2019
Interview schedules or topic guides for participants [Interview Guide V1]	1	19 March 2019
IRAS Application Form [IRAS_Form_15042019]		15 April 2019
Letter from sponsor [Sponsor Letter V1]	1	20 March 2019
Other [Secondary Supervisor CV V1]	1	19 March 2019
Other [REC Covering Letter V1]	1	07 May 2019
Participant consent form [Participant Consent Form V1]	1	19 March 2019
Participant information sheet (PIS) [Participant Information Sheet V1]	2	07 May 2019
Research protocol or project proposal [Qualitative Research Protocol V1]	1	19 March 2019
Summary CV for Chief Investigator (CI) [Chief Investigator CV V1]	1	19 March 2019
Summary CV for supervisor (student research) [Supervisor CV V1]	1	19 March 2019

Appendix J

NHS Trust Approval

[REDACTED]

20/08/19

REDACTED

Letter of access for research

As the holder of an existing NHS contract you do not require an additional honorary research contract with the [redacted]. We are satisfied that such checks as are necessary have been carried out by your employer. This letter confirms your right of access to conduct research through the [redacted] for the purpose and on the terms and conditions set out below. This right of access commences on 20/08/19 and ends on 30/09/20 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct activities associated with such projects as you have received authorisation confirmed in writing from the Research and Development Director of the [redacted]. Please note that you cannot start the research until the Chief Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to the [redacted] premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this Trust, in particular that of an employee.

While undertaking research through the [redacted] you will remain accountable to your employer [redacted] but you are required to follow the reasonable instructions of your nominated manager [redacted] in this Trust or those given on her behalf in relation to the terms of this right of access.

You must act in accordance with the [redacted] policies and procedures, which are available to you upon request, and the Research Governance Framework.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer [redacted] is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

You are required to co-operate with the [redacted]t in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted]premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998.

Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The [redacted]will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the [redacted] in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

Please also ensure that while on the premises you wear your NHS ID badge at all times, or are able to prove your identity if challenged. Please note that this Trust accepts no responsibility for damage to or loss of personal property.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform your employer through its normal procedures. You must also inform the Research and Development Department and your nominated manager in [redacted]

[REDACTED]

Appendix K

University of Essex Approval

University of Essex

[REDACTED]

[REDACTED]

Dear [redacted]

Re: Ethical Approval Application (Ref 18022)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Officer on behalf of the Faculty Ethics Committee.

Yours sincerely,

LMcKee

Lisa McKee
Ethics Administrator
School of Health and Social Care

cc. Research Governance and Planning Manager, REO
Supervisor

Colchester Campus
Wivenhoe Park
Colchester CO4 3SQ
United Kingdom

School of Health and Social Care
T 01206 872854
E hsc@essex.ac.uk

www.essex.ac.uk
@uni_essexhealth /EssexHSC /uniofessex

Appendix L
Interview Guide

University of Essex

[REDACTED]

INTERVIEW GUIDE

1. **Introduction**
Introduction to interview including review of Participant Information Sheet and Consent Form to discuss what the interview will cover. Information to be given about the duration of interview (approximately one hour), debrief period (approximately 15 minutes) and procedures for terminating the interview or involving ward staff should any risk arise to the participant or interviewer. Participants should also be reminded of ethical issues of consent and confidentiality with support from the Participant Information Sheet and Consent Form. Time should also be allowed for any final questions.

2. **Demographic Information**
Brief questionnaire to include:
    - Age
    - Gender
    - Ethnicity
    - Time of detention
    - Time since detention began
    - Clinical/recorded/official rationale for detention

3. **Interview**
Open-ended questions (answers may overlap):
    - Can you describe the circumstances that led to your detention?
    - Can you describe your experience of being admitted to hospital under detention?
    - How appropriate do you feel detention was for you at that time?
    - Can you describe your experience of detention since being admitted?
    - How appropriate do you feel detention is for you currently?
    - Is there anything that you feel has been particularly helpful from your experience?
    - Is there anything that you feel has been particularly harmful from your experience?
    - How would you describe or summarise your experience of detention overall?
    - Is there anything else that you would like to add about your experiences of detention?

4. **Debrief**
Questions to include:
    - How are you feeling following this interview?
    - Do you have any questions for me about this research?
    - Would you like to receive a summary of the findings of this research?
    - We plan to invite participants to review the findings and check that they reflect experiences appropriately. Would you like to take part in such a review?

