# Black Men Speak: Making Sense of Trust in the Context of Forensic Mental Health Services among Black Men in London, UK.

by

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# Thesis Overview

This thesis is submitted in partial fulfilment for the degree of Doctor of Clinical Psychology at the University of Birmingham. This thesis includes three chapters. The first chapter presents a meta-analysis examining the impact of ethnicity on legal status on admission to mental health in-patient units in England, UK. Findings revealed a significant difference between ethnicity and legal status in the use of emergency police holding powers for Black and Asian populations compared to their white counterparts. However, further research is required to explore the intersectional factors, such as ethnicity and gender on legal status.

The second chapter is an empirical qualitative study that applied Interpretative Phenomenological Analysis (IPA) to examine the experiences of trust among eight Black men before admission into forensic services. Six main themes were identified: Life Stresses, Self-reliance, Disillusioned, it didn't make sense, Invisible and frustrated, and they don't care. The findings provide valuable insights into Black men's lived experiences of trust before involuntary admission into statutory services. This can be used to develop guidelines for culturally competent mental health care.

The third chapter contains two press release articles that provide accessible summaries of the meta-analysis and empirical research. The press releases outline the main findings of each paper in a format suitable for public dissemination.

# Acknowledgements

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# Glossary of Terms

| Term | Study Definition |
|---|---|
| Black Men | Black African/Caribbean Ethnicity, and/or Black with mixed heritage |
| BME | Black and Minority Ethnic groups |
| Race | A group of people that share certain distinctive physical traits linked to biology and physical characteristics such as skin colour and hair. |
| Ethnicity | Ethnicity can be defined as “the social categorization of people into groups based on common attitudes, beliefs, religion, language, and/or cultural lifestyle... with important social consequences for individuals" (Dennis *et al.,* 2021, p. 302). |
| Culture | The customary beliefs, social forms, and material traits of a racial, religious, or social group |

# Chapter 1

Literature Review:

**A Meta-Analysis examining the impact of ethnicity on legal status on admission to mental health in-patient units in England, UK.**

## Abstract

***Background:*** Studies indicate that individuals from Black and Minority Ethnic (BME) backgrounds are more likely to be involuntarily detained in psychiatric hospitals. However, no meta-analysis to date has included ethnicity and legal status in examining rates of compulsory admission to psychiatric hospitals in England, UK. Therefore, this review aimed to identify and assess literature on mental health admissions in England, with a focus on evaluating potential variations in rates among various ethnic groups.

***Methodology:*** PsycINFO, MEDLINE, EMBASE and Web of Science electronic databases were searched for studies reporting the legal status on admission to psychiatric in-patient units by ethnic groups. Findings were synthesised for eligible studies relevant to the review question.

***Findings:*** A total of 509 studies were screened, and nine studies were eligible for the current review, with sample size varying from 110 to 3873. The focus of the analysis was to examine if there were significant differences in legal status across different ethnic groups. Findings demonstrated no significant difference between ethnicity and legal status for civil and forensic sections. However, a significant difference existed in the use of emergency police holding-powers for Black and Asian populations as compared with White populations.

***Interpretations:*** Further research could examine the impact of intersectional factors such as ethnicity, gender, and socioeconomic status on the legal status of patients admitted to psychiatric units in England, UK. This research is fundamental to inform clinical practice and policy development, which can ultimately lead to improvements in mental health care for diverse patient populations in the UK.

## Introduction

Black and Minority Ethnic (BME) communities face inequalities in their experiences of mental health services in the UK (Memon et al., 2016). BME individuals are less likely to access mental health services through primary care pathways and are disproportionately represented in crisis care. This often leads to more negative than positive experiences, as evidenced by studies such as Jeraj et al. (2015) and Rabiee et al. (2014). In addition, Black men are 40% more likely to access mental health services via the criminal justice system than White individuals (Health and Social Care Information Centre, 2014).

The Mental Health Act (1983, amended in 2007) (MHA) was implemented in England and Wales (Lawton-Smith et al., 2007). The Mental Health Act (1983) allows professionals to detain and treat individuals with mental health difficulties without their consent in the interest of their health or the public's safety. Lawlor (2012) conducted research on the predictors of the MHA assessments and detentions in the UK and found that the relationship between ethnicity and detention is complex and multi-dimensional; particularly among women experiencing mental health crises (Lawlor, 2012) and first-episode psychosis (Mann et al., 2014). In London, UK, a partial explanation for higher rates of compulsory detention in BME women is reduced help-seeking and variances in pathways to care (Gajwani et al., 2016).

Several studies have highlighted that ethnic minority groups are subjected to a disproportionate risk of compulsory detention in psychiatric in-patient facilities (Bhui et al., 2003; Singh et al., 2013; Singh et al., 2013). Research also indicates that individuals from BME groups have higher instances of involuntary psychiatric admission into psychiatric hospitals (Bebbington et al., 1994; Gajwani, Parsons, Birchwood & Singh, 2016), longer in-patient admissions (Mohan et al., 2006) and more readmissions (Priebe et al., 2009). Conversely, several studies have

reported either no significant association or weak associations between detention rates and ethnicity.

However, the rates of involuntary detention in psychiatric units were not consistently higher within all or specific ethnic groups (Dannerbeck et al., 2009; Gupta, 1991; Singh et al., 2007). Nonetheless, several studies in the UK have reported increased detention rates for African and Caribbean populations under the Mental Health Act (1983) (Singh et al., 2007; Mann et al., 2014; Corrigall & Bhugra, 2013).

The notable disparities have been attributed to various factors, including a higher incidence of schizophrenia in certain BME (Bebbington et al., 1994; Bhui et al., 1999) and migrant populations (Bourque et al., 2011; Missinne & Bracke, 2010). Another explanation suggested is the possibility of limited information and awareness around mental health difficulties (Singh et al., 2007; Bhugra et al., 1999), more incidences of difficult experiences with mental health services (Sashidharan, 2003), experiences of racism or discrimination from health care providers (McKenzie & Bhui, 2007; Paradies et al., 2013) and the use of differing psychiatric services (Lay et al., 2005; Mulder et al., 2006). However, few explanations are accompanied by sufficient supporting evidence (Singh et al., 2007).

### *Ethnic disparities of compulsory admissions*

Various studies have demonstrated that ethnic disparities of compulsory admission decrease or are eliminated once confounding variables such as age, gender, diagnosis, risk, and pathways to care are controlled for (Singh et al., 2014; Singh et al., 2007; Lawlor et al., 2012; Corrigall et al., 2013). Conversely, some studies proposed that ethnicity significantly determines involuntary admissions to psychiatric facilities, irrespective of other factors (Morgan et al., 2005; Singh et al., 1997). (Morgan et al., 2005; Singh et al., 1997) with disparities in BME

populations' experience of mental health services compared with their white counterparts (Raleigh, 2007).

An existing meta-analysis by Singh et al. (2013) examined the relationship between ethnicity and involuntary detention rates in psychiatric settings in the UK. The findings indicated that individuals from ethnic minority backgrounds were more likely to be involuntarily detained under the Mental Health Act compared to individuals from the White ethnic group. The review highlighted ethnic disparities in the rates of involuntary psychiatric detention, suggesting that ethnicity could be a factor linked to involuntary detention. In addition, it is well acknowledged that research indicates BME groups are at a greater risk of compulsory detention under the Mental Health Act (1983) in England and Wales. However, little evidence exists to update current knowledge regarding the overrepresentation of BME populations among those detained under the Mental Health Act (1983) in England under specific Mental Health Act legal status classifications.

Barnett et al. (2019) conducted a systematic review and meta-analysis of international data examining compulsory admission and readmission in BME populations. They found a significant increase in compulsory detention within BME populations, with the highest rate of compulsory admission observed among Black Caribbean populations. While not as prominent, there were still notable increased rates of compulsory admission within South Asian populations as well.

The current meta-analysis builds upon previous studies by Singh et al. (2013) and Barnett et al. (2019) by further exploring the association between ethnicity and the Mental Health Act legal status on admission to psychiatric hospitals in England and Wales. The present study

includes a specific focus on exploring whether an elevated risk of detention for ethnic minority groups exists in both the civil and criminal sections of the Mental Health Act (1983). By considering the relative risk according to the type of Mental Health Act section, this meta-analysis aims to provide an understanding of the disparities in detention rates for different ethnic groups and within different sections of the Mental Health Act.

The examination of relative risk according to the type of MHA section was considered useful because it sheds light on the specific legal provisions under which ethnic minority groups may experience a heightened risk of detention. By differentiating between civil and criminal sections, the meta-analysis proposes to offer insights into how systemic factors, such as the application of the Mental Health Act, may contribute to the elevated risk of detention among ethnic minority populations. This approach allows for a more detailed understanding of disparities in Mental Health Act status.

### *Rationale*

The current study aims to update and extend existing systematic reviews and meta-analyses (Bhui et al., 2003; Singh et al., 2007; Singh et al., 2013; Barnett et al., 2019) on the rates of detention among various BME populations, more specifically ethnicity and subsequent legal status. This meta-analysis will attempt to highlight explanations for any disparities between the groups.

### *Objectives*

This meta-analysis aims to examine and synthesise available literature to determine the rates of compulsory detention among various ethnic groups. To our knowledge, prior studies have not fully documented or specified the potential ethnic differences concerning legal status and compulsory detention in psychiatric settings. Therefore, this meta-analysis seeks to fill this

gap in the literature and provide valuable insights into the impact of ethnicity and legal status in mental health care.

The objectives of the current study are:

I. To conduct a comprehensive review of published and original studies reporting the prevalence of the Mental Health Act (1983) legal status on admission within various ethnic groups.

II. To identify any additional evidence that could highlight potential reasons for any observed variations in prevalence by ethnicity if such evidence exists.

# Method

## Identifying primary studies

### *Search of Electronic Databases*

A systematic literature search was initially carried out on 10th July 2022 using PsycINFO, MEDLINE, EMBASE and Web of Science electronic databases. The search aimed to obtain a comprehensive overview of the literature examining the compulsory detention rates under the Mental Health Act (1983) of various ethnic populations and the legal status on admission to mental health facilities in England. The search terms used to identify these studies are outlined in Table 1.

*Table 1: Search Criteria*

| Construct | Free Text Search Terms | Method of Search |
|---|---|---|
| Ethnic Groups | ethnic* or multi-ethnic* or multiethnic* or indig* (african or africaan or caribbean* or afro-caribbean* or afrocaribbean* or asian* or * or (Black or Blacks) or (Black patient or BME or BAME<br>AND | Free search terms<br>All search terms combined with *OR All fields*<br><br>All construct terms linked with AND |
| Psychiatric Hospital care/admission | Mental health act, in-patients or in-patients or *mental disorders or Forensic Psychiatry or mental or psychiatr* or psychotic or risk or crisis or crises or (psychiatr* or psychology or health or medicine)<br>AND | Free search terms<br>All search terms combined with *OR All fields*<br><br>All construct terms linked with AND |
| Legal status | law or legal or legal status legislat* or jurisprudence) and (commit* or admission? or admitt* or detain* or detention? or section* or hospitalisation?) or involuntary or in- voluntary or rate? or status) or (admission freq) or (acute admission) or (police or policing or local authority polic*) or (prison* or custody or incarcerat*) (transfer* or transition* or referral?) or readmission<br>AND | Legal status used on all databases<br>All fields |
| Study design | "Randomised controlled trial or randomised or randomisation or randomising) or (RCT or "at random" or (random* or crossover or cross-over or design* or divide* or division or number) list* or (treatment or care) usual) or no intervention* or non-intervention* or non-intervention* or without any intervention*) or (control group? or (controlled (trial or study) or (single or double) blind*) | Free search terms<br>All search terms combined with *OR All fields*<br><br>All construct terms linked with AND |

### *Inclusion and Exclusion Criteria*

Full inclusion/exclusion criteria are described in Table 2 which includes patients in England detained under the Mental Health Act before 1983, under civil sections, forensic sections and police emergency-holding powers. Only studies from England and Wales were included in the current review due to the Mental Health Act (1983) applying in England and Wales.

*Table 2: Inclusion and exclusion criteria*

| **Inclusion criteria** | **Justification** |
|---|---|
| *Participant focus* | |
| Participants in papers should be adults over 18 and have been detained under the Mental Health Act (1983) | Previous studies have analysed and compared hospital admission rates for adults. To avoid skewing data, studies examining hospital admission rates in the young people population will not be included. |
| *Study content* | |
| Articles that presented data on combined civil and forensic sections were excluded from the analysis. | These articles do not provide the outcome data needed for this meta-analysis. |
| Excluded articles that do not report specific ethnic categories. | These articles do not provide the outcome data needed for this meta-analysis. |
| *Type of article* | |
| The following article types were excluded: a meta-analysis/theoretical papers/ reviews/commentaries/ clinical guidance/qualitative papers. | These articles do not provide the outcome data needed for this meta-analysis or have not been checked to ensure their quality by a peer review process. |
| *Language* | |
| Papers written or translated into English were included. | The Mental Health Act (1983) exclusively applies to England and Wales. |
| *Study location* | |
| Studies reporting international data on compulsory admission rates were excluded. | The Mental Health Act (1983) exclusively applies to England and Wales. |
| *Date Range* | |
| The date range was applied; papers were only used if they used the Mental Health Act 1983. | Studies reporting legal status based on The Mental Health Act (1983) onwards were included. Papers published prior to 1983 would have utilised The Mental Health Act (1959), which is outdated and may not reflect the current legal framework and practices |

Figure 1 below presents the results of the systematic search. A total of 509 papers were identified, 494 remained, once duplicates, removed. A total of 11 articles were included in the study through a combination of backward reference search and forward citation search. Subsequently, the titles and abstracts of the remaining articles were screened using the exclusion criteria. The three most common reasons for exclusion were: Studies conducted outside England and Wales (n=282), studies reporting outcomes on adolescent populations (n=16), and papers discussing ethnic disparities in the use of restraint and seclusion in psychiatric hospitals (n=15). Additionally, (n=11) more articles were discovered from the reference lists of the included studies. The full text of the remaining (n=20) articles were reviewed in detail using the exclusion criteria. Thus, nine articles met the criteria for inclusion in this meta-analysis.

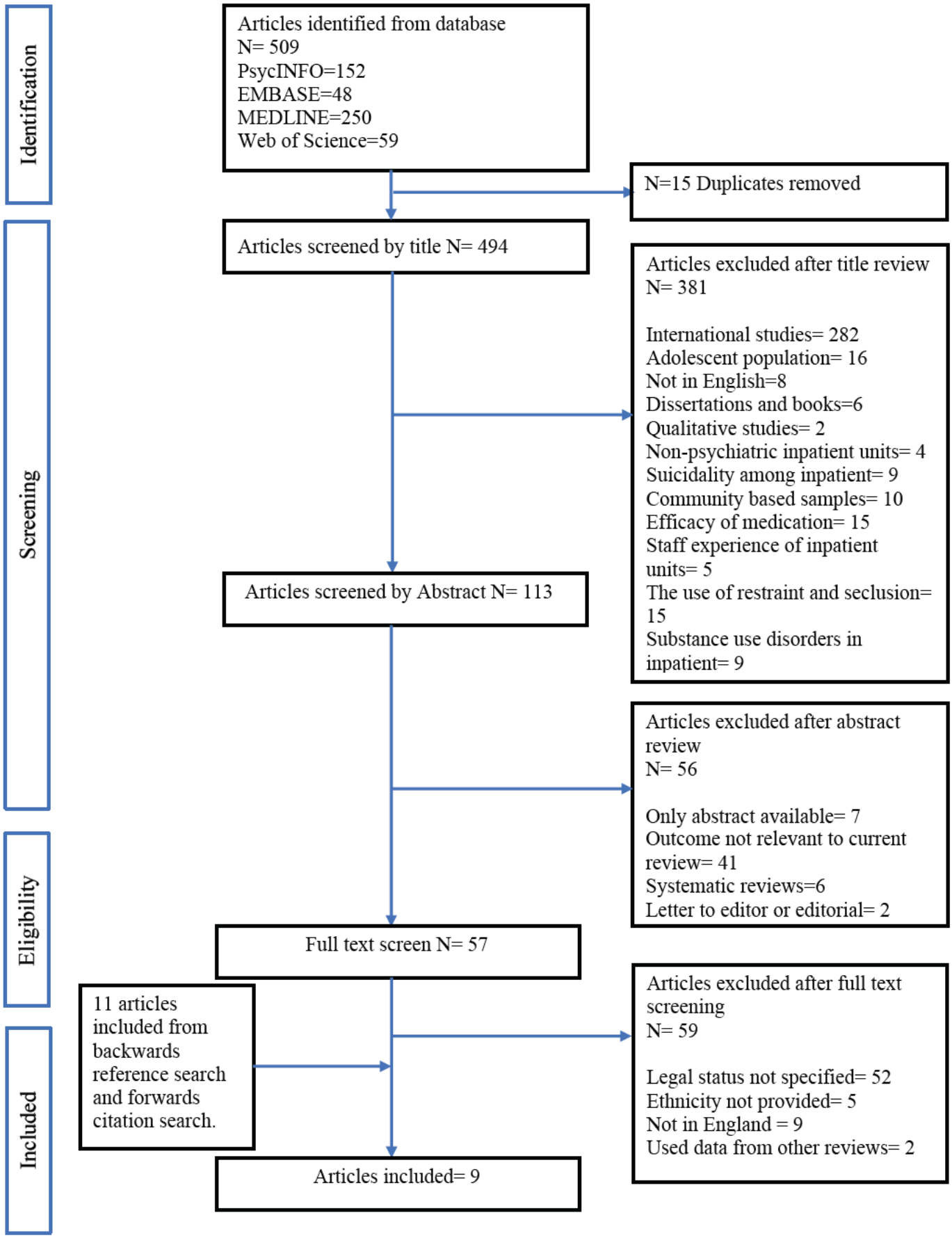



*Figure 1: Results of the systematic search and the application of the inclusion criteria.*

### *Data extraction*

The author conducted data extraction, a total of nine papers provided information required such as participants' ethnicity and their legal status of detention under the Mental Health Act (1983). The event rates, representing the number of participants subjected to detention under the Mental Health Act (1983) out of a consecutive case, were reported. In order to calculate relative risk or risk difference estimates, the event rates should be reported separately for ethnic minority groups and a reference population, typically consisting of white patients. Regression-based procedures, such as logistic regression, may also be utilised to calculate event rates. However, it is important to note that such rates are often computed from data that has been adjusted for their association with one or more additional covariates. This adjustment highlights the idiosyncratic character of the reported regression coefficients, which may differ from the effects reported in other primary studies. If problematic heterogeneity is identified in the random effects model, the contribution of standardised regression coefficients to overall heterogeneity will be evaluated empirically.

Multiple outcomes reporting can occur when primary studies report several variations of the same outcome or when they use the same outcome measure across multiple subgroups. To the extent possible, multiple outcomes will be combined into a single quantitative outcome using the procedures outlined by Borenstein et al. (2009). If it is not feasible to combine the multiple effects into a single quantitative effect, the multiple effects will be included directly in the meta-analysis. The inclusion of multiple outcome reporting from the same primary study may result in a minor reduction in confidence intervals for the random effects model since the sample size of that primary study will be included twice.

### *Defining problematic variance*

A study-level effect is considered heterogeneous if it presents with variation from the meta-analysis synthesis that cannot be attributed to true variation in the population's effect distribution. Heterogeneity can result from methodological variation in the included studies, measurement error or uncontrolled individual difference factors. Higgins $I^2$ is a commonly used measure of heterogeneity, with greater values of $I^2$ indicating variation in weighted average effect that may reflect methodological artefact, bias, or confounding factors. As considerable variation in methodologies of the included studies was used to calculate the meta-analytic synthesis, problematic heterogeneity was defined as a Higgins $I^2$ value greater than 75%, (Higgins, 2003). Where unacceptable or problematic heterogeneity is observed, the focus of the subsequent analyses will be on identifying the sources of heterogeneity between the estimates of the prevalence of detention ordered in the included studies.

### *Assessment of Study Quality*

A set of quality criteria were developed to assess any risk to internal validity, external validity, and precision within this literature. The developed framework evaluates these risks in four areas determination of ethnicity and determination of legal status (which relate to internal validity), sample size and sample method (which relate to external validity and precision.

The risks to internal validity and the criteria for Low, Unclear or High risk are described in Table 3 below, and the risks to external validity and precision (which in this case relate to the generalisability of the findings) are described in Table 4. The application of these criteria is reported in Figure 2.