Thank you for your time. If you have any questions, please do not hesitate to contact me using the e-mail address given. I will now let the Ward Manager know the interview has ended.

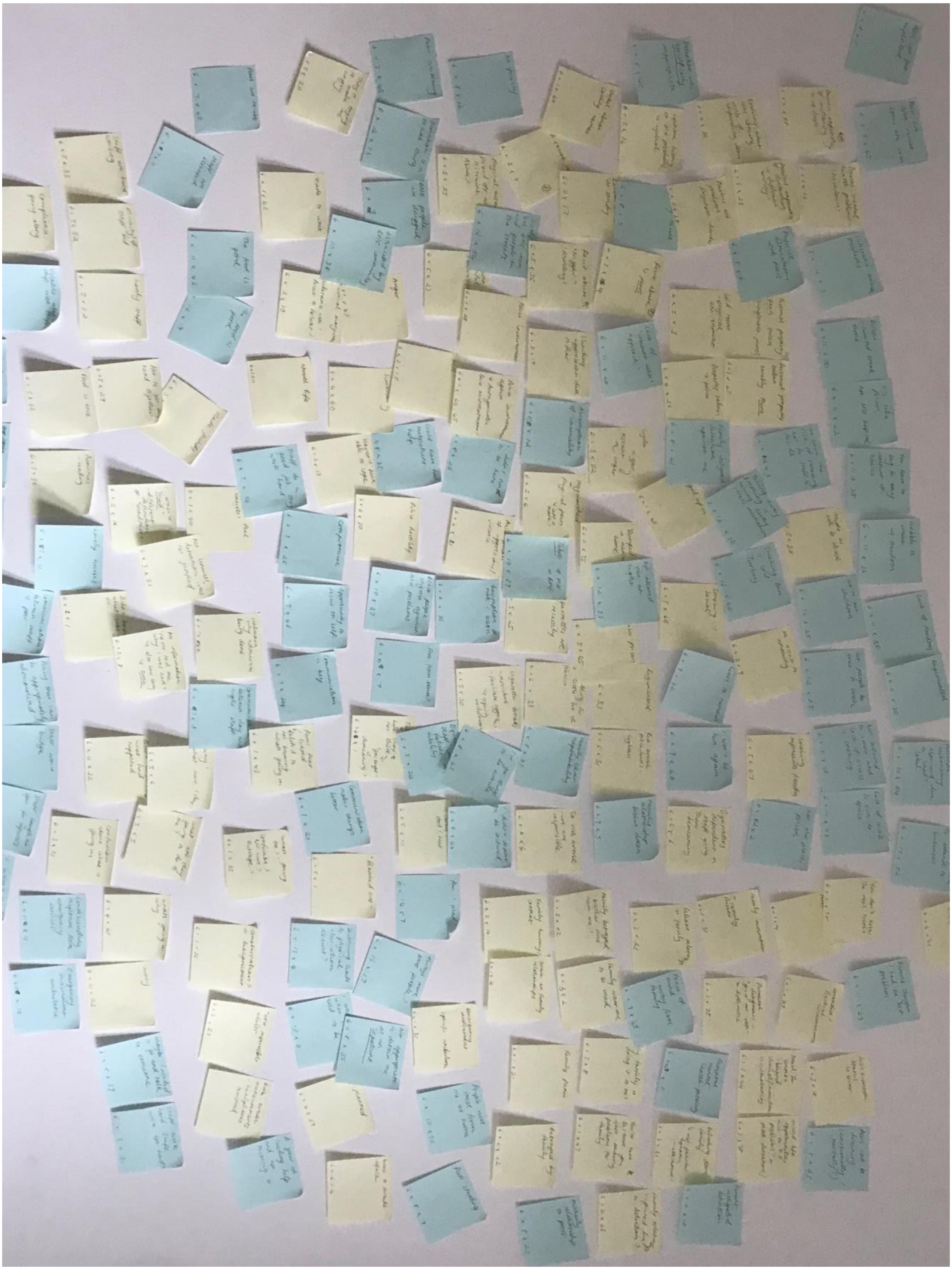
Appendix M

Example Transcript Extract

11:43	CI	So how did you feel about that?
11:46	P	I was used to it because I was already sectioned in [REDACTED – PREVIOUS HOSPITAL], um, I, I just followed the rules ‘cause I knew that if I just be good and then eventually I won’t be sectioned, I’ll have leave, which I did. And I got to go home, so I’m happy. I tell everyone the same thing, just be good, don’t cause any trouble and hopefully they follow in my footsteps ‘cause I’m being discharged early, so I’m very happy about that.
12:15	CI	What does it mean to have been good, can you explain that a bit for me?
12:19	P	Um, maybe being friendly with staff, talking more, interacting, helping out if they need help, ‘cause it can be quite hectic trying to deal with twenty different patients at a time and they all have different needs. Um, going to the morning meeting every morning definitely helps, if you have any problems, you can explain it to staff and other patients and put in requests for things like activities to do, just to kill time in here, make it more, like, you’re not in a hospital, yeah, that definitely helps. I made sure that I went to most of the morning meetings, otherwise I’d just be miserable. That’s it, yeah.