*Table 3: Risk of bias assessment and the criteria for ratings of low, unclear, or high risk*

| Details of Bias | Risk of Bias |
|---|---|
| Determination of ethnicity is relevant to potential limitations or biases in the method used to determine participants' ethnicity. If the method for determining ethnicity primarily relies on clinicians' or observers' subjective judgments, it could introduce bias. Clinicians' observations may not be consistent or accurate, leading to misclassification of participants' ethnicities. This misclassification can, in turn, affect the results of a study, potentially creating a bias by artificially inflating or deflating the association between ethnicity and outcomes e.g., legal status | High Risk- If the method for determining participants' ethnicity relies solely on clinicians' subjective observations, and there is a high likelihood that these observations are inaccurate or inconsistent, then this would be considered a high risk of bias.<br>Unclear Risk- If the study does not provide sufficient information about the method used to record participants' ethnicity or the level of subjectivity in the process, it would be considered an unclear risk of bias.<br>Low Risk- If the study uses objective or standardised methods for recording participants' ethnicity, such as participant self-reporting or predefined categories that minimise observer subjectivity, then this would be a low risk of bias. |
| Determination of legal status, refers to potential misrepresentation or selective reporting of information concerning the legal status of study participants, which may impact the accuracy and validity of the study's findings. | High Risk – If there is evidence that information about participants' legal status has been selectively reported or misrepresented based on the study's objectives or findings. For example, if the study reports only the legal status of participants who experienced specific outcomes while omitting the legal status of others.<br>Unclear Risk- If the study lacks sufficient details about how the legal status of participants was determined or does not clarify the reporting process.<br>Low Risk- If the study provides transparent and complete information about how the legal status of all participants was determined, without selective reporting or misrepresentation, e.g., clinical notes and original section papers were used to determine the legal status of participants. |

*Table 4: Risk of bias assessment and the criteria for ratings of low, unclear, or high risk*

| Details of Bias | Risk of Bias |
|---|---|
| Sampling method was determined when selecting or recruiting participants into the study was not random or unbiased, leading to a sample not representative of the population from which it was drawn. | High Risk- The process of selecting or recruiting participants into the study groups is flawed, e.g., excluding certain groups from the study without valid reasons, resulting in the omission of critical subpopulations from the analysis.<br>Unclear Risk- Unclear risk is assigned when the information provided in the study is insufficient to confidently judge whether there is a high or low risk of bias.<br>Low Risk- The study's methods for selecting participants are well-designed and minimise the potential for bias, e.g., random, or systematic sampling methods that ensure a representative sample of the target population. |
| Sample size in this context refers to assessing whether the sample size in the study was sufficient to detect meaningful effects or relationships. | High Risk- If the study lacks a clear rationale or adequate sample size. If the sample size was too small, it would be considered high risk e.g., <20<br>Unclear Risk- If the study does not provide sufficient information to assess the appropriateness of the sample size or if the information is unclear or ambiguous it would be considered unclear risk<br>Low Risk- If the study provides a clear sample size that is adequate would be considered low risk e.g., >100 |

| Study Name | Determination of Ethnicity | Determination of Legal Status | Sample Method | Sample size |
|---|---|---|---|---|
| Ali et al (2007) | Low risk | Low risk | Low risk | Unclear risk |
| Borschmann et al (2010) | Low risk | Unclear risk | High risk | Low risk |
| Davies et al (1996) | Low risk | Low risk | Low risk | Unclear risk |
| Gajwani et al (2016) | Low risk | Low risk | Low risk | Low risk |
| Koffman et al (1997) | Low risk | Low risk | Low risk | Low risk |
| Maden et al (1999) | Unclear risk | Low risk | Unclear risk | High risk |
| Mann et al (2004) | Low risk | Low risk | Unclear risk | Low risk |
| Owens et al (1991) | Low risk | Low risk | Unclear risk | Unclear risk |
| Webber & Huxley (2004) | High risk | Unclear risk | High risk | High risk |
| | | | | |

*Figure 2: Ratings of risk of bias. Red indicates a high risk of bias, amber marks an unclear risk, and green is a low risk of*

### *Determination of Ethnicity*

Overall, the methods used to determine participants' ethnicities were suitable. The majority of studies reported data on ethnic groups were recorded in various ways, e.g., census data, self-reported ethnic groups and from staff who knew patients and checked for errors using electronic records. Several studies clearly defined specific ethnic categories (Ali et al., 2007; Borschmann et al., 2010; Davies et al., 1996; Gajwani et al., 2016; Mann et al., 2004; Owens et al., 1991). One study was rated as unclear risk as ethnic groupings were oversimplified, e.g., white vs Black, which included mixed-race participants (Maden et al., 1999). In contrast, one study was rated as high-risk as the method for determining participants' ethnicity relied solely on clinicians' subjective observations. Relying heavily on clinicians' or observers' subjective judgments in this regard may introduce bias. Clinicians' observations may not consistently align with each other or with the actual ethnic backgrounds of the participants, leading to misclassifications.

### *Determination of Legal Status*

Overall, reporting the outcomes within the studies was considered good, with seven rated as low risk of determining legal status, as the study provided transparent and complete information about how the legal status of all participants was determined, without selective reporting or misrepresentation. Two papers were found to be of unclear risk as all demographic details of all individuals highlighted that the study lacked sufficient details about how the legal status of participants was determined or did not clarify the reporting process. (Borschmann et al., 2010; Webber & Huxley, 2004). No studies were rated as a high risk of bias, as there was no evidence that information about participants' legal status had been selectively reported or misrepresented based on the study's objectives or findings.

### *Sample Method*

Overall, sampling method was unclear within the studies. Three studies were rated as unclear risk of bias, with four rated as low risk. The low-risk studies reported sampling methods as representative samples of the target population. Ali et al., 2007; 2010; Davies et al., 1996; Gajwani et al., 2016; Koffman et al., 1997). Three studies were categorised as having an unclear risk. These studies solely included participants diagnosed with psychotic disorders, thus excluding those with different diagnoses and limiting generalisability to other mental health conditions. The unclear studies' sampling methods were often vague, but they used convenience sampling overall. Two studies (Borschmann et al., 2010 and Webber & Huxley, 2004) were deemed to have a high risk of sampling method. This judgment was based on the studies collecting data exclusively from suburban areas, potentially excluding crucial subpopulations from the analysis.

### *Sample Size*

Small sample sizes contributed to generalisability being the most prominent risk area among the studies, with two rated as high risk. Some studies, despite having a substantial sample size, did not appear to adequately represent the broader population encompassing various mental health conditions. (Ali et al., 2007; Davies et al., 1996; Owens et al., 1991). Three studies were rated as low risk of sample size (Borschmann et al., 2010; Gajwani et al., 2016; Mann et al., 2004). Three studies were rated as low risk of sample size bias (Borschmann et al., 2010; Gajwani et al., 2016; Mann et al., 2004); they were rated as such, as they used suitable sample sizes and the sample was a good representation of the target sample.

### *Summary*

Overall, the studies included in the meta-analysis displayed varying degrees of bias. There was a high risk of bias reported for two studies concerning sample size. In addition, sample method

was unclear across most studies. Given the limited number of studies in this field, studies with unclear or high risk of bias were included. One study was rated high risk of determining ethnicity and two studies were rated as unclear risk for determining legal status. Nonetheless, the studies included are deemed a representative summary of the existing research literature, and it is anticipated that future research will include higher-quality studies.

## Results

Under the Mental Health Act (1983), Community Treatment Order (CTO) Recall refers to patients being recalled back into the hospital for treatment while under a Community Treatment Order. As there was only one study available for the CTO Recall Sections, it was not included in the comparison with other categories of detention orders.

Table 4 below displays the legal frameworks from The Mental Health Act (1983) for detaining and treating individuals with mental health conditions in a variety of circumstances for civil, forensic and police emergency holding powers sections.

*Table 5: Definitions of included sections from The Mental Health Act (1983)*

| | **Section** | **Duration** | **Purpose** |
|---|---|---|---|
| Civil Sections | Section 2 | 28 days | Assessment |
| | Section 3 | 6 Months | Treatment |
| | Section 4 | 72 hours | Emergency detention (Social workers) |
| | Section 5(2) | 72 hours | Emergency detention (Doctors) |
| | Section 5(4) | 6 hours | Emergency detention (Nurses) |
| Forensic Sections | Section 35 | 28 days | Remand for reports |
| | Section 36 | 28 days | Remand for treatment |
| | Section 37 | 6 months | Court hospital order |
| | Section 38 | Up to 12 months | Interim hospital order |
| | Section 41 | Set by court | Hospital restrictions (S37) |
| | Section 47 | Up to the end of the sentence | Sentenced prisoner transfer to hospital |
| | Section 48 | Until trial or sentencing | Remand prisoner transfer to hospital |
| | Section 49 | Up to the end of the sentence | Hospital restrictions (S47 and S48) |
| Police emergency holding powers | Section 136 | Up to 72 hours | Emergency detention to convey patients from a public place to a place of safety. |
| | Section 135 | Up to 36 hours | Emergency detention, with magistrate permission to enter the patient's home and convey to a place of safety |

### *Relative risk being detained under section: Black Vs White Ethnicity*

The relative risk ratio compares the risk of detention under a section for Black participants with the risk of detention under a section for white participants. A relative risk higher than one would suggest a greater risk of detention for Black participants. In contrast, a relative risk of

less than one suggests a greater risk of detention for white participants. All calculations were undertaken on the log-transformed relative risk ratio, which was converted back into the relative risk ratio for reporting in tables and figures.

### *Selection of the meta-analytic model*

The distribution of primary study effects is shown in Figure 3. The between-studies variance ($tau^2$) was calculated using the DerSimonian-Laird estimator (DerSimonian & Laird, 1986).

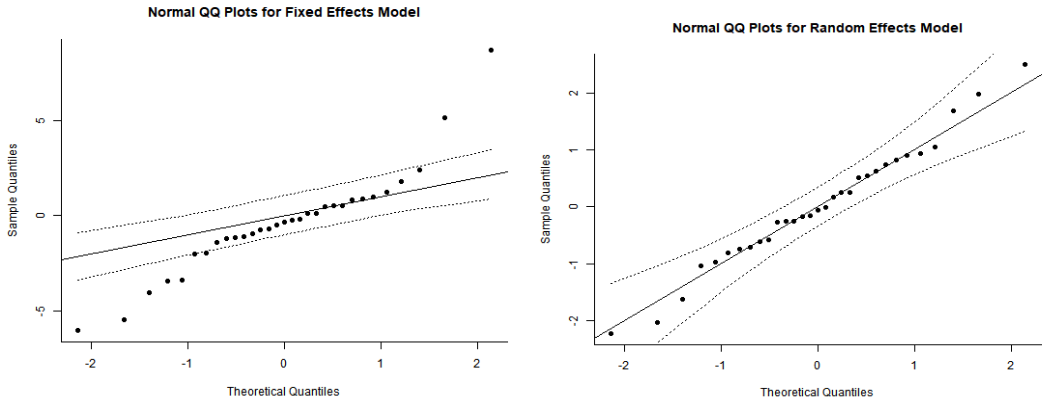



*Figure 3: QQ plot of the distribution of relative risk ratios within the primary studies.*

Figure 3 demonstrates clear evidence of non-normality in the distribution of effects using the fixed effects model. In contrast, non-normality is absent in the distribution of study-level effects in the random effects model. Therefore, using the random effects model using the DerSimonian-Laird estimator of between-studies variation is an appropriate method for calculating the weighted average relative risk ratio.

### *The omnibus test*

The relative risk ratios AND 95% CI described in the included studies are reported in Table 5 A total of 6,502 participants' data were taken from seven studies.

*Table 5: Study level effects reported in this meta-analysis*

| Study name and Section type | Year | Ethnicity sectioned | Ethnicity N | White cases | White N | Ethnicity | Section type | Section Code | Relative risk | Log RR | Log Variance RR | Log SE RR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ali et al 2007 Section 2 | 2007 | 20 | 45 | 117 | 189 | Asian | Section 2 | Civil | 0.72 | -0.33 | 0.03 | 0.18 |
| Ali et al 2007 Section 3 | 2007 | 25 | 45 | 72 | 189 | Asian | Section 3 | Civil | 1.46 | 0.38 | 0.03 | 0.16 |
| Borschmann et al 2010 Informal | 2010 | 14 | 35 | 165 | 359 | Asian | Informal | Civil | 0.87 | -0.14 | 0.05 | 0.21 |
| Borschmann et al 2010 Section 2 | 2010 | 16 | 35 | 164 | 359 | Asian | Section 2 | Civil | 1.00 | 0.00 | 0.04 | 0.19 |
| Borschmann et al 2010 Section 3 | 2010 | 4 | 35 | 30 | 359 | Asian | Section 3 | Civil | 1.37 | 0.31 | 0.25 | 0.50 |
| Borschmann et al 2010 Section 4 | 2010 | 1 | 35 | 0.5 | 359 | Asian | Section 4 | Civil | 20.51 | 3.02 | 2.97 | 1.72 |
| Gajwani et al 2016 Informal | 2016 | 10 | 189 | 43 | 438 | Asian | Informal | Civil | 0.54 | -0.62 | 0.12 | 0.34 |
| Gajwani et al 2016 Section 2 | 2016 | 33 | 189 | 54 | 438 | Asian | Section 2 | Civil | 1.42 | 0.35 | 0.04 | 0.20 |
| Gajwani et al 2016 Section 3 | 2016 | 13 | 189 | 28 | 438 | Asian | Section 3 | Civil | 1.08 | 0.07 | 0.11 | 0.32 |
| Gajwani et al 2016 Section 135 | 2016 | 10 | 189 | 36 | 438 | Asian | Section 135 | Police | 0.64 | -0.44 | 0.12 | 0.35 |
| Gajwani et al 2016 CTO recall | 2016 | 12 | 189 | 7 | 438 | Asian | CTO recall | Recall | 3.97 | 1.38 | 0.22 | 0.47 |
| Koffman et al 1997 Section 2 or 4 | 1997 | 62 | 160 | 911 | 2978 | Asian | Section 2 or 4 | Civil | 1.27 | 0.24 | 0.01 | 0.10 |
| Mann et al 2004 Section 2 or 3 | 2004 | 37 | 66 | 141 | 251 | Asian | Section 2 or 3 | Civil | 1.00 | 0.00 | 0.01 | 0.12 |
| Mann et al 2004 Part 3 forensic sections | 2004 | 6 | 66 | 24 | 251 | Asian | Part 3 forensic sections | Forensic | 0.95 | -0.05 | 0.19 | 0.43 |
| Borschmann et al 2010 Informal | 2010 | 22 | 96 | 165 | 359 | Black | Informal | Civil | 0.50 | -0.70 | 0.04 | 0.20 |

| Study name and Section type | Year | Ethnicity sectioned | Ethnicity N | White cases | White N | Ethnicity | Section type | Section Code | Relative risk | Log RR | Log Variance RR | Log SE RR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Borschmann et al 2010 Section 2 | 2010 | 58 | 96 | 164 | 359 | Black | Section 2 | Civil | 1.32 | 0.28 | 0.01 | 0.10 |
| Borschmann et al 2010 Section 3 | 2010 | 15 | 96 | 30 | 359 | Black | Section 3 | Civil | 1.87 | 0.63 | 0.09 | 0.29 |
| Borschmann et al 2010 Section 4 | 2010 | 1 | 96 | 0.5 | 359 | Black | Section 4 | Civil | 7.48 | 2.01 | 2.99 | 1.73 |
| Davies et al 1996 Section 2 | 1996 | 20 | 144 | 17 | 254 | Black | Section 2 | Civil | 2.08 | 0.73 | 0.10 | 0.31 |
| Davies et al 1996 Section 3 | 1996 | 21 | 144 | 17 | 254 | Black | Section 3 | Civil | 2.18 | 0.78 | 0.10 | 0.31 |
| Davies et al 1996 Section 4 | 1996 | 3 | 144 | 3 | 254 | Black | Section 4 | Civil | 1.76 | 0.57 | 0.66 | 0.81 |
| Davies et al 1996 Section 135 | 1996 | 1 | 144 | 0.5 | 254 | Black | Section 135 | Police | 3.53 | 1.26 | 2.99 | 1.73 |
| Davies et al 1996 Section 136 | 1996 | 9 | 144 | 3 | 254 | Black | Section 136 | Police | 5.29 | 1.67 | 0.43 | 0.66 |
| Davies et al 1996 Forensc Section 35 | 1996 | 0.5 | 144 | 1 | 254 | Black | Forensc Section 35 | Forensic | 0.88 | -0.13 | 2.99 | 1.73 |
| Davies et al 1996 Forensic Section 37 | 1996 | 1 | 144 | 4 | 254 | Black | Forensic Section 37 | Forensic | 0.44 | -0.82 | 1.24 | 1.11 |
| Davies et al 1996 Forensic Section 37/41 | 1996 | 3 | 144 | 3 | 254 | Black | Forensic Section 37/41 | Forensic | 1.76 | 0.57 | 0.66 | 0.81 |
| Gajwani et al 2016 Informal | 2016 | 8 | 182 | 43 | 438 | Black | Informal | Civil | 0.45 | -0.80 | 0.14 | 0.37 |
| Gajwani et al 2016 Section 2 | 2016 | 28 | 182 | 54 | 438 | Black | Section 2 | Civil | 1.25 | 0.22 | 0.05 | 0.22 |
| Gajwani et al 2016 Section 3 | 2016 | 15 | 182 | 28 | 438 | Black | Section 3 | Civil | 1.29 | 0.25 | 0.09 | 0.31 |
| Gajwani et al 2016 Section 135 | 2016 | 23 | 182 | 36 | 438 | Black | Section 135 | Police | 1.54 | 0.43 | 0.06 | 0.25 |
| Gajwani et al 2016 CTO recall | 2016 | 14 | 182 | 7 | 438 | Black | CTO recall | Recall | 4.81 | 1.57 | 0.21 | 0.45 |
| Koffman et al 1997 Section 2 or 3 | 1997 | 400 | 631 | 911 | 2978 | Black | Section 2 or 3 | Civil | 2.07 | 0.73 | 0.00 | 0.04 |
| Maden et al 1999 Section 2 or 3 | 1999 | 29 | 104 | 33 | 125 | Black | Section 2 or 3 | Civil | 1.06 | 0.05 | 0.05 | 0.22 |
| Maden et al 1999 Forensic remand (35, 36, 48) | 1999 | 21 | 104 | 10 | 125 | Black | Forensic remand (35, 36, 48) | Forensic | 2.52 | 0.93 | 0.13 | 0.36 |
| Maden et al 1999 Forensic Hospital Orders (37,38) | 1999 | 36 | 104 | 64 | 125 | Black | Forensic Hospital Orders (37,38) | Forensic | 0.68 | -0.39 | 0.03 | 0.16 |
| Maden et al 1999 Forensic Sentenced Prisoners (47) | 1999 | 17 | 104 | 15 | 125 | Black | Forensic Sentenced | Forensic | 1.36 | 0.31 | 0.11 | 0.33 |

| Study name and Section type | Year | Ethnicity sectioned | Ethnicity N | White cases | White N | Ethnicity | Section type | Section Code | Relative risk | Log RR | Log Variance RR | Log SE RR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Prisoners (47) | | | | | |
| Mann et al 2004 Section 2 or 3 | 2004 | 228 | 321 | 141 | 251 | Black | Section 2 or 3 | Civil | 1.26 | 0.23 | 0.00 | 0.07 |
| Mann et al 2004 Part 3 forensic sections | 2004 | 140 | 321 | 24 | 251 | Black | Part 3 forensic sections | Forensic | 4.56 | 1.52 | 0.04 | 0.20 |
| Owens et al 1991 Section 2 | 1991 | 37 | 55 | 36 | 55 | Black | Section 2 | Civil | 1.03 | 0.03 | 0.02 | 0.14 |
| Owens et al 1991 Section 3 | 1991 | 3 | 55 | 5 | 55 | Black | Section 3 | Civil | 0.60 | -0.51 | 0.50 | 0.70 |
| Owens et al 1991 Section 4 | 1991 | 4 | 55 | 5 | 55 | Black | Section 4 | Civil | 0.80 | -0.22 | 0.41 | 0.64 |
| Owens et al 1991 Section 5 | 1991 | 3 | 55 | 1 | 55 | Black | Section 5 | Civil | 3.00 | 1.10 | 1.30 | 1.14 |
| Owens et al 1991 Forensic Section 35/37 | 1991 | 7 | 55 | 5 | 55 | Black | Forensic Section 35/37 | Forensic | 1.40 | 0.34 | 0.31 | 0.55 |
| Owens et al 1991 Section 135 | 1991 | 1 | 55 | 2 | 55 | Black | Section 135 | Police | 0.50 | -0.69 | 1.46 | 1.21 |
| Owens et al 1991 Section 136 | 1991 | 0.5 | 55 | 1 | 55 | Black | Section 136 | Police | 0.50 | -0.69 | 2.96 | 1.72 |
| Borschmann et al 2010 Informal | 2010 | 6 | 14 | 165 | 359 | Chinese | Informal | Civil | 0.93 | -0.07 | 0.10 | 0.31 |
| Borschmann et al 2010 Section 2 | 2010 | 7 | 14 | 164 | 359 | Chinese | Section 2 | Civil | 1.09 | 0.09 | 0.07 | 0.27 |
| Borschmann et al 2010 Section 3 | 2010 | 1 | 14 | 30 | 359 | Chinese | Section 3 | Civil | 0.85 | -0.16 | 0.96 | 0.98 |
| Borschmann et al 2010 Section 4 | 2010 | 0.5 | 14 | 0.5 | 359 | Chinese | Section 4 | Civil | 25.64 | 3.24 | 3.93 | 1.98 |
| Borschmann et al 2010 Informal | 2010 | 1 | 9 | 165 | 359 | Mixed | Informal | Civil | 0.24 | -1.42 | 0.89 | 0.94 |
| Borschmann et al 2010 Section 2 | 2010 | 5 | 9 | 164 | 359 | Mixed | Section 2 | Civil | 1.22 | 0.20 | 0.09 | 0.30 |
| Borschmann et al 2010 Section 3 | 2010 | 2 | 9 | 30 | 359 | Mixed | Section 3 | Civil | 2.66 | 0.98 | 0.42 | 0.65 |
| Borschmann et al 2010 Section 4 | 2010 | 1 | 9 | 0.5 | 359 | Mixed | Section 4 | Civil | 79.78 | 4.38 | 2.89 | 1.70 |
| Mann et al 2004 Section 2 or 3 | 2004 | 20 | 36 | 141 | 251 | Mixed | Section 2 or 3 | Civil | 0.99 | -0.01 | 0.03 | 0.16 |
| Mann et al 2004 Part 3 forensic sections | 2004 | 4 | 36 | 24 | 251 | Mixed | Part 3 forensic sections | Forensic | 1.16 | 0.15 | 0.26 | 0.51 |
| Webber and Huxley 2004 Informal | 2004 | 32 | 120 | 88 | 120 | Non-White | Informal | Civil | 0.36 | -1.01 | 0.03 | 0.16 |
| Webber and Huxley 2004 Section 2, 3 or 4 | 2004 | 82 | 180 | 98 | 180 | Non-White | Section 2, 3 or 4 | Civil | 0.84 | -0.18 | 0.01 | 0.11 |

A random effects models was calculated using the generic inverse variance method for each of the civil, forensic, police holding powers and recall section types (see Figure 5). For civil sections, the random effects model suggested a statistically nonsignificant weighted average relative risk of 1.23 and a 95% confidence interval of between 0.97 to 1.57. For forensic sections, the random effects model suggested a statistically nonsignificant weighted average relative risk of 1.52 and a 95% confidence interval of between 0.13 to 17.67. For police sections, the random effects model suggested a statistically nonsignificant weighted average relative risk of 1.82 and a 95% confidence interval of between 0.36 to 9.11. Finally, for recall sections a statistically significant relative risk reported in a single study was observed (RR = 4.81, 95%CI 1.98 to 11.73). Given that the effect for recall sections was estimated from a single study it is not possible to estimate the variability of the effect and it should be noted that this estimate may significantly change with the publication of future studies.