Appendix N

Initial Codes in Thematic Analysis for 1 Transcript



Appendix O

Thematic Analysis Quality Assessment (Terry et al., 2017)

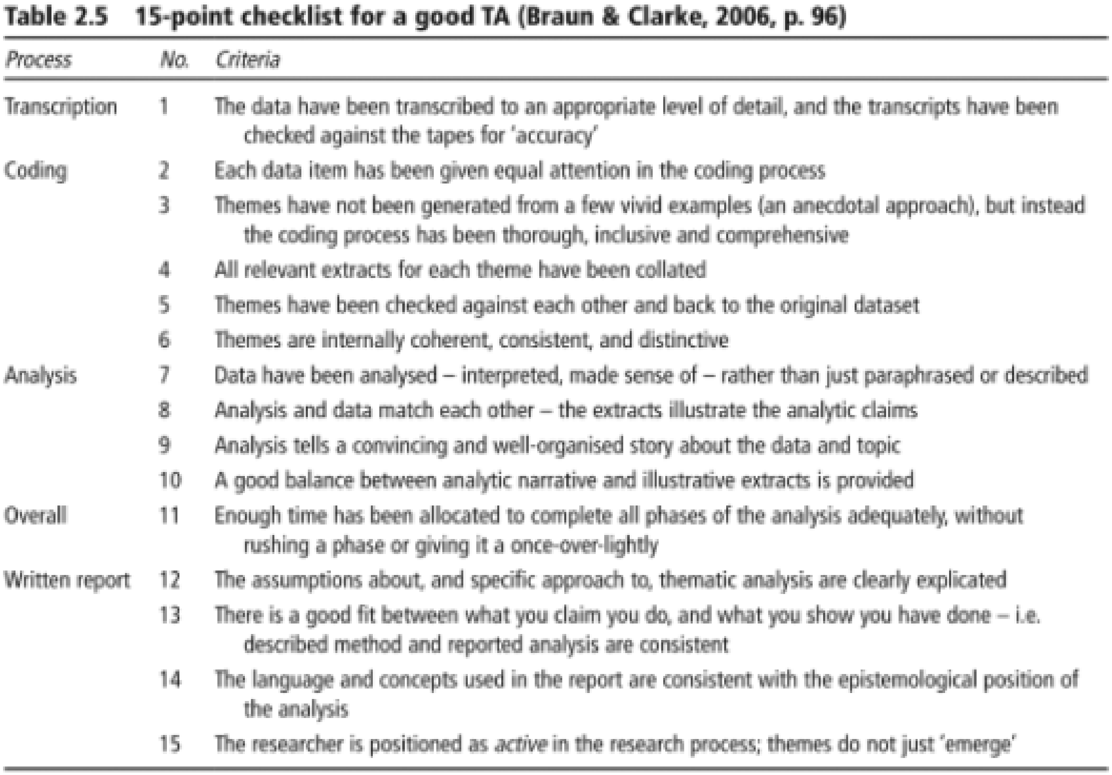


Table 2.5 15-point checklist for a good TA (Braun & Clarke, 2006, p. 96)

Process	*No.*	*Criteria*
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'
Coding	2	Each data item has been given equal attention in the coding process
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive
	4	All relevant extracts for each theme have been collated
	5	Themes have been checked against each other and back to the original dataset
	6	Themes are internally coherent, consistent, and distinctive
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described
	8	Analysis and data match each other – the extracts illustrate the analytic claims
	9	Analysis tells a convincing and well-organised story about the data and topic
	10	A good balance between analytic narrative and illustrative extracts is provided
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated
	13	There is a good fit between what you claim you do, and what you show you have done – i.e. described method and reported analysis are consistent
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'