A high level of heterogeneity in the primary studies was observed for the relative risk of civil sections (Higgin's I2 = 87%; tau2 = 0.1518, p <0.01) and forensic sections (Higgin's I2 = 88%; tau2 = 0.8526, p < 0.01), suggesting that the estimates of relative risk in the primary studies may be affected by the presence of uncontrolled or confounding factors. Therefore, the focus of the subsequent analyses will be upon the identification of the sources of heterogeneity between the estimates of relative risk in the primary studies.

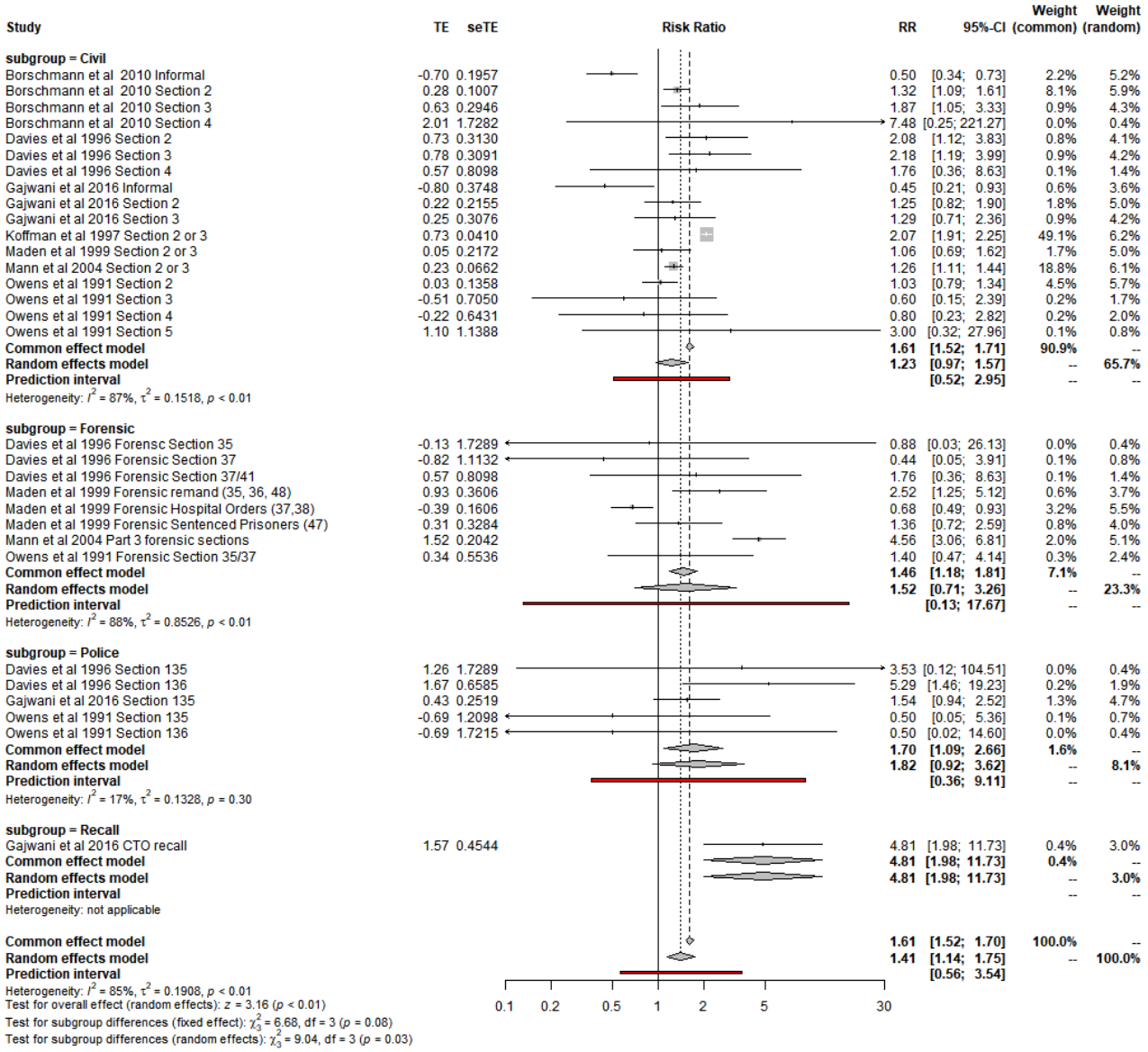
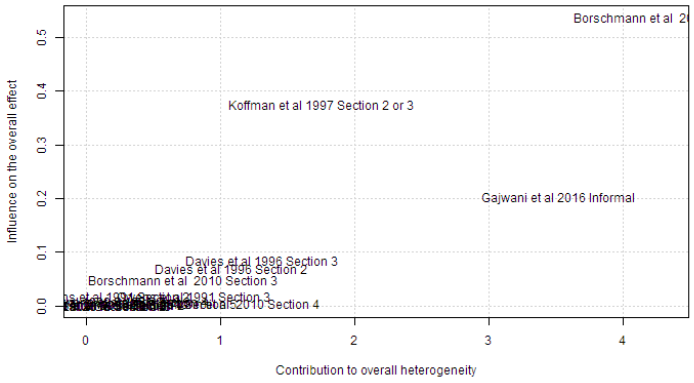


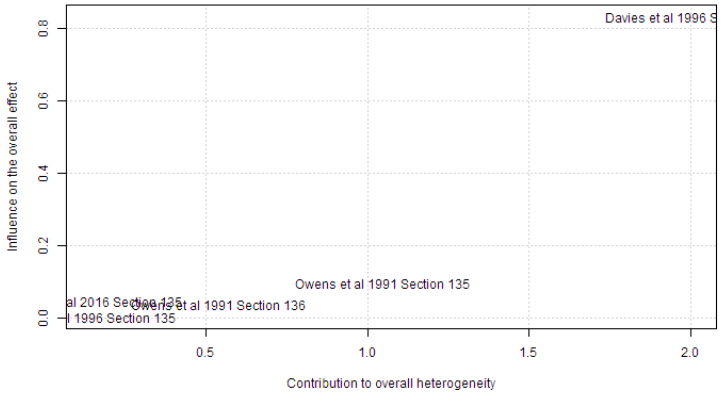

*Figure 4: Forest plot of the relative risk of civil, forensic, police or recall section comparing Black and white populations*

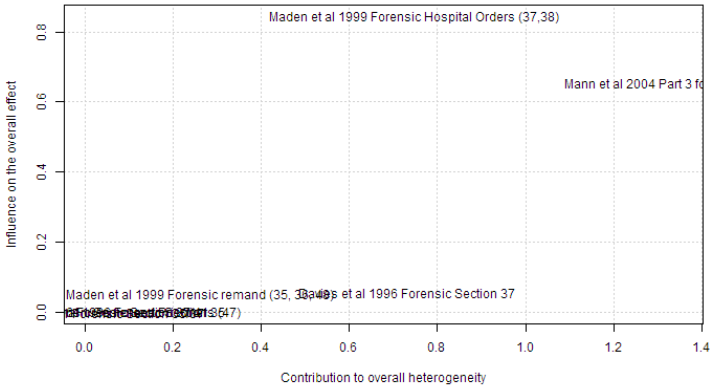
### *The impact of influential primary studies*

The impact of disproportionately influential studies was assessed using a "leave-one-out" analysis, in which the random effects model was calculated with each of the primary studies removed in turn and change in weighted average effect size (i.e., influence) and the change in heterogeneity (i.e., discrepancy) was recorded. The result of this "leave-one-out" analysis is presented in the Baujat plots (Baujat et al., 2002) in Figure 5.




*A). Civil*




*B). Police.* *C). Forensic*

*Figure 5: Baujat diagnostic plot of sources of heterogeneity by section type. The vertical axis reports the influence of the study on the overall effect, and the horizontal axis reports the discrepancy of the study with the rest of the literature.*

For the civil section data, the study by Borschmann et al., (2010) showed considerable influence on the overall since its synthesis. It was discrepant from the risks reported in other studies (see Graph A of Figure 5). The random effects model was recalculated with the removal of Borschmann et al. (2010). The corrected random effects model reported a synthesis of RR = 1.34 (95% CI 1.0731 to 1.6756). The corrected random effects model evidenced an approximately 8.6% increase relative to the uncorrected estimate.

For the police section data, the study by Davis et al., (1996) showed considerable influence on the overall synthesis. It was discrepant from the risks reported in other studies (see Graph B

of Figure 5). The random effects model was recalculated with this study removed. The corrected random effects model reported a synthesis of RR = 1.77 (95% CI 0.7448 to 4.2173). The corrected random effects model evidences an approximately 2.7% decrease relative to the uncorrected estimate.

For the forensic section data, the studies by Maden et al., (1999) and Mann et al., (2004) were both influential to the synthesis and discrepant from the risks reported in other studies (see graph C of Figure 5). The random effects model was recalculated with these studies removed. The effect of omitting Maden et al., (1999) was a 31.7% increase in the estimate of risk to 2.0034 (95% CI 1.1125 to 3.6077), whereas omitting Mann et al., (2004) resulted in a 20.1% decrease in the estimated risk are equal to 1.2151 (0.7082 to 3.2650).

***The impact of publication and small study biases***

Publication bias occurs when there is a tendency to publish studies with statistically significant results and the reticence to publish papers with non-significant results. In addition, small study bias occurs when studies with smaller sample sizes show more significant variability in their relative risk measurement. These biases can be identified using a funnel plot, which charts the magnitude of the study's relative risk (i.e., the importance of the study in the synthesis) and estimates the study's deviation from the meta-analytic average (i.e., the discrepancy of the study within the literature). If publication bias is not present, the effects from studies with smaller sample sizes, which show more significant variability, will scatter widely at the bottom of the plot compared to studies with larger samples at the top, creating a symmetrical funnel shape. If there are no studies in the area of the plot associated with small sample sizes and non-significant results, it is likely that publication bias could lead to an overestimation of the actual effect. Figure 6 shows the funnel plot of the log of the relative risk.

The effect of publication bias was simulated using a trim-and-fill procedure (Duval & Tweedle, 2000). This procedure is based on the assumption that publication bias can cause an asymmetrical funnel plot. The trim-and-fill procedure sequentially removes the most extreme small studies from the positive effects side of the funnel plot, re-calculating the effect size at each iteration until the funnel plot is symmetrical about the (corrected) effect size. Although this trimming provides an adjusted effect size, it also reduces the variance of the effects, leading to biased and artificially narrowed confidence intervals. Therefore, the original studies are returned to the analysis, and the procedure imputes a mirror image for each on the negative effects side of the funnel plot. The confidence intervals are then calculated based on the data set, including the additional imputed studies.

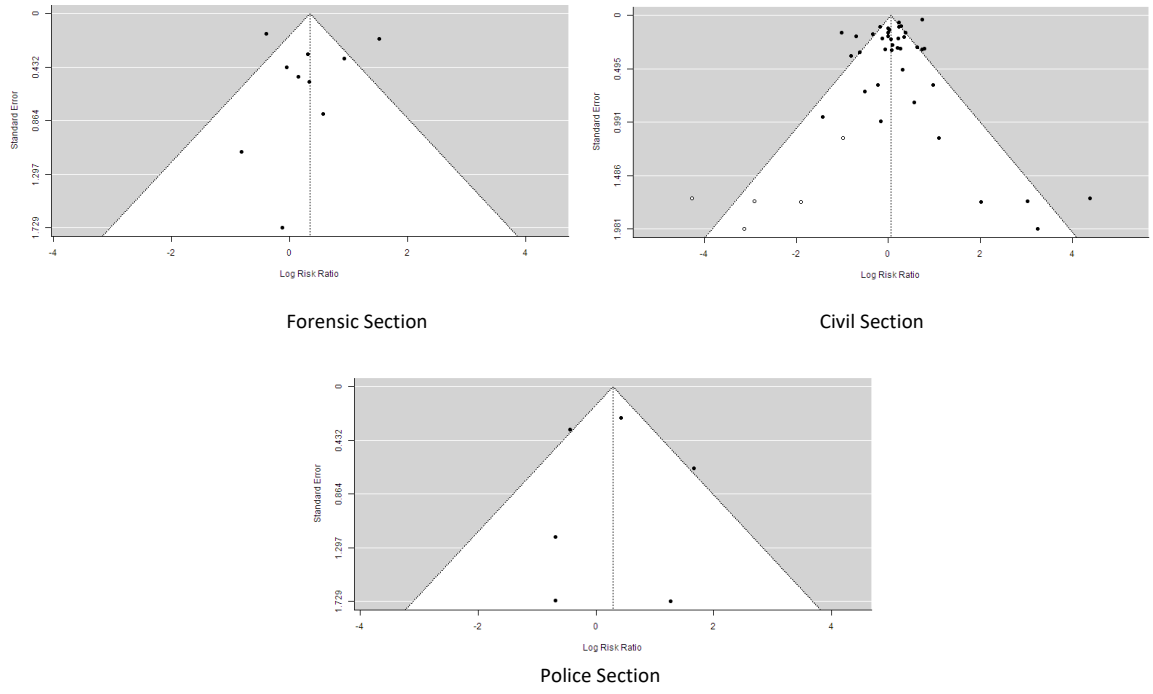



*Figure 6: Funnel plot of the log of the relative risk. The 95% confidence interval of the expected distribution of relative risk is shown as an inverted "funnel". Where appropriate, trim and fill imputations are shown as white circles.*

For forensic and police sections, there was no evidence of publication bias or small study effects. Therefore, correction to the omnibus overall effect was not undertaken.

For civil sections, in the above funnel plot, the observed studies are shown as dark circles, and the imputed studies are shown as empty circles. The uncorrected omnibus estimate of the log of the relative risk is 0.0906 (95% CI -0.0855, 0.2667), whereas the corrected estimate is 0.0546 (95% CI -0.1230, 0.2321). The adjusted point estimate represents a 39.7% decrease relative to the original omnibus analysis and suggests that the original omnibus synthesis may be vulnerable to publication bias and small study effects.

### *Differences between ethnic groups*

A series of subgroup analyses were conducted to evaluate potential differences between ethnic groups in their relative risk (i.e., compared to the white population) of detention for each of the civil, forensic, police holding powers and recall section types.

*Table 6: Comparison of different ethnic groups regarding their relative risk of detention under civil, police, and forensic detention orders.*

| | Number of Effects | RR | 95% CI | tau^2 | tau | $X^2$ | p |
|---|---|---|---|---|---|---|---|
| **Civil Sections** | | | | | | | |
| Asian | 11 | 1.0582 | 0.8817 to 1.2700 | 0.0435 | 0.2086 | 1.08 | 0.5837 |
| Black | 17 | 1.2336 | 0.9684 to 1.5714 | 0.1518 | 0.3897 | | |
| Chinese | 4 | 1.0479 | 0.7071 to 1.5529 | -- | -- | | |
| **Police Sections** | | | | | | | |
| Black | 5 | 1.8224 | 0.9165 to 3.6238 | 0.1328 | 0.3644 | 4.45 | 0.0348 |
| Asian | 1 | 0.6437 | 0.3263 to 1.2701 | -- | -- | | |
| **Forensic Section** | | | | | | | |
| Black | 8 | 1.5207 | 0.7082 to 3.2650 | 0.8526 | 0.9234 | 0.65 | 0.4214 |
| Asian | 1 | 0.9508 | 0.4053 to 2.2301 | -- | -- | | |

*Please Note: Recall Sections were not included in this comparison due to the small number of studies in this category of a detention order.*

Table 6 shows no significant difference between the relative risk of detention (compared to white populations) for civil or forensic sections. Conversely, for the use of police sections, there was a significant difference (X2 = 4.45, p = 0.04) between Black and Asian populations in their relative risk of detention. However, the relative risk estimate for the Asian group was based on a single study (Gajwani *et al.,* 2016) that reported detentions under Section 135.

Therefore, this difference in relative risks should not be considered robust, and this estimate of relative risk in the Asian population will likely change upon the publication of further studies.

## Discussion

The aims of this meta-analysis were: (i) to review published and original studies reporting the prevalence of the Mental Health Act (1983) legal status within defined ethnic groups. (ii) highlight additional evidence, if available, on the possible explanations if such variations by ethnicity exist.

A random effects model was used to analyse ethnicity and legal status for civil, forensic, police holding powers, and recall sections. The results demonstrated no significant difference in risk for civil, forensic, and police sections compared to the average. Studies on civil and forensic legal sections demonstrated considerable variation in the results, which suggests other factors may have influenced the outcome. To understand this better, the relative risk for each type of legal status section was calculated for civil, forensic, and emergency police holding powers. There was no significant difference in risk between the groups studied.

Two studies that included recall sections were excluded from the comparison as that category had only a small number of studies available for analysis. As a result, including those studies in the comparison could lead to unreliable or skewed results due to the limited sample size. To ensure the integrity and reliability of the analysis, the decision was made to exclude the two studies from the comparison. For recall sections, there was a significant difference found in one study. However, since it was based on one study, it is difficult to determine how much the effect varies between different conditions; this could change if more research is conducted in the future.

Subgroup analyses were conducted to examine potential variations in the relative risk of detention orders (compared to white populations) among different ethnic groups for each of the

civil, forensic, police holding-powers, and recall section types. Results indicated no significant difference in the relative risk of detention for civil or forensic sections among ethnic groups. However, a significant difference was observed for the use of police-holding powers, with Black and Asian populations exhibiting different relative risks of detention. It is important to note that the relative risk estimate for the Asian group was based on a single study (Gajwani et al., 2016), which reported detentions under Section 135. Therefore, this finding should be interpreted with caution, and the relative risk estimate for the Asian population is likely to change as more studies become available.

Findings from the current meta-analysis indicated a relative risk of detention for sections 135 and 136 police emergency holding-powers for Black and Asian populations. Nonetheless, it is important to note that the results were primarily founded on a single study that diverges significantly from the overall data. The single study should be viewed with a degree of caution as it deviates from the broader patterns observed. Thus, when interpreting the analysis, it becomes apparent that the available evidence may not provide a robust foundation to firmly assert that Black and Asian patients were overrepresented in crisis pathways to care.

### *Areas for future research*

Future studies could explore the intersectionality of ethnicity and other factors that influence legal status, such as gender and socioeconomic status. This approach could provide a more nuanced understanding of the factors contributing to legal status disparities among various ethnic groups. Research examining the relationship between ethnicity, gender, and mental health admission in the UK is minimal. Much is still unknown about the complex interplay between ethnicity, gender, and other intersectional factors and mental health admission; further research is needed to comprehend the concerns fully.

Research could explore the barriers individuals from ethnic minority populations with mental health difficulties may face, possibly preventing help-seeking, which may impact their detention order on first admission to psychiatric units. As well as the impact of detention and compulsory treatment on their mental health and well-being. Research could also examine the role of cultural factors, and socioeconomic factors in disparities in admission rates for various ethnic groups.

The effectiveness of community-based mental health services could be explored for individuals from diverse ethnic backgrounds. Community-based care should include culturally-specific services tailored to different communities' needs. In addition, they should provide culturally sensitive support to individuals in a way that is accessible. For example, studies could investigate whether there are differences in the severity of symptoms, the availability and accessibility of community mental health services, or the cultural acceptability of mental health treatment in communities. This may support in addressing the barrier of ethnic minority populations accessing mental health services. Policies could be developed to promote equality and diversity within mental health care settings, which could involve initiatives to increase the representation of ethnic minority clinicians within mental health professions to address the possible lack of cultural competencies in mental health services.

### *Strengths and Limitations*

The review has some limitations that could affect the validity of the results. For example, it was difficult to examine the effects' variability due to the nature of the recall sections. Additionally, the estimates may have been biased due to confounding factors. To address these limitations, the study considered various sources of bias, such as determination of ethnicity bias, determination of legal status, sample size and sample method. Three of the seven studies included in the review had ambiguous results, while four had a minimal risk of determining

ethnicity It is essential to consider the potential biases in the studies included in the review, given that biases can affect the validity and reliability of the results. Given that three studies had unclear risk for sample method, there may be inconsistencies in the findings across studies. This emphasises the need for further investigation into this area to clarify the results and better understand the impact of ethnicity on legal status in mental health services. Considering potential biases in the studies included in the review can better understand the limitations of the results and the need for further research to address these limitations. It can also improve understanding of the relationship between ethnicity and legal status in mental health services.

The study found that determination of ethnicity was good overall, as most studies received ethnic group data from multiple sources. Determination of legal status was modest, with seven studies rated as low risk. However, the study notes that the information reported on compulsory admissions could have been more explicit. Data was gathered from clinical notes provided by ward management based on clinical observations, which did not use the legal Mental Health Act (1983) section. Therefore, the accuracy of this information may need to be interpreted with caution.

One significant limitation of the study is that the search terms used in the research primarily focused on intervention studies. The terms related to intervention designs may have inadvertently limited the scope of the searches and potentially led to the omission of relevant papers. In future research, it would be beneficial to broaden the search terms to encompass a broader range of study designs and methodologies, ensuring a more diverse range of studies could be captured. This could include terms related to observational studies and other relevant study designs commonly employed in the field.

A limitation of the study is the limited number of papers available to complete a thorough meta-analysis. The inclusion of specific Mental Health Act sections as criteria for the meta-analysis may have restricted the pool of eligible papers due to the smaller number of studies meeting the inclusion criteria. This limited pool of studies could affect the statistical power and generalisability of the findings, as a smaller sample size may reduce the robustness of the meta-analysis results. Future research in this area should consider whether the inclusion criteria should be adjusted to allow for a larger pool of studies, enabling a more robust meta-analysis that incorporates a variety of study designs e.g., observational studies.

A particular strength of the analysis used in the study includes the use of the omnibus model, which is believed to produce high-quality results compared to other models. Using the relative risk ratios allows for the combination of data from multiple studies, which increases the sample size and statistical power of the analysis. It is a useful metric for examining the association between two categorical variables, such as ethnicity and legal status, in mental health admissions.

### *Clinical Implications*

Further research could ensure that individuals from BME backgrounds have equitable access to appropriate and timely mental health support. Mental health services could also work on addressing the disparities through culturally appropriate services, such as healthcare professionals training on cultural competence. For example, policies could include regular diversity training, ensuring that staff represent the communities they serve, and promoting a culture of inclusion and respect. Targeted outreach could be implemented to reduce discrimination and perhaps bridge the gap between mental health services and service users of ethnic minority groups. Policies and legal frameworks should also be reviewed to ensure they do not perpetuate disparities.

These principles link into the wider context of psychological knowledge by highlighting the importance of understanding the social and cultural context in which mental health services are offered. Research has demonstrated that cultural beliefs and practices can influence how individuals perceive mental health issues and seek treatment (Choudhry et al., 2016). Therefore, it is essential to recognise the impact of unconscious bias and social determinants in mental health services to provide culturally sensitive and equitable care to all service users.

***Summary***

There may be further opportunities to explore and address current disparities and inequalities in mental health care provision in England UK, with a particular focus on understanding the role of intersectional factors on the legal status on admission to mental health in-patient units. This can inform the development of policies and interventions to ensure more equitable access to mental health care for diverse populations, ultimately improving mental health outcomes for all.

## References for the Literature Review


Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., & Ariyo, K. et al. (2019). Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry*, *6*(4), 305-317. https://doi.org/10.1016/s2215-0366(19)30027-6

Bebbington, P., Feeney, S., Flannigan, C., Glover, G., Lewis, S., & Wing, J. (1994). Inner London Collaborative Audit of Admissions in Two Health Districts. *British Journal of Psychiatry*, *165*(6), 743-749. https://doi.org/10.1192/bjp.165.6.743

Bhui, K., Brown, P., Hardie, T., Watson, J., & Parrott, J. (1999). African-Caribbean men remanded to Brixton prison. Psychiatric and forensic characteristics and outcome of final court appearance. *Journal of Clinical Forensic Medicine*, *6*(1), 57–58. https://doi.org/10.1016/s1353-1131(99)90188-8

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. *British Journal of Psychiatry*, *182*(2), 105-116. https://doi.org/10.1192/bjp.182.2.105

Bhugra, D., Corridan, B., Rudge, S., Leff, J., & Mallett, R. (1999). Early manifestations, personality traits and pathways into care for Asian and white first-onset cases of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, *34*(11), 595–599. https://doi.org/10.1007/s001270050180

Bourque, F., Malla, A., & van der Ven, E. (2011). Exploring sources of variation in the risk for psychotic disorders among first- and second-generation migrants. *International Clinical Psychopharmacology*, *26*, e66-e67. https://doi.org/10.1097/01.yic.0000405745.81951.a9

Choudhry, F. R., Mani, V., Ming, L., & Khan, T. M. (2016). Beliefs and perception about mental health issues: A meta-synthesis. *Neuropsychiatric Disease and Treatment*, *Volume 12*, 2807–2818. https://doi.org/10.2147/ndt.s111543

Corrigall, R., & Bhugra, D. (2013). The role of ethnicity and diagnosis in rates of adolescent psychiatric admission and compulsory detention: a longitudinal case-note study. *Journal of the Royal Society Of Medicine*, *106*(5), 190-195. https://doi.org/10.1177/0141076813480995

Compton, E., & Morgan, G. (2022). The Experiences of Psychological Therapy Amongst People Who Identify as Transgender or Gender Non-conforming: A Systematic Review of Qualitative Research. *Journal of Feminist Family Therapy*, 1-24. https://doi.org/10.1080/08952833.2022.2068843

Crenshaw, K. (2006). Intersectionality, Identity Politics and Violence Against Women of Color. *Kvinder, Køn & Amp; Forskning*, (2-3). https://doi.org/10.7146/kkf.v0i2-3.28090

Dannerbeck Janku, A., & Jiahui Yan. (2009). Exploring Patterns of Court-Ordered Mental Health Services for Juvenile Offenders. *Criminal Justice and Behavior*, *36*(4), 402-419. https://doi.org/10.1177/0093854808330799

DerSimonian, R., & Laird, N. (1986). Meta-analysis in clinical trials. *Controlled Clinical Trials*, *7*(3), 177–188. https://doi.org/10.1016/0197-2456(86)90046-2

Dennis, A. C., Chung, E. O., Lodge, E. K., Martinez, R. A., & Wilbur, R. E. (2021). Looking back to leap forward: A framework for operationalizing the structural racism construct in minority and Immigrant Health Research. *Ethnicity & Disease*, *31*(Suppl), 301–310. https://doi.org/10.18865/ed.31.s1.301

Equality Impact Assessment Final Assessment for the Revised Code of Practice (the code) for the Mental Health Act 1983 as amended by the Mental Health Act 2007. (2008). *PsycEXTRA Dataset*. https://doi.org/10.1037/e593242010-001

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. (2016). Ethnicity and detention are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007. *Social Psychiatry and Psychiatric Epidemiology*, *51*(5), 703-711. https://doi.org/10.1007/s00127-016-1181-z

Gupta, S. (1991). Psychosis in Migrants from the Indian Subcontinent and English-Born Controls. *British Journal of Psychiatry*, *159*(2), 222-225. https://doi.org/10.1192/bjp.159.2.222

Higgins, J. P. (2003). Measuring inconsistency in meta-analyses. *BMJ*, *327*(7414), 557–560. https://doi.org/10.1136/bmj.327.7414.557

In-patients formally detained in hospitals under the mental health act 1983 and other legislation, England: 1991-1992 to 2001-2002. (2002). *PsycEXTRA Dataset*. https://doi.org/10.1037/e616322007-001

Jeraj, S, Shoham, T and IslamBarratt, F, (2015). *Mental health crisis services for Black and minority ethnic people*, Race Equality Foundation, https://raceequalityfoundation.org.uk/healthcare/mentalhealthcrisisservicesforBlackandminorityethnicpeople/

Kasmi, Y. (2009). Profiling medium secure psychiatric intensive care unit patients. *Journal of Psychiatric Intensive Care*, *6*(02), 65-71. https://doi:10.1017/s1742646409990185

Lawlor, C., Johnson, S., Cole, L., & Howard, L. (2010). Ethnic variations in pathways to acute care and compulsory detention for women experiencing a mental health crisis. *International Journal of Social Psychiatry*, *58*(1), 3–15. https://doi.org/10.1177/0020764010382369

Lawton-Smith, S. (2007). UK's mental health bill. The Lancet, 370(9592), 1029–1030. https://doi.org/10.1016/s0140-6736(07)61467-6

Lay, B., Lauber, C., & Rossler, W. (2005). Are immigrants at a disadvantage in psychiatric in-patient care? *Acta Psychiatrica Scandinavica*, *111*(5), 358-366. https://doi.org/10.1111/j.1600-0447.2004.00509.x

Marcelin, J. R., Siraj, D. S., Victor, R., Kotadia, S., & Maldonado, Y. A. (2019). The impact of unconscious bias in healthcare: How to recognize and mitigate it. *The Journal of Infectious Diseases*, *220*(Supplement_2). https://doi.org/10.1093/infdis/jiz214

Mann, F., Fisher, H., Major, B., Lawrence, J., Tapfumaneyi, A., & Joyce, J. et al. (2014). Ethnic variations in compulsory detention and hospital admission for psychosis across four UK Early Intervention Services. *BMC Psychiatry*, *14*(1). https://doi.org/10.1186/s12888-014-0256-1

Mann, F., Fisher, H. L., & Johnson, S. (2014). A systematic review of ethnic variations in hospital admission and compulsory detention in first-episode psychosis. *Journal of Mental Health*, *23*(4), 205–211. https://doi.org/10.3109/09638237.2014.910641

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among Black and Minority Ethnic (BME) communities: A qualitative study in southeast England. *BMJ Open*, *6*(11). https://doi.org/10.1136/bmjopen-2016-012337

McKenzie, K., & Bhui, K. (2007). Institutional racism in mental health care. *BMJ*, *334*(7595), 649-650. https://doi.org/10.1136/bmj.39163.395972.80

Missinne, S., & Bracke, P. (2010). Depressive symptoms among immigrants and ethnic minorities: a population-based study in 23 European countries. *Social Psychiatry and Psychiatric Epidemiology*, *47*(1), 97-109. https://doi.org/10.1007/s00127-010-0321-0

Mohan, R., McCrone, P., Szmukler, G., Micali, N., Afuwape, S., & Thornicroft, G. (2006). Ethnic Differences in Mental Health Service Use Among Patients with Psychotic Disorders. *Social Psychiatry and Psychiatric Epidemiology*, *41*(10), 771-776. https://doi.org/10.1007/s00127-006-0094-7

Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., & Fearon, P. et al. (2005). Pathways to care and ethnicity. 1: Sample characteristics and compulsory admission. *British Journal of Psychiatry*, *186*(4), 281-289. https://doi.org/10.1192/bjp.186.4.281

Mulder, C., Koopmans, G., & Selten, J. (2006). Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to the Netherlands. *British Journal of Psychiatry*, *188*(4), 386-391. https://doi.org/10.1192/bjp.188.4.386

Paradies, Y., Truong, M., & Priest, N. (2013). A Systematic Review of the Extent and Measurement of Healthcare Provider Racism. *Journal Of General Internal Medicine*, *29*(2), 364-387. https://doi.org/10.1007/s11606-013-2583-1

Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., & Rose, D. et al. (2009). Patients' views and readmissions one year after involuntary hospitalisation. *British Journal of Psychiatry*, *194*(1), 49-54. https://doi.org/10.1192/bjp.bp.108.052266

Rabiee, F., & Smith, P. (2014). Being understood, being respected: An evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK. *International Journal of Mental Health Promotion*, *15*(3), 162–177. https://doi.org/10.1080/14623730.2013.824163

Raleigh, V., Irons, R., Hawe, E., Scobie, S., Cook, A., & Reeves, R. et al. (2007). Ethnic health service provision from service providers and users' perspectives in Birmingham, UK. *International Journal Of Mental Health Promotion*, *15*(3), 162–177. https://doi.org/10.1080/14623730.2013.824163

Sashidharan, S. (2003). From Outside to Inside: Improving Mental Health Services for Black and Minority Ethnic Communities in England. *Mental Health Review Journal*, *8*(3), 22-25. https://doi.org/10.1108/13619322200300025

Singh, S., Burns, T., Tyrer, P., Islam, Z., Parsons, H., & Crawford, M. (2013). Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine*, *44*(5), 997–1004. https://doi.org/10.1017/s003329171300086x

Singh, S., Islam, Z., Brown, L., Gajwani, R., Jasani, R., Rabiee, F., & Parsons, H. (2013). Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for Black and minority ethnic patients: the ENRICH programme, a mixed-

methods study. *Programme Grants for Applied Research*, *1*(3), 1-168. https://doi.org/10.3310/pgfar01030

Singh, S., Croudace, T., Beck, A., & Harrison, G. (1997). Perceived ethnicity and the risk of compulsory admission. *Social Psychiatry and Psychiatric Epidemiology*, *33*(1), 39–44. https://doi.org/10.1007/s001270050020

Singh, S., Greenwood, N., White, S., & Churchill, R. (2007). Ethnicity and the Mental Health Act 1983. *British Journal of Psychiatry*, *191*(2), 99-105. https://doi.org/10.1192/bjp.bp.106.03

# Chapter 2:

Empirical Research Paper:

**Black Men Speak: Making Sense of Trust in the Context of Forensic Mental Health Services among Black Men in London, UK.**

## Abstract

***Background:*** The Health and Social Care Information Centre (2014) reported that Black and minority ethnic (BME) population have significantly higher access rates to hospital care and longer-term detention compared to the White British population. In the UK, BME communities are often overrepresented in crisis care and have less access to mental health services via primary care, leading to more negative experiences (Jeraj et al., 2015; Rabiee et al., 2014). Additionally, Black men are 40% more likely to access mental health services through the criminal justice system than their white counterparts, (Health and Social Care Information Centre, 2014). While quantitative research highlights the socioeconomic and health disparities experienced by Black men, there is little research on their lived experiences regarding trust in mental health services and appropriate care pathways before involuntary admission.

***Methodology:*** A qualitative Interpretative Phenomenological Analysis (IPA) research framework was used to explore Black men's experiences of trust prior to involuntary admission into forensic mental health services. Eight in-depth one-to-one semi-structured interviews were conducted with Black men previously detained under the Mental Health Act (1983; 2007).

***Results:*** Data was organised into six main themes "Life Stresses, Self-reliance, Disillusioned, it didn't make sense, Invisible and frustrated, and they don't care". Themes highlighted participants' experiences and perceptions related to trust, emphasising the interplay between life stresses, individual coping mechanisms, and their interactions with mental health services.

***Clinical implications:*** Findings on Black men's lived experience of trust before involuntary admission into statutory services can be used to develop culturally-competent mental health care guidelines. Recommendations may include a system-wide approach to tackling bias and acknowledging intersectionality in practice.

## Introduction

Black and minority ethnic (BME) communities experience inequalities in accessing mental health services. Studies show that BME populations have higher hospital care rates and longer-term detention rates than the white British population (Health and Social Care Information Centre, 2014). In the UK, BME communities face barriers to accessing mental health services through primary care and are overrepresented in crisis care, often resulting in negative experiences (Jeraj et al., 2015; Rabiee et al., 2014). Additionally, Black men are 40% more likely to access mental health services through the criminal justice system than their white counterparts (Health and Social Care Information Centre, 2014). While quantitative research highlights the socioeconomic and health inequalities affecting Black men, almost no research exists about their lived experiences of trust in mental health services and appropriate pathways to care prior to involuntary admission.

Black African/Caribbean communities and men have reported less favourable experiences of mental health services (Kyere & Fukui, 2022). According to research, individuals from marginalised groups often reported coercive treatment from services that do not understand their needs or experiences (Barnett et al., 2019). Some researchers suggest institutional racism and gender discrimination existing within the mental health system, which may affect individuals' experiences (Memnon et al., 2016). This raises important questions about the experience of trust among Black men in mental health settings, particularly before involuntary admission. Understanding these experiences is essential for improving mental health care for Black men and addressing disparities in the system.

### *Racial disparities*

Evidence suggests that Black African/Caribbean patients are more likely to experience involuntary admissions than other groups. Data from the Health and Social Care Information Centre (2014) reveals that Black African and Caribbean patients were admitted at a rate 20% higher than White patients. Their length of stay in the hospital were longer (with a median length of 62 days for Caribbean patients and 54 days for African patients, compared to 37 days for White patients). Additionally, police involvement in the admission process was more frequent for Black African/Caribbean patients than White patients.

### *Gender disparities*

International research has identified young men as reluctant to seek help for mental health problems (Lynch, 2018). Additionally, Memnon et al., (2016) found that BME men were less likely than other groups, particularly White British men, to use mental health support services. Although not exclusive to BME men, it is linked to broader ideas about masculinity, pride, and self-reliance in the face of physical and mental illness (Bignall et al., 2019). Stigma among men may still be present, preventing seeking help for mental health treatment. According to Stein (2018), more than one-third of men delayed sharing their mental health condition for over two years, primarily due to feelings of embarrassment. They were also reluctant to take time off work for mental health reasons but were more willing to take time off for physical health ailments.

### *Trust*

Trust is the expectation that institutions and professionals will act in one's interests, and trust in health services is usually earned via personal experience (Madden et al., 2017). Numerous studies have demonstrated that individuals from BME groups report lower levels of trust compared to their White counterparts (Smith, 2010). This pattern of distrust appears to extend

across various social contexts, such as interpersonal relationships with friends, family, and neighbours (Sampson et al., 1997; Smith, 2005), interactions with the healthcare and criminal justice systems (Doescher et al., 2000; Tyler, 2005), and engagement in the political sphere (Avery, 2006). A recent study by Evangelist (2021) examined the impact of discrimination on trust within racially diverse societies. This study reported that discrimination can influence individuals' trust in various social contexts, including institutions and interpersonal relationships. These findings highlight the pervasiveness of distrust among minority populations and the need for combined efforts to address and further understand the underlying causes. The importance of interpersonal trust is closely tied to the vulnerability individuals experience while being mentally unwell, as well as the unequal dynamics and information gaps that arise due to the specialised nature of scientific and medical knowledge (Rowe & Calnan, 2006). Interpersonal trust plays a vital role in ensuring patients' confidence in the care they receive.

Research conducted by Best et al. (2021) explored institutional distrust among African Americans, particularly in the context of the COVID-19 pandemic. They found that within the context of health and healthcare, perceptions of safety and trust were deeply intertwined. Individuals often rely on expert and institutional knowledge to shape their understanding of risks to make informed decisions. Best et al. (2021) suggest that trust is critical in individuals' ability to observe and navigate the healthcare system, particularly during public health crises such as the COVID-19 pandemic. Other studies examined factors contributing to institutional distrust and highlighted the importance of trustworthiness in public health responses and decision-making (Warren et al., 2019). The findings have implications for promoting ethical practices in public health to meaningfully engage, educate, and inform diverse communities about health issues, thus fostering trust among marginalised communities (Best et al., 2021).

The current study builds upon existing literature by exploring the experiences of interpersonal and institutional trust among specific marginalised communities, specifically within the context of Black men accessing forensic mental health services in the UK, to offer a more specific understanding of trust within a significant yet underexplored area. While previous studies have highlighted the pervasive nature of distrust among racial and ethnic minority groups in various social contexts, such as healthcare, criminal justice, and politics, the current research narrows its focus to a specific group within forensic mental health service settings.

### *Aims and Rationale*

The current research aims to investigate the role of trust as a central theme in the experiences of ethnic minority groups, with a specific focus on Black men's experience of trust in the context of forensic mental health services. By exploring the concept of trust, this study seeks to understand the unique challenges and barriers this population faces, in the hope to offer insights into how trust may impact help-seeking behaviours.

Regarding the aspects of trust within the current study, the researcher aims to explore the experience of interpersonal trust in both individuals (such as family members and healthcare professionals) and systems (such as community and inpatient mental health services). It also considers trust at different points in the participants' life history, taking into account past experiences that may influence their perceptions of trust in their experiences of mental health services.

By exploring the role of trust, this study aims to contribute to the ongoing discourse on the importance of trust in mental health services. It highlights the need for tailored approaches to address trust-related barriers for marginalised populations (Gaebel et al., 2014).

# Method

### *Participants and Recruitment Procedure*

IPA recommends a small homogenous sample of n=6-8 individuals, with n=10 as a maximum Smith et al. (2021). Eight participants were recruited through third-sector organisations and charities that specialise in providing forensic mental health step-down support from secure services. Background information on the study was presented to third-sector organisations in the form of a brief research summary and an information sheet for prospective participants. The primary researcher was contacted by participants who expressed an interest in participating voluntarily in the study and provided consent for contact. Details about the study were provided and guided by the Participant Information Sheet. The first contact with participants was made by telephone to brief participants on the purpose of the study, what their participation would involve, and to answer any questions. The details of the participants included in the study can be seen in Tables 1 and 2.

*Table 1: Inclusion and exclusion criteria*

| **Inclusion Criteria** | **Exclusion Criteria** |
|---|---|
| Black African/Caribbean ethnicity, and/or Black with mixed heritage | Females |
| Over 18 | Individuals who may be experiencing high levels of distress, presenting with significant risk issues, or deemed not to have the capacity to consent, |
| Located and residing in England, UK | Non-English speakers or unable to understand and communicate in English |
| Previously sectioned under the Mental Health Act (part 2 civil and part 3 forensic) in the last 10 years | Those who were not detained in forensic inpatient hospitals. |
| Discharged from a forensic hospital and residing in the community | Currently an inpatient in a forensic or acute psychiatric hospital |
| To be able and willing to provide informed consent | Lack of capacity to give informed consent. In cases where there is doubt about the participant's capacity to provide consent, they will be excluded from the study. |

*Table 2: Demographics of participants*

| Demographic characteristics | Study participants |
|---|---|
| Age of participants | Mean age: 32 years (range 29-39 years) |
| Mental Health Act legal status on admission | Section 3: N=3<br>Section 37/41: N=4<br>Section 47/49: N=1 |
| Length of time since discharge | <1 years: N=2<br><2 years: N=1<br><3 years: N=1<br><4 years: N=2<br><5 years: N=1<br><6 years: N=1 |
| Ethnic heritage | Black African: N= 2<br>Black Caribbean: N=4<br>Mixed Black Caribbean/African: N=1<br>Mixed Black Caribbean/White: N=1 |
| Clinical Diagnosis (self-reported) | Paranoid Schizophrenia: N=7<br>Schizoaffective Disorder: N=1<br>Autism Spectrum Disorder (Dual diagnosis): N=1 |

### *Development of the project design*

The current qualitative phenomenological research design was co-produced and consulted with an expert by experience (i.e., a Black British man previously detained under the Mental Health Act). The aim was to shift the power by breaking "traditional" power dynamics and inviting lived, experienced peers' insights and perspectives. It may be difficult for Black men to have their voices heard through traditional academic discourse; therefore, qualitative research, such as this project, can offer that opportunity. The involvement of the expert-by-experience was primarily in the initial planning stage of the study, where the concepts to focus on and the importance of trust were decided in collaboration with the expert-by-experience. Their input was valuable in shaping the research direction of the study. The expert-by-experience did not contribute to the interview schedule or analysis of the data.

### *Semi-Structured Interviews*

Data was collected using in-depth one-to-one semi-structured interviews. The use of semi-structured interviews enables participants to discuss the phenomenon under study, to have a voice, to provide a rich, in-depth account, and to make sense of their experience. Interviews also enable the researcher to pose questions related to gaps in the literature (Smith & Osborn, 2007). As IPA is an idiographic method (i.e., individual case-by-case study approach), the interview format was considered optimal for creating an intimate interpersonal safe space for the participant to openly discuss sensitive personal experiences, feelings, thoughts, and reflections. Finally, semi-structured interviews were deemed particularly important and respectful to this participant group's needs, whose individual voices within research have often been limited, neglected, or ignored.

### *The Semi-Structured Interview Guide*

A flexible interview guide was used with specific questions designed to probe for relevant accounts to answer the research questions (See Appendix D). In developing the interview schedule, the researcher identified gaps in the literature and engaged in discussions with supervisors to refine the questions. The interview schedule served as a framework for conducting interviews to guide the conversation and ensure consistency across participants. It provided a list of key topics and questions covered during the interviews. The researcher followed the interview schedule as a reference to ensure that all relevant areas were explored with each participant. However, flexibility was maintained to allow for fluid, in-depth discussions to occur, while follow-up questions were asked when necessary to explore specific issues or to seek clarification on participants' responses. This approach allowed for a flexible exploration of participants' experiences and insights related to the research topic.

### *The Interview Schedule*

The interview schedule explored key aspects of trust and mental health experiences. Participants defined trust and explored its development while also discussing their experiences of trust before and after engaging with Forensic Mental Health Services. Participants discussed the events leading up to their hospital admissions, including stressors, decision-making processes, and self-initiation of mental health support. Participants' understanding of detainment under the Mental Health Act and the needs behind hospitalisation were explored, with a focus on life changes, consequences, and the role of ethnicity in trust. Experiences accessing statutory services and their impact on trust were discussed, along with insights into helpful and hindering factors, desired care, and attempts to access psychological support. Participants were also asked to discuss post-admission feelings, the appropriateness of hospital admission, and accessibility of mental health services for Black men who have been sectioned, addressing positive encounters and obstacles, expectations, and their influence on trust.

Before interviews were conducted, the interview schedule was circulated amongst confirmed participants for two reasons: (1) to build trust in the researcher by displaying transparency in what will be asked, and (2) to ask participants to reflect on questions in advance, to support the memory of those experiences, and to enhance the freedom to speak about those experiences. The interview schedule also included a definition of trust to enable participants to understand this terminology and to develop a shared understanding of the meaning of 'trust'. Due to the nature of video calls, the researcher considered the absence of embodied cognition. Embodied cognition is the idea that our thoughts and understanding of the world are deeply rooted in our interactions and physical experiences with the environment (Varela et al., 2017). Therefore, the absence of embodied cognition can significantly impact the ability to process and make sense of information. This can result in a sense of detachment or disengagement from the

experiences around us, creating difficulties with understanding and connecting with our environment.

### *Interview Procedure*

Participants consented for their interviews to be conducted via a planned Zoom meeting and for their interviews to be recorded on a Dictaphone. Participants were asked to attend the interview, based in a quiet room, and to position the camera with a clear view of themselves. Each interview started with a brief warm-up to allow participants to feel comfortable and further build trust and concluded with a wrap-up of their understanding of what they shared. Participants were provided with the opportunity to ask the researcher any questions or to discuss any concerns.

### *Transcription and data management*

All interviews were audiotaped using a Dictaphone provided by the University of Birmingham. Following each interview, audio remained on the Dictaphone for verbatim transcribing, including conversational pauses, sighs, and important nonverbal communication. As transcription is seen as an interpretative act (Lapadat & Lindsay, 1999), every interview was transcribed immediately after, and the researcher made detailed reflective notes on what was shared. The researcher made detailed reflective notes that captured interpretation and reflections about the content shared during the interviews and any important information in the context of the participant during the interview. All identifying names or events were removed from the transcript. The University of Birmingham provided a secure research data depository for the safe storage of all research data. The researcher backed up the audio data to the Research Data Store (RDS), and once transcribed, all audio was deleted.

### *Ethical approval for the study*

Ethical approval to conduct this study was obtained from the University of Birmingham Research Ethics Committee (Ethics Code: ERN_21-1528).

### *Anonymity*

All identifiable participant information was removed, and participant names were anonymised using pseudonyms. When compiling the thesis, appropriate measures were implemented to avoid including information that might permit the identification of participants, their families/carers, staff, and/or the organisation the participants were recruited from. To protect confidentiality and anonymity, the researcher omitted details, altered information, anonymised data, and was suitably vague/general about participants. Participant names, staff names, and service names, and other relevant locality details were altered or replaced with a pseudonym or alternative dates. Under GDPR, an individual's voice is considered an identifying characteristic, and any research interviews were recorded using an encrypted Dictaphone.

### *Minimising Risk of Harm to Participants*

The researcher took precautions to minimise any potential harm or distress to participants caused by discussing sensitive issues in the interview. This was discussed with participants during the initial briefing call. All participants were reminded about the nature of the topics discussed in the study. The confidentiality limits were discussed in disclosing information related to current risks to participants or others. Participants were informed that they have the right to refuse to answer any questions, take breaks, reschedule and/or discontinue interviews without explanation. The researcher utilised check-ins throughout to ascertain any levels of discomfort. All participants were provided details of supporting agencies before the interview.

### *Data Analysis*

The present study uses IPA to make sense of the interviews. IPA aims to develop an understanding of the participants' shared experiences, both their common experience and idiosyncratic experiences personal to various participants, and to identify the phenomena (Alase, 2017).

### *Developing the IPA Coding Frame*

Steps for analysis were followed using Smith, Flowers, and Larkin (2021). To begin IPA analysis, the first step involves immersing oneself in the data. This includes re-reading the transcript, taking exploratory notes on areas of interest, and reflecting on the phrases used by the participants to describe their experiences and the world around them. Exploratory notes were written on transcripts with a phenomenological focus, reflecting on participants' claims, concerns, thoughts, emotions, and experiences of trust prior to, during and following their admission to forensic services. Notes contained descriptive, linguistic, and conceptual commentary with observations on repeated words/phrases and their emotions (see Appendix F). The researcher transformed exploratory notes into Personal Experiential Statements relating to participants' experiences (see Appendix G). Connections were identified across experiential statements and were clustered for each participant (see Appendix H). These were eventually formed into Personal Experiential Themes (PETS) and organised (see Appendix I). These steps were completed for each transcript. The themes were clustered as the researcher saw fit and labelled Group Experiential Themes (GETS) (see Appendix J). Quotes that captured the GETs and the research question were selected from the GETs table and included in this review (see Appendix K). This provided a structure for writing up the findings, where the themes were supported with extracts from the original interviews. To facilitate the rigour of the analysis procedure, the researcher discussed the Personal Experiential Themes and Group Experiential Themes with the academic supervisors.

### *Reflexivity*

Reflexivity is an essential component of all stages of qualitative research. It acknowledges that the researcher is not an objective authority and has subjective feelings, reactions, and assumptions about the phenomenon under study, which may influence the data collection and analysis (Dodgson, 2019). Reflexivity extends beyond the act of reflecting and questioning "our ways of doing" (Hibbert et al., 2010) to include turning the researcher's focus inward and examining, acknowledging, and accepting accountability for how identity, experiences, and context could influence the study (Berger, 2013; Harper, 2011). Hermeneutics is a key concept in IPA that explores how individuals make sense of their personal experiences. The double hermeneutic refers to the idea that the researcher must interpret the participant's interpretation of their experience. It emphasises the importance of understanding how broader social and cultural factors can shape personal experience and encourages researchers to be reflexive in their approach to data analysis. Researchers must be aware of their assumptions and biases when examining participants' interpretations.

The primary researcher of the current study is a Black British female who has a strong interest in understanding the lived experiences of individuals with severe mental illness among ethnic minority groups. The researcher acknowledges that her experience and research interests could influence the analysis. Therefore, the researcher documented reflections and declarations of her own subjective biases, assumptions, influences, and experiences of trust as a Black female in a reflexive journal as well as utilising supervision and peer discussions. The researcher engaged in bracketing (Finlay, 2009), this involves reflecting on biases, background, and assumptions, documenting them, and setting them aside so they do not influence the data collection and analysis process.

## Results

Six Group Experiential Themes were identified and developed from the interviews. The themes represented by the groups are displayed in Table 3.

*Table3: Group Experiential Themes and the participants contributing to each.*

| Group Experiential Themes | Gabriel | Jeremiah | Kaleb | Malachi | Noel | Reece | Simeon | Terrell |
|---|---|---|---|---|---|---|---|---|
| **Life stresses**: substance use, money, relationship breakdowns & betrayal. | x | x | | | x | x | x | x |
| **Self-Reliance:** I can handle problems myself; I don't need help. | x | x | x | | x | x | x | x |
| **Disillusioned:** A lack of understanding and mismatch between me and them. | x | x | x | | x | x | x | x |
| **It didn't make sense:** Lack of communication and cultural competency. | x | x | x | x | x | x | x | x |
| **Invisible and frustrated** | x | x | x | x | x | x | | x |
| **They don't care:** Exclusively medical, overly dismissive, and uncollaborative. | x | x | x | x | x | x | x | x |

### *A.* ***Life stresses:*** *Substance use, money, relationship breakdowns and betrayal.*

The first theme describes several stressful life experiences that participants referred to as potential explanations for their difficulties with trust. However, they also acknowledged that such challenges are a part of life. While some of these life stressors contributed to reduced well-being more generally, in some instances, it was acknowledged that the stressors involved betrayal and other experiences that inherently eroded participants' sense of trust. Specific quotes from participants illustrate how this theme encompasses various aspects of their lives: for example, Reece's belief that his workmates spiked him reflects a lack of trust in their intentions and actions. His account indicates a perceived betrayal of trust, as he believes his workmates intentionally administered a substance without his consent, leading to the distressing experience of hearing voices.

> I believe I was spiked because I was round some workmates house, and they gave me some speed and the next day I started hearing voices. […] I was doing my final exams for a three-year apprenticeship, but I had been doing that for a while and it didn't seem to be any problem.... Like I said, I believe I was spiked. Because these guys said like, they'll give me speed. When I took it two of them gave each other a look. They looked at each other in a strange way when I took it. And then a week later, after I've been hearing voices for like, a week. I mentioned that I'm hearing people slagging me off next door. And they gave each other that same look again, the same two. (Reece, Page 3-4).

The experiences shared by other participants highlighted a history of broken trust. The detrimental impact of betrayal from close family members suggested that the theme of trust is shaped not only by current interactions but also by historical relationships, affecting one's

ability to trust and potentially leading to difficulties in forming trusting relationships later in life.

> My childhood was… I had a very, very tough upbringing, basically a very, very tough upbringing. You know, back in [A country in Africa], where I come from, I can say the person I did trust was my grandmother, she was the only person that looked after me, you know, from day one to day Z. And sadly, when I was about one year old, my mum actually passed on, she died, sadly. I put trust in my dad, my father, who actually let me down. He let me down to an extent where he brought me to this country telling me my step mum is my mum. All a pack of lies. The way she treated me was very very horrible. I was quite confused. I was so confused. (Page 4)

Trust and safety are interrelated concepts essential to creating healthy and supportive communities, as highlighted in participants' reflections on growing up in adverse communities in London. The heightened awareness of potential dangers and the consequences of placing trust in the wrong people resonated across the group, echoing the vulnerabilities associated with particular environments and community members' ability to trust. This sentiment is not exclusive to personal relationships but extends to broader societal environments, where misjudging trust could lead to tragic outcomes.

> Safety is massively important. I mean, I grew up in [part of London], [Part of London] it's nice now but it was the hood init. Yeah, man. Trusting the wrong person saying the wrong thing to the wrong person... can get you killed. You could be killed. It's happened to people I know; it's happened to people I love. (Simeon, Page 3)

These experiences shed light on the relationship between safety, trust, and survival in challenging environments. These factors can influence an individual's response to life stressors. Participant's experiences demonstrate how betrayal and living in communities with a history of violence and danger can shape an individual's perceptions of trust and impact their ability to form trusting relationships. It highlights the significance of context in understanding an individual's life stressors and the profound impact of mistrust on their sense of safety and security.

### *B.* ***Self-Reliance:*** *I can handle problems myself; I don't need help*

The concept of self-reliance is complex, and the experience of this can vary depending on circumstances. Challenges and difficult life experiences may contribute to a sense of self-reliance and resilience. Trust often involves relying on others, seeking support, and opening oneself to vulnerability (Baghramian et al., 2020). Seven participants shared how they asserted their strength and self-sufficiency from an early age, suggesting that they may have developed coping mechanisms of self-reliance to protect themselves from potential disappointments or betrayals within interpersonal relationships.

> "No, I depend on myself. […] I think I would have felt shit about myself cos I should be able to handle whatever comes my way […] Like I said I'm strong, I should be able to handle it…I've always been that way…since I was born". (Kaleb, Page 5)

Several participants acknowledged that their approach to seeking help was not effective. However, they were aware that they had developed strong patterns of self-reliance. They also described difficulties in recognising when help was required, particularly in the context of their mental health conditions. Trust in this context involves a willingness to depend on others and believe in their ability to offer support. For example, Simeon's tendency to view problems as "unsolvable" if he cannot resolve them independently suggests a lack of trust in others' ability to help effectively.

> Honestly, I'm not very good at that. I'm not very good at seeking help. Even when I need it to this day. Like if I was becoming unwell, I wouldn't notice. That's just how my condition works for me, I wouldn't be able to tell. I'd still think everything was cool. And... in any other aspect where I would need help in my life... I rarely ever, like really ever delegate that responsibility to anyone, to others. If I can't

> solve it myself then I consider it unsolvable more time, which is not healthy, and I know that... but... it's definitely who I am. […] Very rarely, very rarely. But now and again I'll ask for advice from people. But that doesn't really colour my decision. That's just more information, that's it. But yeah, I'm not very good at asking for help from people." (Simeon, Page 8)

The theme of self-reliance speaks to participants' leaning towards independently managing difficulties. The reluctance to seek help may be rooted in various factors, including past experiences, societal expectations, and concerns about personal safety (Lynch et al., 2016). Participants described complex relationships with trust and their willingness to share their experiences. They discussed a willingness to open up about their mental health challenges to some extent. However, they also shared a sense of apprehension and difficulty in fully trusting others with their sensitive information and were inclined to solve difficulties themselves. For example,

> "You don't get looked after or cared for. You have to look after yourself. [...] I used to kind of look after myself when I was younger, but I've had to more because mental health services are trying to mess me up. If I'm not careful I could end up locked up in hospital again on a medication what's gonna kill me". (Reece, Page 19-20)

Participants' descriptions highlight the complex interplay between trust and self-reliance in shaping an individual's coping strategies and sense of identity. While emphasising their inner strength, the reluctance to seek external support and trusting others may also present as a guarded approach to relationships, possibly influenced by past experiences or environmental stressors as discussed in theme A) Life Stressors. Exploring the dynamics of trust and self-

reliance in the context of mental health experiences may provide an opportunity to understand how individuals' perceptions of trust in others and themselves can influence their help-seeking behaviours.

### *C.* ***Disillusioned:*** *A lack of understanding and mismatch between me and them.*

This theme highlights participants' experiences of losing trust in individuals they previously considered trustworthy, particularly once mental health support was initiated, indicating a potential disruption in interpersonal trust. The comments highlight a disconnect between what the participants experienced and what others perceived as their need for help. While some participants reported distressing unusual experiences, others expressed feelings of low mood, potentially linked to life stressors. However, the value placed on self-reliance may have prevented them from seeking help from others, contributing to their disillusionment. Jeremiah shared, "I didn't feel like I needed anything. I thought I was normal" (Jeremiah, Page 8), suggesting a sense of self-sufficiency, indicating trust in his abilities to manage his situation independently.

Several participants described experiencing confusion and uncertainty, particularly concerning auditory hallucinations. For instance, one participant described his repeated search for the origins of the voices he was hearing. The struggle to make sense of the situation could potentially impact his trust in his perceptions or the trust he may have in others' ability to understand and support him during this confusing time.

> I didn't know it was voices, I didn't know what it was so... I was confused you know what I mean. I remember the first time I started hearing voices, the first night I kept going out my back doors looking for where the voices were coming from. (Reece, Page 3)

Almost all participants described feeling a sense of disillusionment and mistrust in the diagnosis they received. A lack of alignment with the diagnosis could indicate a lack of trust in healthcare professionals' understanding of participants' experiences or a sense of scepticism

regarding the accuracy of the diagnosis. Gabriel shared how he did not characterise his experiences as Paranoid Schizophrenia but rather as depression and stress. Additionally, the mention of hearing voices from family members may also influence his perception of his experiences as normal, further reflecting a complex relationship between trust, self-perception, and the perception others may have.

> Cos they've just diagnosed me as paranoid schizophrenia but at the time, I wouldn't say that, at the time I would say that I was more depressed and just stressed out. I don't know, it just developed over time cos I started hearing voices and things like that, you know. But it's not random voices, my family members, and things like that so I wouldn't say its abnormal if that makes sense? (Gabriel, Page 8)

Growing up in challenging environments can create unique responses, possibly influencing participants' experiences, as Jeremiah describes. The exposure to adversity and potential threats in such communities may create a heightened sense of vigilance and suspicion. The concept of trust is relevant as heightened distrust of others may influence behaviour, including social withdrawal and isolation. Others could perceive this behaviour as a symptom of psychosis, e.g., paranoia:

> When I was unwell, I always thought there was like people watching me from an unknown place. […] I couldn't get over the feeling if you get what I'm saying. I was stressed out. I was depressed. I was sad. I would stay in my room for days on end not really go anywhere sometimes. (Jeremiah, Page 6)

Jeremiah goes on to offer context by describing his challenging experience, differentiating between genuine friends and people who had negative intentions towards him. This experience of blurred boundaries between friends and enemies could indicate a loss of trust in the

authenticity and sincerity of the people in his life at that time. Jeremiah shared his experiences feeling real at the time and that they could have been a reflection of his actual circumstances. He described feeling unsafe in his environment, which may have contributed to his belief that he was being followed or monitored.

> Not everyone in my life at that time had the best intentions for me. So, it was difficult for me to differentiate between friends, people I can trust and enemies, because enemies were trying to make themselves look like friends and just mix up my life. (Jeremiah, Page 3)

The theme of disillusionment encompasses the challenges of feeling misunderstood. Kaleb's perspective resonates widely for the group.

> "I think my mum wanted to spite me… my mum knows that she can't threaten police with me, so the next best option is to dose me up init." (Kaleb, Page 8).

Kaleb's suggestion that his mother might have harboured harmful intentions, including wanting to harm him with medication, speaks to a significant breakdown of trust within their relationship. His perception reflects mistrust that extends beyond just their familial bond. The mention of "spite" and medication as a means of control demonstrates a sense of betrayal. This not only affects his trust in his mother but also the broader theme of trust within familial dynamics. The impact of family betrayal of trust was a recurring theme within the group.

In summary, the current theme captures the intricate struggle between participants' internal experiences and external perceptions. Participants' accounts emphasise the initial confusion, the struggle to align personal interpretations with clinical diagnoses, and the unique perspective of what might be perceived as "normal". Several participants point to misinterpretation of their experiences, and the disconnect highlights the internal struggles that can arise from a mismatch

between how one perceives their experiences and how others perceive them. Trust becomes a central factor in this dynamic—the trust individuals place in their understanding and the trust they may or may not have in external perspectives. The current theme serves as a reminder of the profound impact of understanding—or misunderstanding—of individual experiences.

### *D.* ***It didn't make sense:*** *Lack of communication and cultural competency.*

This theme resonates with experiences of marginalisation and navigating systemic neglect, capturing the group's shared encounters with inadequate communication, cultural insensitivity, and systemic biases within healthcare services. Several participant quotes exemplify experiences that have affected their trust in healthcare providers.

Participants suggested a sense of fear and mistrust in mental health services, expressing apprehension about potential punitive actions, such as being locked up or facing consequences, such as "Punish me and have me locked up and stuff like that". (Jeremiah, Page 5). The lack of communication echoes throughout their experiences, as they describe the hospitalisation process as unclear and confusing. Kaleb shared, "They came to my house; they asked me a few questions, and then they said that I need to be sectioned." (Kaleb, Page 13). The experience of lack of clear communication or explanation might have contributed to his mistrust of the system and its intentions. Malachi identified the absence of effective communication: "Well communication wasn't there I don't think…yeah…communication wasn't there I don't think between staff and the patient yeah" (Malachi, Page 10). This can be understood to lead to misunderstandings, frustration, and a diminished sense of trust in the healthcare professional's ability to understand and address service user needs adequately.

Participants reflected on their experiences related to cultural competency and biases within mental health services. They observed the over-representation of Black men within the forensic setting, which may reflect systemic biases and discriminatory practices (Barnett et al., 2019). Several participants shared reflections about their views that both prisons and hospitals were places where Black people were mistreated and subjected to harmful practices. This lack of trust in the healthcare services could lead to a perception of systemic biases, further

reinforcing the negative views towards seeking help and receiving treatment. Reece's beliefs may reflect his experiences of systemic biases and discriminatory practices, which may have shaped his perceptions of mental health services fairness and trustworthiness.

> It's just it's just a dustbin for Black people. Same way, the prison and the hospital are dustbins for Black people. They just mash you up and throw you in there, lock you up for a long time. And some Black people, they don't fight for their rights. Because if they lock you up, if you don't try and get out through a tribunal or something, they're not going to let you out. They'll keep you in there, experimenting on you with their poisons. (Reece, Page 10)

Simeon reflects on the significant impact of cultural misunderstanding by sharing his personal experiences related to his religious beliefs. He shared how discussing religious experiences, which are meaningful to him as a Black individual, with specific predominantly White British individuals may lead to a quick dismissal and the labelling of these experiences as symptoms of psychosis. This reaction and lack of cultural understanding can create a significant barrier to trust between the participant and mental health professionals or others from different cultural backgrounds.

> There's one thing I'll come back to a lot, which is... I wouldn't say, yeah, culturally, as well, socially, and culturally, Black people are much more... I guess the easiest way to describe would be religious, kind of people. So... considering the kind of things that unwell, people are usually fixated on, God, and religion is one of them. And... I, in my experience, I've found that as a Black person... if I'm talking to a certain person of a different ethnicity, about my current conception of God, or how I'm struggling with God. I find certain groups of people, particularly predominantly White British people are much, much quicker... to call that like...

like I'm suffering delusions at that point. A lot of the time if, if you talk about... having, God being on your mind, they just write that off as you being unwell. That's like, that's a symptom of psychosis. Whereas...if I was to say that to... to a random Black person, we'll have a discussion about it, because they believe too. So yeah, that's, that's a mad. That's a major hurdle. Because yeah... I still struggle to think right now, because it upsets me that you know, yeah, to think about God is synonymous with being mentally ill. Well, that's sad. That's beyond sad. (Simeon, Page 26)

Participants discussed instances where they felt racially stereotyped by mental health professionals, leading to concerns about their diagnoses being influenced by race rather than their symptoms and experiences. These experiences of perceived racism and racial bias can create significant barriers to trust and may affect participants' willingness to engage fully with mental health services.

I think that Dr [Consultant]… I think he's racist. I think he wants to characterise every Black person as having paranoid schizophrenia. That's what I've observed. (Kaleb, Page 11)

I see White people come into the hospital with the same symptoms as I had, hearing voices. They get called bipolar or drug induced psychosis or something else. Yeah. Every Black person coming in, all different symptoms, and they all get called schizophrenic, paranoid schizophrenic. I don't see how me hearing voices makes me a paranoid schizophrenic. It's just auditory hallucinations. How's that schizophrenia? Yet, still someone can believe that they're God and they get called schizophrenic as well. (Reece, Page 10)

In this context, participants' perceptions of racism and bias may impact their ability to trust mental health professionals, particularly with receiving an accurate diagnosis and appropriate treatment. Building trust with individuals from diverse backgrounds requires mental health professionals to actively listen, validate experiences, and ensure that diagnostic decisions are based on objective assessments and understanding of the person's unique experiences (Moudatsou et al., 2020).

Participants' observations of an overrepresentation of Black men in mental health hospitals can contribute to a sense of mistrust, particularly considering the historical context of systemic racism and discrimination. Such longstanding difficulties may have led to disparities in access to mental health support and differences in the quality of care experienced by Black men. Consequently, participants recounted their observations of disparities in treatment within forensic settings and expressed a sense of acceptance of the mistreatment.

> Well, on the forensic… I've actually realised is a lot of Black people, Black patients get treated anyhow. That is life, isn't it? Some of them, get treatment that's not good, when they are in the hospital, you know. It's...it's just way it is (Noel, Page 24-25)

In essence, the theme summarises the group's collective experiences within forensic services, marked by breakdowns in communication, cultural insensitivity, and perceptions of systemic biases. A lack of communication and cultural competency can significantly impact the ability to trust mental health services. As demonstrated in this section, when mental health providers fail to communicate effectively with Black men, it can result in feelings of isolation and mistrust. Moreover, the absence of cultural competency among mental health professionals may lead to a failure to understand and acknowledge the unique experiences and challenges

faced by Black men. These factors collectively may create an environment where individuals may find it challenging to understand and navigate forensic services, leading to confusion and frustration.

### *E. Invisible and Frustrated*

Gabriel's expression of feeling "Invisible and frustrated" (Gabriel, Page 18) reflects a significant issue with the lack of collaboration in decision-making about his care. He perceived his needs as unimportant and may have experienced a sense of powerlessness as others were in control of his treatment. A lack of involvement in the decision-making process may lead to feelings of frustration and invisibility, eroding trust in mental health services. The erosion of trust, resulting from a lack of collaboration in care decisions, can have a detrimental impact on the overall therapeutic relationship and treatment outcomes for participants like Gabriel.

Several participants shared that mental health teams were somewhat detached and medicalised in their approach. Jeremiah shares his experience of not being involved, seen, or heard by staff: "Like I said they don't believe anything you tell them, and they don't really want to take it on board. So, it's just that... it's kind of pointless" (Jeremiah, Page 18). This could lead to feelings of helplessness and futility in engaging with mental health services, as he feels that his efforts to communicate and seek support are disregarded. Reece also shared this view of feeling invisible when he shared his experiences but did not feel like it was taken on board "I told them straight away what I was going through...I didn't hide it from anyone. I told them, I told people at work. I told friends, I told everyone." (Reece, Page 13). This can have implications for trust in the responsiveness and effectiveness of mental health services and broader support networks.

Participants shared beliefs that healthcare professionals failed to acknowledge their experiences and needs during the decision-making process for their treatment. The lack of trust participants hold may stem from their perception of mental health professionals lacking empathy and understanding. This perception, in turn, appeared to sow doubts in the accuracy

and depth of the assessments conducted by healthcare professionals. Jeremiah's experience paints a vivid picture of feeling dismissed and marginalised within the forensic setting.

> Like consultants, doctors, key workers, support workers and stuff like that. I just believe that as soon as it sounds like it's anything to do with mental health, they will shut you down. Like, bear in mind, they don't know what you're going through. […] So, it's just that I think they should look more deep into things before they just judge people and say, no, that's mental health or he's unwell or he's this or he's that because there's too many things in this world. (Jeremiah, Page 13)

The recurring pattern of invisibility and frustration highlights the fundamental importance of trust. The lack of trust in healthcare professionals arises not only from a sense of being overlooked but also from the perceived absence of genuine empathy and understanding. Experiences of being dismissed and ignored appeared linked to a sense of frustration with mental health services, which could discourage individuals from seeking help in the future. These feelings collectively represent a general scepticism about the intentions and competence of mental health professionals.

### *F.* ***They don't care:*** *exclusively medical, overly dismissive, and uncollaborative.*

Participants' experiences with mental health services varied, with some encounters described as exclusively medical, overly dismissive, and uncollaborative. However, the concept of trust in mental health services is closely linked to the quality of care received (Gaebel et al., 2014). When participants encountered compassionate, collaborative, transparent, culturally-sensitive, and empathic care, it enhanced their trust in the mental health services. Negative experiences with healthcare professionals, such as encountering a lack of empathy and understanding, contributed to feelings of mistrust, especially concerning power and control.

All participants reflected on the complexities and unpredictability of trust in relationships with mental health professionals and expressed difficulties in determining whom to trust. They described power dynamics within mental health services, which can contribute to feelings of vulnerability and helplessness. Participants emphasised the importance of trust in the therapeutic relationship, acknowledging that the decisions made by mental health professionals can profoundly impact their lives. Consequently, such a perception may be associated with heightened sensitivities in interactions with staff, particularly with expressing their thoughts and feelings.

> There's a big, big range of people who are in mental health services, and not all of them are particularly good at their own position. So, you have no idea... who to trust, how much to trust them. And what they're going to do, depending on what you do, it's really nuts actually. It's probably the most chaotic relationship you could have because they have control over your life. Like... when you're unwell already, you don't want that. So yeah, it's *impossible* to say. There're certain staff members, you can say anything to, they'll be cool with it, you'll buss joke, you'll be alright. Next staff member, make a joke, they take it the wrong way.

> Before you know, you go into your ward round, it's being mentioned that you're this way and saying these things you know. Like I trusted this person and I've been betrayed for something I said, so. Yeah, it's like that really. (Simeon, Page 6)

Participants collectively conveyed negative sentiments, characterised by mistrust and a belief that mental health professionals lack a genuine commitment to treatment, echoed in a quote from Reece:

> They're not to be trusted...Don't think that 'I've got a problem; I better go hospital'. They're not to be trusted. They'll put you on a poisonous medication. And they'll lock you up for as long as possible. They're not interested in treating you. They don't treat you. They think giving you medication is treatment.... They don't treat you.... You don't ever talk about what problems you might have had what stresses you might have been going through... nothing! (Reece Page 14)

This quote crystallises the sentiment shared by the group which demonstrates a conviction that mental health professionals, particularly psychiatrists, may not be invested in patient care, instead focusing on medication as the sole approach. There was a perception that the focus of mental health services is specifically on symptom management through medication, without addressing the underlying difficulties or providing meaningful therapeutic support. The quotes further highlight the absence of meaningful engagement with patients' difficulties and stresses, contributing to an overarching sense of neglect and mistrust.

The widespread experiences among participants emphasised the importance of trust in a therapeutic relationship, suggesting that sharing problems and experiences should lead to recovery and support rather than a sense of vulnerability and fear. However, a lack of

trust in mental health services could create a barrier to open communication and hinder willingness to discuss difficulties with healthcare professionals.

> Like it was hard for me to trust at that that time because you just think if I tell them anything, they're gonna put me in hospital or something like that […] I felt like... anything that I was telling them or whatever was going on, was getting me closer to hospitalisation, but I feel like it should be the other way around if you're actually speaking about your problems, they're not devouring you they're not they're taking over your life like you're not scared to discuss them so I would have thought that it would mean it's getting closer to recovery if you want to talk about it… (Jeremiah, Page 19)

Participants expressed a desire for more involvement in decision-making around their care and treatment plan, which may help reclaim a sense of control over their lives. Gabriel shared, "To trust, yeah, if they, I think if the doctors. If the patient had more say in their care process that would, I think that would help." (Gabriel, Page 17). Gabriel's focus on the doctor-patient relationship and the need for mutual respect and collaboration emphasises the importance of trust in these settings. Trust is foundational in healthcare, as patients often rely on healthcare professionals to make decisions that are in their best interest (Birkhäuer et al., 2017); as such, when patients feel included and valued in the care process, it can strengthen trust in the healthcare system and providers.

The emphasis on community-based mental health support acknowledges the significance of providing care in a familiar and accessible setting. By accessing services within their community, individuals may feel more comfortable and at ease, which can have a positive impact.

> But like, it doesn't take like you to be locked up to get better. […] With the right meds and with the right people around you people that have your best interests, like you should be able to get somewhere without going inside. (Jeremiah, Page 10)

Community-based services may also facilitate a more personalised and culturally sensitive approach to mental health care. Individuals may feel better understood and supported when their care providers are familiar with their cultural background and social context, contributing to a deeper level of trust in the therapeutic relationship.

Overall, the current theme illustrates the perception that mental health professionals may prioritise other factors, such as medication, over developing a genuine, empathic therapeutic environment. This was experienced as a lack of genuine caring and understanding. Participants' encounters with mental health professionals played a critical role in shaping their trust in mental health services. Positive experiences facilitated trusting relationships and a willingness to seek support, while negative experiences eroded trust and discouraged further engagement.

## Discussion

The current review aimed to explore Black men's experience of trust in the context of forensic mental health services in the UK. The current study describes experiences of betrayal, discrimination and prejudice across healthcare settings and broader society and how these may contribute to feelings of doubt, uncertainty, and mistrust of mental health services. The findings of the current study suggest that life stresses, feelings of betrayal and an inclination towards self-reliance, along with a reluctance to seek help when faced with difficulties, all contributed to how trust was understood and experienced.

### *Navigating Trust in Mental Health Services*

Through the participants' narratives of their experiences, several key themes related to trust were identified. The study described how trust could be experienced as interpersonal trust, such as in families and healthcare professionals, and systemic trust in mental health services as institutions. The study also highlighted how trust can be influenced by past experiences of mistreatment, discrimination, and a lack of culturally sensitive care. The current findings align with existing literature, which emphasises the particular significance of self-reliance among men in managing mental health issues (Sheikh et al., 2000). These collective experiences contribute to a sense of mistrust and apprehension towards engaging with mental health services.

Furthermore, the study findings emphasise the importance of communication and collaboration in establishing trust, which supports the work of Memon et al. (2016). Their research highlighted that poor communication between service users and healthcare providers hindered the development of effective relationships. In the current study, participants expressed their concerns about mental health professionals' perceived inability to listen and understand their needs (e.g., Theme F: They don't care). Instead, they felt that healthcare providers adopted a

generalised approach, overlooking individual needs, leaving participants feeling invisible and frustrated (Theme E). This lack of personalised attention contributed to mistrust and dissatisfaction among the participants.

### *Life Experiences Shaping Trust*

The study also highlighted the impact of personal experiences on trust at different points in the participants' life history. Participants described various experiences that may have shaped trust and influenced their perceptions of mental health services. For instance

One participant recounted the traumatic experience of losing a close friend to a violent crime in their community. This event may have had a significant impact on their trust in others, leading to more guarded and sceptical behaviours, which may include interactions with mental health professionals. Healthcare professionals may interpret behaviours displayed by individuals with a lack of trust as a symptom of mental illness rather than considering other potential explanations. For example, feeling suspicious may be misconstrued as symptoms of paranoia when they may be reasonable responses to negative experiences or experiencing a history of systemic biases.

### *Diagnosis and Trust*

Participants' experiences of predominantly receiving a diagnosis of paranoid schizophrenia resonate with the concept of trust. The diagnosis process involves trust in the expertise and objectivity of healthcare professionals. However, should participants believe that their diagnoses may be influenced by their ethnic backgrounds rather than their actual symptoms, it can erode their trust in mental health services. This was demonstrated by a participant describing hospitals and prisons as "dustbins for black people", which illustrates a profound mistrust towards mental health services, perceiving them as oppressive and biased institutions

where individuals are locked away and subjected to harmful treatments, further eroding trust. This finding is consistent with Halvorsrud et al. (2019), they found that ethnic minority groups were more likely to receive severe mental illness diagnoses.

### *Trust in Forensic Mental Health Settings*

It is important to note that the current study explored the experiences of individuals previously detained in forensic inpatient units. Forensic mental health services specialise in the assessment, treatment, and risk management of individuals with a mental disorder who are either currently engaged in or previously involved in legal or court proceedings. As such, service users within forensic hospitals are often subject to greater restrictions and supervision than service users in general mental health facilities. In forensic hospitals, trust is likely influenced by the forensic setting in several ways. For example, service users may feel they are treated as criminals rather than service users receiving treatment for their mental health difficulties, which can erode trust in the system. Service users may also feel their rights and freedoms are unfairly restricted, which can further undermine trust (Chambers et al., 2014)

Additionally, forensic hospitals often have a complex power dynamic between healthcare professionals and service users (Oates et al., 2021). A significant theme (Theme F: They don't care) described service users as having little control over their treatment and their view that decisions were made without their input or consent. This dynamic can create challenges when establishing trust between service users and healthcare professionals, particularly if service users feel uncared for and their autonomy dismissed or ignored. Addressing the issue of trust is fundamental in healthcare, particularly in mental health services, where establishing a solid therapeutic relationship is essential for positive outcomes (Gaebel et al., 2014).

Theme D: It Didn't Make Sense, highlights the importance of healthcare professionals being

mindful of potential barriers to trust and should seek to build rapport and create a safe and supportive environment for patients. Participants collective experiences included breakdowns in communication, cultural insensitivity, and the perception of systemic biases, suggesting that trust in mental health services can be affected by these factors. Acknowledging and validating individuals' experiences and concerns can create a foundation of trust that enables more accurate assessments and effective treatment interventions.

### *Areas for future research*

One key area of research is conducting longitudinal studies to understand trust in mental health services among Black men. Thus, providing insights into the long-term impact of mistrust in mental health services on treatment outcomes, mental health trajectories, and overall well-being among Black men. Understanding trust over time can inform interventions to build and maintain trust in mental health care. Research can explore the intersectionality of race, gender, and other social identities in shaping mental health experiences. Understanding how various intersecting identities impact trust and mental health helps develop more tailored interventions and support systems.

In addition, there seems to be a place for studies examining the impact of systemic changes and policy interventions aimed at addressing racism and discrimination in mental health care. Research on policy changes that promote equity and inclusivity may shed light on best practices for reducing disparities in mental health care access and quality. Conducting qualitative studies in different healthcare settings (e.g., outpatient, inpatient, community-based) may be useful to understand the role of trust and cultural competency in influencing mental health experiences, which can help identify specific challenges and strengths in each setting.

Research on trauma-informed care models specific to the experiences of Black men can inform practices that prioritise safety, empowerment, and trustworthiness. Examining those areas can contribute to the development of more effective, culturally appropriate, and equitable mental health care for Black men and other marginalised communities.

Another critical area of research is to explore alternative approaches to involuntary admission that may be more effective and culturally appropriate for Black men. This may include community-based mental health services, peer support, and culturally-specific interventions that address the social and cultural factors contributing to mistrust of mental health services. Future research could explore long-term outcomes for Black men who have experienced involuntary admission into inpatient units in the UK. To inform policy and practice in providing forensic mental health services, particularly for Black men, it is important to explore various aspects such as their mental health outcomes, experiences with the criminal justice system, and social outcomes, including employment and housing. A more comprehensive understanding can contribute to improving the delivery of forensic mental health services and addressing the specific needs of Black men within this context.

### *Strengths and Limitations*

As participants offered retrospective accounts of experiences from 12 months to six years, some recollections may not be accurate. It was acknowledged that some participants' recollections might be influenced by various biases, such as recall bias, mood bias, and socially desirable responses. Additionally, participants' level of personal insight and their emotional connection to the discussed issues could also impact their recollections of their experiences.

To ensure ethical conduct, the researchers carefully considered the implications of offering a £10 high street shopping voucher as a token of gratitude for participating in the study.

Discussions with supervisors and references to relevant literature (Grant & Sugarman, 2004; BPS, 2014) concluded that this gesture was appropriate for consenting adults voluntarily participating in the study and that the value was not substantial enough to risk experiences of coercion.

Interviews for this study were conducted remotely via Zoom, and the researcher experienced occasional connectivity issues. However, using remote interviews also offered flexibility and ease of access, a strength of the research. Additionally, the study provides an opportunity to explore the mental health experiences of Black men with a diagnosis of schizophrenia who have been admitted into inpatient services. By exploring their experiences and identifying potential areas for improvement, this research contributes to the broader goal of enhancing the quality of mental health care and support for this specific population.

The researcher, a Black woman, is committed to leveraging her professional position and lived experiences to empower Black and other marginalised communities through clinical practice and research. This presents a valuable advantage as a Black psychologist researching the lived experiences of Black individuals, as she can be positioned as both an insider and an outsider (Zavella, 1993). As an insider, the researcher has familiarity with the various strengths, challenges, and needs of Black individuals. However, Black individuals are not a homogenous group, and the researcher acknowledges the nuances and variations in cultural identities, values, and practices across Black communities. Despite these differences, Black individuals share similar experiences of being perceived by society through their phenotypical features. Ethical considerations were taken to ensure that the researcher's insider status did not compromise the quality and validity of the research.

As such, it is acknowledged that some assumptions are entrenched. Therefore, it informed interpretations and decision-making to some extent. Engaging in several reflective practices enabled the researcher to acknowledge potential underlying assumptions and interpretations. For example, keeping a reflective diary allowed the researcher to document thoughts and feelings about the research process, allowing the researcher to identify potential biases. Supervision was used, and the supervision process allowed the researcher to identify potential blind spots and biases that may not have been noticed. Attending peer qualitative analysis workshops also played a role in the researcher's awareness of feelings, personal triggers, and responses to those. The workshops provided a collaborative space for the researcher to receive feedback, challenge biases, and gain new insights into the data. Thus, the researcher was able to take an empathic and curious stance on the participant's experiences. Personal feelings and triggers emerging throughout the research process were discussed in supervision.

### *Clinical Implications*

Findings from the current study may have implications for developing targeted interventions intended to strengthen trust within mental health services. Mental health professionals could undergo training to focus on understanding the unique experiences and challenges faced by Black men and women, as well as understanding how cultural factors can impact mental health experiences. This helps mitigate the risk of misinterpreting cultural differences as symptoms of mental illness with the aim of reducing the perception of systemic biases.

Findings also highlight the importance of not pathologising trust; instead, they emphasise the disparity between participants' experiences and external perceptions of their experiences. To address this, efforts could be directed towards de-pathologising trust. Building trust between mental health professionals and patients emerges as a central recommendation. Mental health professionals could maintain curiosity in understanding cultural differences, which can expand

their understanding of diverse backgrounds. Mental health professionals should prioritise creating a safe and supportive environment with open and empathic communication wherein patients can feel heard, respected, and validated. This approach to trust-building is essential in developing enhanced mental health experiences and outcomes for Black men.

To promote trust and improve mental health outcomes for Black men accessing forensic services, clinicians may need to incorporate trauma-informed care principles into their practice (Procter et al., 2017). However, it is essential to acknowledge and address the root causes of Black men's lack of trust in mental health services. This requires tackling the historical experiences of discrimination, stereotyping, and mistreatment within the mental health system that have contributed to distrust (McKenzie et al., 2022).

Participants in the current study suggested engaging Black men and their communities in developing and implementing culturally sensitive mental health services. The delivery of safe and equitable person-centred care demands a mental health model responsive to its users' lived experience, particularly from marginalised groups. For this specific population, mental health services must align with social and anti-racist models of care. The current findings indicate that intersections related to discrimination, gender and complex trauma may be more pertinent than broad ethnic group classifications.

The experience within the UK is particularly interesting, given that The National Health Service (NHS) is provided without a charge for all UK residents. However, there appears to be a need for more progress in addressing inequalities (Humphreys et al., 2014; Fitzpatrick et al., 2014; Vernon et al., 2020), despite several policies and legislations present to improve mental healthcare (Race Relations Act 2000; Equality Act 2010)

Clinical implications of this research include the need for culturally-sensitive and responsive mental health services that acknowledge and address the distinct experiences and needs of Black men. This may include delivering training to mental health care professionals in cultural competence and providing tailored interventions that consider the role of intersectional factors in the experience of hospital admissions. To address the ethnic disparities in mental health care, it is important to evaluate the individual, systemic, and structural barriers that hinder meaningful collaborations between healthcare providers, community organisations, and individuals from ethnic minority backgrounds. These collaborations could be useful in developing and implementing community-informed recommendations for mental health services. Suggestions could be provided by the community members themselves, particularly those with lived experiences of mental health difficulties or members of specific ethnic minority groups. These recommendations could be based on the community's collective knowledge, experiences, and understanding of the barriers and facilitators to accessing and receiving adequate mental health support, potentially reducing disparities and inequalities within mental health services.

### *Summary*

Participants in the current study demonstrated good insight and understanding into their experiences. They could reflect on the various factors that impacted their lives and shaped their experiences, including family involvement, wider society, and mental health services. They had a good understanding of external factors contributing to their experiences of trust in mental health services and how their ability to trust may have been affected by broader systemic issues such as discrimination and inequality. This awareness suggests that involving service users in designing and delivering mental health services could lead to more effective and responsive care. Including service users in the planning and implementing mental health services can allow providers to gain insight into the needs and preferences of the individuals

they serve and the barriers they may face in accessing care. This can lead to more tailored and effective interventions that better meet the needs of service users.

This study suggests the value of incorporating the voices and perspectives of service users, in this instance, Black men, in mental health service design and delivery, which could improve the quality of care and promote more positive mental health outcomes. By adopting a collaborative, trauma-informed approach to care that values the insights and experiences of service users, mental health services can create a more supportive and responsive healthcare environment.

## Reference for the Empirical Research Paper


Adler, R. B., & Towne, N. (2005). Looking out, looking in Interpersonal Communication (11th ed.). Fort Worth, TX: Harcourt Brace.

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, *5*(2), 9. https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

Avery, J. M. (2006). The sources and consequences of political mistrust among African Americans. American Politics Research, 34(5), 653–682. https://doi.org/10.1177/1532673x06286366

Baah, J., & Yeboah, K. (2020). Mobilising intersectionality as a framework to organise against inequality: A review of Mythbusting intersectionality UK, Westminster University, 28 May 2019. *QMiP Bulletin*, *1*(29), 43–46. https://doi.org/10.53841/bpsqmip.2020.1.29.43

Baghramian, M., Petherbridge, D., & Stout, R. (2020). Vulnerability and trust: An introduction. International Journal of Philosophical Studies, 28(5), 575–582. https://doi.org/10.1080/09672559.2020.1855814

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). Qualitative methods in psychology: A research guide. Open University Press.

Bansal, N. *et al.* (2022). "Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography," *PLOS Medicine*, 19(12). Available at: https://doi.org/10.1371/journal.pmed.1004139.

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., & Ariyo, K. et al. (2019). Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry*, *6*(4), 305-317. https://doi.org/10.1016/s2215-0366(19)30027-6

Bebbington, P., Feeney, S., Flannigan, C., Glover, G., Lewis, S., & Wing, J. (1994). Inner London Collaborative Audit of Admissions in Two Health Districts. *British Journal of Psychiatry*, *165*(6), 743-749. https://doi.org/10.1192/bjp.165.6.743

Berger, R. (2013). Now I see it, now I don't: Researcher's position and reflexivity in Qualitative Research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Best, A. L., Fletcher, F. E., Kadono, M., & Warren, R. C. (2021). Institutional distrust among African Americans and building trustworthiness in the COVID-19 response: Implications for ethical public health practice. Journal of Health Care for the Poor and Underserved, 32(1), 90–98. https://doi.org/10.1353/hpu.2021.0010

Bhui, K., Brown, P., Hardie, T., Watson, J., & Parrott, J. (1999). African-Caribbean men remanded to Brixton prison. Psychiatric and forensic characteristics and outcome of final court appearance. *Journal of Clinical Forensic Medicine*, *6*(1), 57–58. https://doi.org/10.1016/s1353-1131(99)90188-8

Bignall, T., Jeraj, S., Helsby, E. and Butt, J. (2019). *Racial disparities in mental health: Literature and evidence review.* Race Equality Foundation [Online] Available from https:// raceequalityfoundation.org.uk/wp-content/ uploads/2020/03/mental-health-report-v5-2. Pdf

Birkhäuer, J., Gaab, J., Kossowsky, J., Hasler, S., Krummenacher, P., Werner, C., & Gerger, H. (2017). Trust in the health care professional and health outcome: A meta-analysis. PLOS ONE, 12(2). https://doi.org/10.1371/journal.pone.0170988

Boonstra, N., Klaassen, R., Sytema, S., Marshall, M., De Haan, L., Wunderink, L., & Wiersma, D. (2012). Duration of untreated psychosis and negative symptoms — a systematic review and meta-analysis of individual patient data. *Schizophrenia Research*, *142*(1-3), 12–19. https://doi.org/10.1016/j.schres.2012.08.017

Breakwell, G. M., Smith, J. A., & Wright, D. B. (Eds.) (2012). *Research methods in psychology* (4th ed.). Sage.

Bryman, A. (2008). Of methods and methodology. *Qualitative Research in Organizations and Management: An International Journal*, *3*(2), 159–168. https://doi.org/10.1108/17465640810900568

Burns, M. (2003). I. Interviewing: Embodied Communication. *Feminism & Psychology*, *13*(2), 229–236. https://doi.org/10.1177/0959353503013002006

Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice*, *34*(3), 278–286. https://doi.org/10.1037/0735-7028.34.3.278

Chambers, M., Gallagher, A., Borschmann, R., Gillard, S., Turner, K., & Kantaris, X. (2014). The experiences of Detained Mental Health Service users: Issues of dignity in care. *BMC Medical Ethics*, *15*(1). https://doi.org/10.1186/1472-6939-15-50

Cochrane R, Bal SS. Mental hospital admission rates of immigrants to England: a comparison of 1971 and 1981. Soc Psychiatry Psychiatr Epidemiol. 1989; 24(1):2–11. https://doi.org/10.1007/ BF01788193

Corrigall, R., & Bhugra, D. (2013). The role of ethnicity and diagnosis in rates of adolescent psychiatric admission and compulsory detention: a longitudinal case-note study. *Journal of the Royal Society of Medicine*, *106*(5), 190-195. https://doi.org/10.1177/0141076813480995

Colizzi, M., Lasalvia, A., & Ruggeri, M. (2020). Prevention and early intervention in youth mental health: Is it time for a multidisciplinary and trans-diagnostic model for care? *International Journal of Mental Health Systems*, *14*(1). https://doi.org/10.1186/s13033-020-00356-9

Craig, T., Power, P., (2010). Inpatient provision in early psychosis. In: French, P., Smith, J., Shiers, D., Reed, M., Rayne, M. (Eds.), Promoting Recovery in Early Psychosis. A Practice Manual. Wiley-Blackwell, Chichester.

Dennis, A.C., Esther, O., Lodge, E.K., Evans, K., Martinez, R. and Wilbour R.E. (2021), "Looking back to leap forward: A framework for operationalizing the structural racism construct in minority and immigrant health research", Ethnicity & Disease, Vol. 31, pp. 301-310. https://doi.org/10.18865/ed.31.S1.301.

Dell'Osso, B., Glick, I. D., Baldwin, D. S., & Altamura, A. C. (2012). Can long-term outcomes be improved by shortening the duration of untreated illness in psychiatric disorders? A conceptual framework. *Psychopathology*, *46*(1), 14–21. https://doi.org/10.1159/000338608

Humphreys, M., & Smith, H. (2014). Department of Health Review of Research on the mental health act 1983. *International Journal of Mental Health and Capacity Law*, (3), 58. https://doi.org/10.19164/ijmhcl.v0i3.316

Doescher, M. P. (2000). Racial and ethnic disparities in perceptions of physician style and trust. Archives of Family Medicine, 9(10), 1156–1163 https://doi.org/10.1001/archfami.9.10.1156

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35*(2), 220–222. https://doi.org/10.1177/0890334419830990

Evangelist, M. (2021). Narrowing racial differences in trust: How discrimination shapes trust in a racialized society. Social Problems, 69(4), 1109–1136. https://doi.org/10.1093/socpro/spab011

Fernando, S. (2017). *Institutional Racism in Psychiatry and Clinical Psychology*. https://doi.org/10.1007/978-3-319-62728-1

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, *3*(1). https://doi.org/10.29173/pandpr19818

Fitzpatrick R, Kumar S, Nkansa-Dwamena O, Thorne L. (2014). Ethnic inequalities in mental health: promoting lasting positive change. Report of findings to LankellyChase Foundation, Mind, The Afiya Trust and Centre for Mental Health.

Gaebel, W., Muijen, M., Baumann, A. E., Bhugra, D., Wasserman, D., van der Gaag, R. J., Heun, R., & Zielasek, J. (2014). EPA guidance on Building Trust in Mental Health Services. European Psychiatry, 29(2), 83–100. https://doi.org/10.1016/j.eurpsy.2014.01.001

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. (2016). Ethnicity and detention are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007. *Social Psychiatry and Psychiatric Epidemiology*, *51*(5), 703-711. https://doi.org/10.1007/s00127-016-1181-z

Grossman, S., Cooper, Z., Buxton, H., Hendrickson, S., Lewis-O'Connor, A., Stevens, J., Wong, L.-Y., & Bonne, S. (2021). Trauma-informed care: Recognizing and resisting re-traumatization in health care. *Trauma Surgery & Acute Care Open*, *6*(1). https://doi.org/10.1136/tsaco-2021-000815

Health and Social Care Information Centre, 2014, *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment*

Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E., & Bhui, K. (2018). Ethnic inequalities and pathways to care in psychosis in England: A systematic review and meta-analysis. *BMC Medicine*, *16*(1). https://doi.org/10.1186/s12916-018-1201-9

Harper, D. (2011). Choosing a qualitative research method. *Qualitative Research Methods in Mental Health and Psychotherapy*, 83–97. https://doi.org/10.1002/9781119973249.ch7

Hibbert, P., Coupland, C., & MacIntosh, R. (2010). Reflexivity: Recursion and Relationality in Organizational Research Processes. *Qualitative Research in Organizations and Management: an International Journal*, *5*(1), 47–62. https://doi.org/10.1108/17465641011042026

Holstein, J. A., & Gubrium, J. F. (1995). The active interview. Thousand Oaks, CA: Sage.

Jeraj, S, Shoham, T and IslamBarratt, F, (2015). *Mental health crisis services for black and minority ethnic people*, Race Equality Foundation, https://raceequalityfoundation.org.uk/healthcare/mentalhealthcrisisservicesforblackandminorityethnicpeople/

Johnstone, L., & Boyle, M. (2018). The Power Threat Meaning Framework. In *British Psychological Society* (Vol. 3, Issue 3). www.bps.org.uk

Kessler, R. C., Mickelson, K. D., & Williams, D. R. (1999). The prevalence, distribution, and mental health correlates of perceived discrimination in the United States. *Journal of Health and Social Behavior*, *40*(3), 208. https://doi.org/10.2307/2676349

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing.* Sage.

Kyere, E., & Fukui, S. (2022). Structural racism, workforce diversity, and Mental Health Disparities: A critical review. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-022-01380-w

Lapadat, J. C., & Lindsay, A. C. (1999). Transcription in research and practice: From standardisation of technique to interpretive positionings. *Qualitative Inquiry*, *5*(1), 64–86. https://doi.org/10.1177/107780049900500104

Lynch, M. F. (2013). Attachment, autonomy, and emotional reliance: A multilevel model. *Journal of Counseling & Development*, *91*(3), 301–312. https://doi.org/10.1002/j.1556-6676.2013.00098.x

Lynch, L., Long, M., & Moorhead, A. (2016). Young men, help-seeking, and mental health services: Exploring barriers and solutions. *American Journal of Men's Health*, *12*(1), 138–149. https://doi.org/10.1177/1557988315619469

Madden, H., Harris, J., Blickem, C., Harrison, R., & Timpson, H. (2017). "Always paracetamol, they give them paracetamol for everything": A qualitative study examining Eastern European migrants' experiences of the UK Health Service. *BMC Health Services Research*, *17*(1). https://doi.org/10.1186/s12913-017-2526-3

Majors, R., Carberry, K., & Ransaw, T. S. (2020). The International Handbook of Black Community Mental Health. https://doi.org/10.1108/9781839099649

Mann, F., Fisher, H. L., & Johnson, S. (2014). A systematic review of ethnic variations in hospital admission and compulsory detention in first-episode psychosis. *Journal of Mental Health*, *23*(4), 205–211. https://doi.org/10.3109/09638237.2014.910641

McKenzie, S. K., Oliffe, J. L., Black, A., & Collings, S. (2022). Men's experiences of mental illness stigma across the lifespan: A scoping review. *American Journal of Men's Health*, *16*(1), 155798832210747. https://doi.org/10.1177/15579883221074789

Mechanic, D. (1998). The functions and limitations of trust in the provision of medical care. *Journal of Health Politics, Policy and Law*, *23*(4), 661–686. https://doi.org/10.1215/03616878-23-4-661

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among Black and Minority Ethnic (BME) communities: A qualitative study in southeast England. *BMJ Open*, *6*(11). https://doi.org/10.1136/bmjopen-2016-012337

Morse, J. M. (1994). Designing funded qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220–235). Sage.

Moudatsou, M., Stavropoulou, A., Philalithis, A., & Koukouli, S. (2020). The role of empathy in health and Social Care Professionals. *Healthcare*, *8*(1), 26. https://doi.org/10.3390/healthcare8010026

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, *18*(3), 369–386. https://doi.org/10.1080/14780887.2020.1854404

Nazroo, J. Y., Falaschetti, E., Pierce, M., & Primatesta, P. (2009). Ethnic inequalities in access to and outcomes of Healthcare: Analysis of the Health Survey for England. *Journal of Epidemiology & Community Health*, *63*(12), 1022–1027. https://doi.org/10.1136/jech.2009.089409

NHS Digital. Mental health act statistics, annual figures 2018-2019.

Oates, J., Topping, A., Ezhova, I., Wadey, E., & Rafferty, A. M. (2021). Factors affecting high secure forensic mental health nursing workforce sustainability: Perspectives from Frontline Nurses and stakeholders. *Journal of Psychiatric and Mental Health Nursing*, *28*(6), 1041–1051. https://doi.org/10.1111/jpm.12740

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice.* Sage

Payne-Gill, J., Whitfield, C., & Beck, A. (2021). The relationship between ethnic background and the use of restrictive practices to manage incidents of violence or aggression in psychiatric inpatient settings. *International Journal of Mental Health Nursing*, *30*(5), 1221–1233. https://doi.org/10.1111/inm.12873

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, *2*(4), 281–307. https://doi.org/10.1191/1478088705qp045oa

Procter N, Ayling B, Croft L, Degaris P, Devine M, Dimanic A, Di Fiore L, Eaton H, Edwards M, Ferguson M, Lang S, Rebellato A, Shaw K & Sullivan R. (2017). *Trauma-informed approaches in mental health: A practical resource for health professionals*, University of South Australia, SA Health, Adelaide.

Rabiee, F., & Smith, P. (2014). Being understood, being respected: An evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK. *International Journal of Mental Health Promotion*, *15*(3), 162–177. https://doi.org/10.1080/14623730.2013.824163

Rowe, R., & Calnan, M. (2006). Trust relations in Health Care: Developing a theoretical framework for the “new” NHS. *Journal of Health Organization and Management*, *20*(5), 376–396. https://doi.org/10.1108/14777260610701777

Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A Multilevel Study of collective efficacy. Science, 277(5328), 918–924. https://doi.org/10.1126/science.277.5328.918

Sashidharan SP. Inside Outside—Improving mental health services for Black and Minority ethnic communities in England. London; 2003.

Shaver, P. R., & Mikulincer, M. (2003). Attachment-related psychodynamics. *Attachment & Human Development*, *4*(2), 133–161. https://doi.org/10.1080/14616730210154171

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology*, *35*(7), 326–334. https://doi.org/10.1007/s001270050246

Singh, S., Burns, T., Tyrer, P., Islam, Z., Parsons, H., & Crawford, M. (2013). Ethnicity as a predictor of detention under the Mental Health Act. *Psychological Medicine*, *44*(5), 997–1004. https://doi.org/10.1017/s003329171300086x

Singh, S., Islam, Z., Brown, L., Gajwani, R., Jasani, R., Rabiee, F., & Parsons, H. (2013). Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: the ENRICH programme, a mixed-methods study. *Programme Grants for Applied Research*, *1*(3), 1-168. https://doi.org/10.3310/pgfar01030

Singh, S., Greenwood, N., White, S., & Churchill, R. (2007). Ethnicity and the Mental Health Act 1983. *British Journal of Psychiatry*, *191*(2), 99-105. https://doi.org/10.1192/bjp.bp.106.030346

Smith, S. S. (2005). "don't put my name on it": Social Capital Activation and Job-finding assistance among the Black Urban Poor. American Journal of Sociology, 111(1), 1–57. https://doi.org/10.1086/428814

Smith, S. S. (2010). Race and Trust. Annual Review of Sociology, 36(1), 453–475. https://doi.org/10.1146/annurev.soc.012809.102526

Smith, J.A., Flowers, P. & Larkin, M. (2022). *Interpretive phenomenological analysis: Theory, Method, and research*. Sage Publications.

Stein, C (2018). *Mind your language: How men talk about mental health*, Men's Health Forum.

Smith, J. A. & Osborn, M. (2007). Interpretative Phenomenological Analysis. In Smith, J. A. (Ed.) (2007) Qualitative Psychology: A Practical Guide to Research Methods. (p. 53-80). London: SAGE.

Tyler, T. R. (2005). Policing in black and white: Ethnic group differences in trust and confidence in the police. Police Quarterly, 8(3), 322–342. https://doi.org/10.1177/1098611104271105

Varela, F. J., Thompson, E., Rosch, E., & Kabat-Zinn, J. (2017). *The Embodied Mind*. https://doi.org/10.7551/mitpress/9780262529365.001.0001

Vernon, P. (2020). Thirty Years of Black History Month and thirty years of overrepresentation in the Mental Health System. The International Handbook of Black Community Mental Health, 137–148. https://doi.org/10.1108/978-1-83909-964-920201010

Vergunst, P. J. (2002). The potentials and limitations of self-reliance and self-sufficiency at the local level: Views from Southern Sweden. *Local Environment*, *7*(2), 149–161. https://doi.org/10.1080/13549830220136454

Warren, R. C., Shedlin, M. G., Alema-Mensah, E., Obasaju, C., & Augustin Hodge, D. (2019). Clinical trials participation among African Americans and the Ethics of Trust: Leadership Perspectives. Ethics, Medicine and Public Health, 10, 128–138. https://doi.org/10.1016/j.jemep.2019.100405

Willig, C. (2013). Introducing qualitative research in psychology. Open University Press.

Zavella, P. (1993). Feminist insider dilemmas: Constructing ethnic identity with "Chicana" informants. *Frontiers: A Journal of Women Studies*, *13*(3), 53. https://doi.org/10.2307/3346743

# Appendices

## *Appendix A: Full ethical approval granted by the University of Birmingham Ethical Committee*

Dear Dr Fox

**Re: "Black Men Speak: Making sense of trust, prior to involuntary admission into forensic mental health services amongst Black men in the UK"**
**Application for Ethical Review ERN_21-1528**

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I confirm that this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly brought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available athttps://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx ) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx ) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards

**Mrs Susan Cottam**
Research Ethics Manager
Research Support Group
University of Birmingham
Email:
Video/phone: If you would like to arrange a Teams/Zoom/telephone call, please email me and I will get in touch with you as soon as possible.
Web: https://intranet.birmingham.ac.uk/finance/RSS/Research-Support-Group/Research-Ethics/index.aspx
Postal address: Mrs Sue Cottam, Finance Office, University of Birmingham, c\o Room 106 Aston Webb, B Block, Edgbaston, Birmingham, B15 2TT.

***Appendix B: Recruitment poster***

BLACK MENS EXPERIENCE OF TRUST

# BLACK MEN SPEAK:

## MAKING SENSE OF TRUST BEFORE ADMISSION INTO A FORENSIC MENTAL HEALTH HOSPITAL

AS PART OF MY DOCTORAL DEGREE IN CLINICAL PSYCHOLOGY, I'M CONDUCTING RESEARCH THAT I HOPE YOU CAN HELP WITH

**What will happen?**

You will be invited to have a 1:1 discussion with me to explore your experience of trust, before you were detained in a secure forensic mental health hospital.

**Following the interview you will receive a £10 Love2Shop gift voucher.**

**What is the study about?**

I would like to have a discussion with Black Men about experiences of trust before being detained under the mental health act. This study aims to help services better understand Black Mens' experiences and possibly offer suggestions to make improvements to services offering mental health support.

**How will this happen?**

The chat will happen via a video call lasting around 1 hour. All of your personal information will be anonymised and kept confidential. You can also withdraw from the study at any time.

**How to participate?**

Black Men of African/Caribbean or mixed heritage, aged 18 or over, previously had experience of a forensic inpatient setting within the last 10 years and now discharged.

If you would like to take part in this study, please contact Faiben via email at [redacted]

*Appendix C: Participant Information Sheet*

**Study Title:** Black Men Speak: Making sense of trust, prior to involuntary admission into forensic mental health services amongst Black Men in England, UK.

My name is Faiben and I am a Trainee Clinical Psychologist, currently completing my Doctorate in Clinical Psychology at the University of Birmingham. As part of my course, I would like to explore Black men's subjective experience of trust prior to detention in forensic mental health service in the UK. I would like to know more about how we can use the concept of trust to understand Black men's help-seeking and experiences of mental health services prior to involuntary admission into forensic mental health services.

Before you decide to take part in this research, please read this information sheet. This is to help explain why the project is being carried out and what the study involves. My contact details are provided at the bottom, so please feel free to contact me if you have any further questions.

**Why is this study relevant?**
It is well-documented that Black and minority ethnic (BME) communities face inequalities in their experiences of mental health services. Evidence suggests that BME communities are less likely to access mental health support in primary care (i.e., through their GP) and more likely to end up crisis care.

Particular groups such as those from Black African/Caribbean communities, report less favourable experiences of mental health services. Research suggests that individuals from those groups felt they were subjected to coercive treatment from services that often did not understand their needs or experiences.

This project aims to improve knowledge and understanding of Black men's trust, so that good practice and effective strategies can be implemented, to enable better outcomes for Black men who require treatment for mental health difficulties.

**Who is being asked to take part?**
You have been invited to take part in this study because you identify as a Black Men, and you live in England. You are aged over 18 and have been detained under the mental health act in the last 10 years (after 2012). You currently have no serious physical or mental health complications affecting you. As the study relies on using interviews without an interpreter, we are looking for men who speak and understand English fluently.

**Do I have to take part?**
No, taking part in this research is up to you and you are free to withdraw from the interview, without giving a reason.

**What will happen if I take part?**
If you decide to take part, we will arrange a telephone call to talk briefly about your experience of trust before you were detained in hospital under the Mental Health Act. We will then arrange a suitable time arrange a virtual appointment. This will take the form of an interview. Questions will be about your thoughts, feelings, and experiences of trust before you were detained in a forensic mental health hospital under the Mental health Act. You will receive a copy of the questions that we plan to discuss. When arranging your appointment, we can use 'Zoom' (or something similar). The interview will last approximately 60-90 minutes and will be recorded using a secure Dictaphone so that I can remember all that you have said.

**Can I bring someone to the interview?**
It is possible to invite someone along to the interview to offer you moral support, however the interview will only take place with the participant.

**Who will know that I have taken part?**
Only myself and my supervisors will know that you have taken part. Your consent form and interview will be linked using a unique code which no one will have access to except myself. Nobody else will know you have taken part.

**What will happen to the information I give?**
The interview will be recorded for data collection purposes only. Your audio recording will be anonymised with a unique code and stored safely with your consent form on the University of Birmingham's Research Data Store. Shortly after the interview has taken place, your responses will be typed onto a Word document. All identifying information will be removed to protect your identity. You will have 2 weeks to read through this and to let me know if there is anything in there you were unsure about. If I have not heard back from you, data analysis will begin, and you will not be able to withdraw your data. Your information will be destroyed in line with the General Data Protection Regulation (GDPR, 2018).

General Data Protection Regulation for health and care research information:

The University of Birmingham is the sponsor for this study based in the United Kingdom. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. University of Birmingham will keep all research data are retained for 10 years.

The only people from the University of Birmingham will have access to information that identifies you will be myself, Faiben Yemane, the researcher, and my supervisor Dr Andrew Fox and Dr Deborah Morris. The University of Birmingham will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.

Your rights to access, change or move your information are limited after (I will insert a date), as we need to manage your information in specific ways for the research to be reliable and accurate. 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 Faiben Yemane [redacted].

**Will my information be confidential?**
All of your responses will be confidential and anonymous. Interview scripts will be stored on a password protected computer and will be identifiable only by a number, not by your name. If you revealed an occurrence of harm or risk of harm to yourself or anyone else, the interview would be stopped, and it may be necessary to breach confidentiality by referring the matter to an appropriate authority.

**Can confidentiality be broken?**
Information you share during the interview will remain confidential; however, it is important to tell you of situations where this may have to be broken. If you share information that you or someone you know is at serious risk of harm or danger, confidentiality will be broken. Similarly, if you share that a serious crime has been committed, we are legally bound to report this. This will be discussed with you if an issue of concern is raised. However, this is incredibly rare.

**What if I change my mind?**
You can choose to leave the interview without giving reason. If you wish to have your information removed, you can tell me directly. If you would like to remove yourself from the study, you will have 2 weeks from the interview to request this. Unfortunately, after this date we will not be able to remove your information. However, everything recorded will be pseudo-anonymised.

**Are there any benefits to taking part?**
We hope taking part in this research will offer a space to talk openly about your experiences, which some participants may find beneficial. Participating in this research will help us understand Black Men's experiences of trust and help-seeking. This research hopes to provide useful information for healthcare services on how to best meet the needs of Black Men. This will help us understand needs particularly important to this group, develop more supportive mechanisms if indicated, and suggest service improvements. We hope you find the interview a useful tool to communicate your experiences and for your voice to be heard by healthcare professions. You will also be provided with details of supporting agencies that may be helpful to access in relation to some of the topics we may discuss. (*All participants will also receive a £10 Love2Shop gift voucher as a small gesture).*

**What will happen to my information once the study is complete?**
Once the data is transcribed, the interview audio-recordings will be destroyed. The written transcripts of your recording will be kept for 10 years as evidence of the research findings to support publications of the outcomes of the research. This is outlined in the University of Birmingham's data retention policy. You will be provided with the outcomes of the study and summary of the research unless you state you do not wish to receive one.

**Who has reviewed the study?**
The study has been approved by the University of Birmingham Research Ethics Committee, to protect your safety, rights, wellbeing, and dignity. This study has been reviewed and given an Ethics Code: ERN_21-1528.

**Are there any risks to taking part?**
We are mindful that talking about your experiences of being detained under the mental health act can raise difficult feelings and potentially upsetting particularly if you have experienced challenges during your admission in hospital. I will check with you if now is the right time for you to take part in this study. You can also refuse to answer any questions, take breaks, and have the right withdraw from the interview during any stage, with no impact on your care. If in the unexpected even you experience distress immediately after the interview, we can terminate the interview at any time. I can offer you some time at the end of the interview to make sure you feel supported before leaving and that you have people to contact, if necessary. If you experience distress after the interview, helpful support and resources is available and information about that is attached at the end of this information sheet. If you have any concerns, please feel free to discuss these with me.

**Who is conducting the research?**
This research is conducted by me, Faiben Yemane, supervised by Dr Deborah Morris and Dr Andrew Fox. The results will be written up in the form of a paper and presented to the University of Birmingham. You will be offered a summary at the end of the study with the overall findings. Please feel free to use the contact details provided below, should you have any concerns or questions about this research.

**Research team:**

| **Principal Investigator** | **Supervised by:** | **Supervised by:** |
|---|---|---|
| Faiben Yemane<br>Clinical Psychologist in training | Dr Andrew Fox,<br>Lecturer and Clinical Psychologist, | Dr Deborah Morris<br>Consultant Clinical Psychologist |

***You may find the following resources/services helpful in relation to obtaining information and support:***

- **The Samaritans:** 116 123. A free 24/7 helpline for anybody experiencing distress.
- **African and Caribbean Community Initiative** Website: http://www.acci.org.uk/ Telephone: +44 (0)1902 571 230, Fax: +44 (0)1902 571 233, Email: support@acci.org.uk
- **Black Minds Matter's** mission is to connect Black individuals and families with free mental health services — by professional Black therapists to support their mental health via an online booking system:
- **The Bl Asian Therapy network,** Website: https://www.baatn.org.uk/**,** Email:

- **BAATN** connect people to therapists around the UK and provide free resources and for people of Black, African, South Asian and Caribbean heritage via an online email to administrator@baatn.org.uk
- **Mind Equality Improvement Team and Young Black Men Programme,** Email: quality@mind.org.uk.
- Qwell is an online emotional wellbeing and mental health support, you can access free and anonymous support online at www.qwell.io
- **Time to Change - 300 Voices,** Website: https://www.time-to-change.org.uk/**,** Email: info@time-to-change.org.uk

- You can access mental health and wellbeing apps such as Headspace, Unmind and Sleepio and Daylight for free.
- Your General Practitioner (GP) can signpost you to additional services if you experience emotional distress.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns or would like more specific signposting information relating to issues raised in the study.

**Thank you for taking the time to consider this project.**

***Appendix D: Electronic Consent form link***

https://qfreeaccountssjc1.az1.qualtrics.com/jfe/form/SV_1H148eKKiwD9KrI

## *Appendix E: Interview topic guide.*

We would like to explore your experience of trust before you were detained in a forensic mental health hospital and your experience of trust right now. For the purpose of the study, we have used the Cambridge definition, we could think about these next few questions in light of that definition. ***The Cambridge dictionary defines trust as "To believe that someone is good and honest and will not harm you, or that something is safe and reliable".***

**1)Trust** *what does trust mean to you? how do you know that you trust someone or something? how does it feel to trust? How is trust developed?*

**2)How was it before and now?**
*What was it like to trust before your experience with Forensic Mental Health Services? What was it like now? Who did you turn to in the process of seeking help, (family, friends, religious organisations, GP, or other primary care professional?) What was it like then and now?*

**3) I am interested in what kind of experiences led up to your hospital admission.**
*Stressors in your life at the time? How was it decided that you went into hospital? Did you initiate contact yourself (help-seeking), Did you feel like you needed to go into hospital?*

**4)We're talking to people who have been detained under the Mental Health Act because they had mental health needs that were thought to have needed meeting/treating….**
*Does that fit with your understanding of why you were detained? What do you think were the needs that led to your hospital admission? Did things in your life change? Were there any consequences or not? If so, what? Do you think being a Black Man had any impact? Did your perception/experience of trust change?*

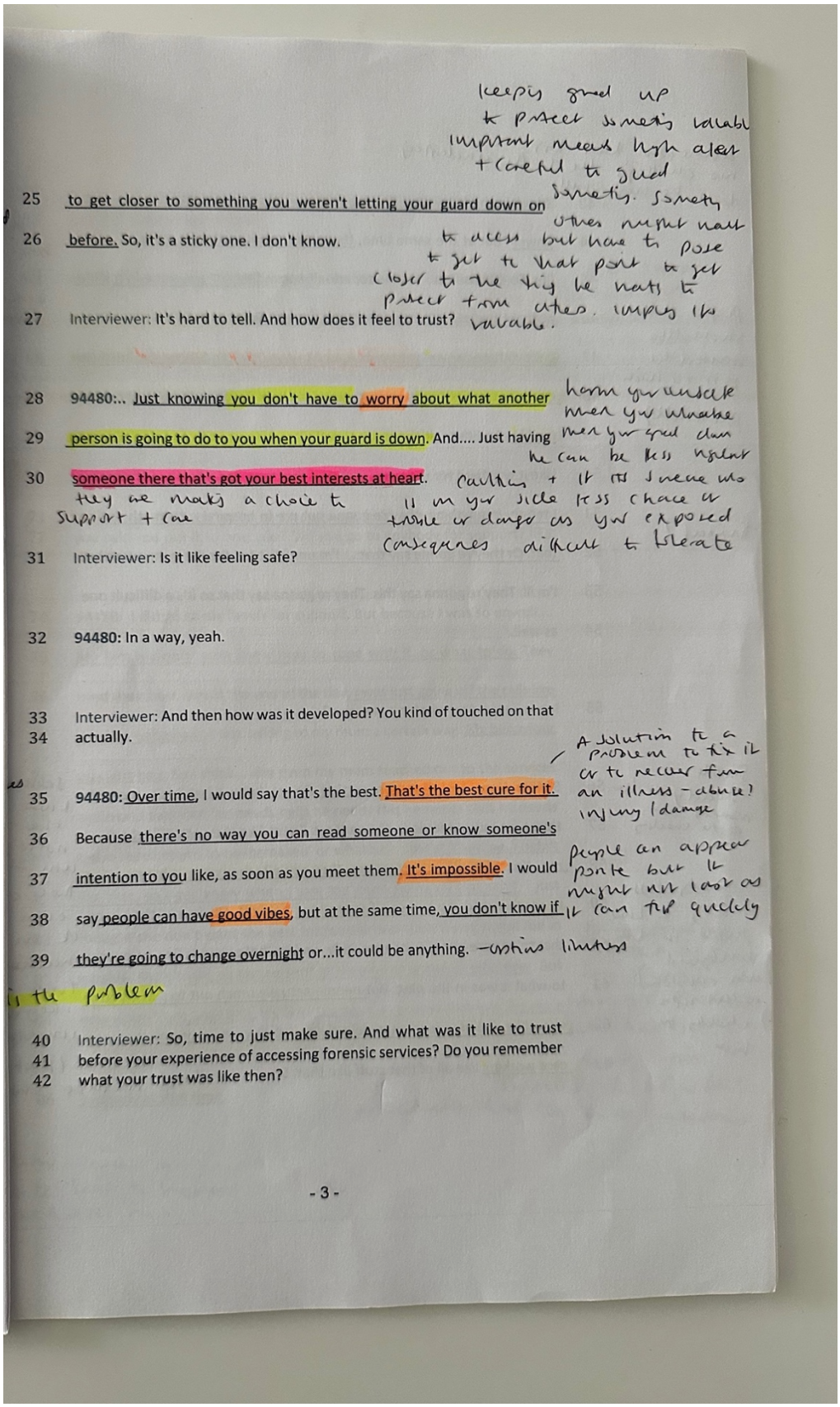
**5) What was your experience of accessing statutory services before your hospital admission and what was offered to you?**
*Could you tell me about anything that helped or got in the way? What was your experience of trust during this time? What was helpful in terms of care offered and what you would have liked from professionals and their network? Did you attempt to access psychological support?*

**6) Following your admission, how did you feel about Forensic Mental Health Services?**
*Did the hospital admission make sense for you (at the time and now)? Did you feel it was appropriate for you as a Black man? Would you have preferred to get support from anywhere else?*

**7) Do you think Mental Health Services are accessible to Black Men who have been sectioned?**
*Have you found anything helpful from mental health services in relation to working with you as a Black man? Can you tell me about a time when you experienced positive encounter with mental health services? Was there anything that made it difficult to engage with mental health services as a Black man? What does accessibility mean to you? Do you have any examples of when a service has been accessible? What would you expect Mental Health Services to provide for Black men who have been sectioned? How can these decisions impact on trust?*

**Closing**
1. Review consent
2. Debrief, including concerns regarding information shared.
3. Discuss how participant experienced the interview, how they are feeling and whether they would like additional support. Ensure participant has researcher's contact details and answer any remaining questions.

*Appendix F: Exploratory notes made on transcript.*



to get closer to something you weren't letting your guard down on before. So, it's a sticky one. I don't know.

Interviewer: It's hard to tell. And how does it feel to trust?

94480:.. Just knowing you don't have to worry about what another person is going to do to you when your guard is down. And.... Just having someone there that's got your best interests at heart.

Interviewer: Is it like feeling safe?

94480: In a way, yeah.

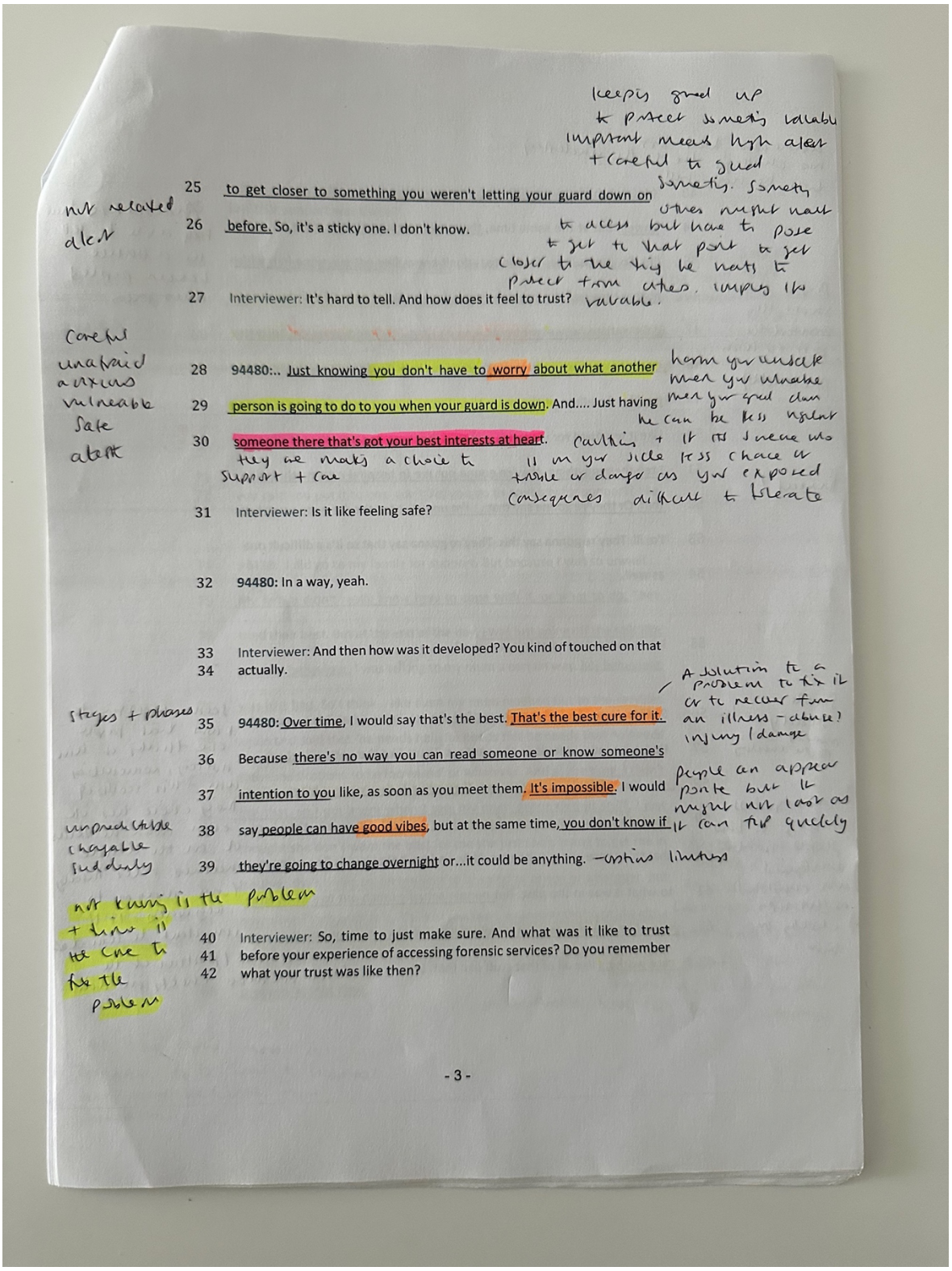
Interviewer: And then how was it developed? You kind of touched on that actually.

94480: Over time, I would say that's the best. That's the best cure for it. Because there's no way you can read someone or know someone's intention to you like, as soon as you meet them. It's impossible. I would say people can have good vibes, but at the same time, you don't know if they're going to change overnight or...it could be anything.

Interviewer: So, time to just make sure. And what was it like to trust before your experience of accessing forensic services? Do you remember what your trust was like then?

- 3 -

## *Appendix G: Experiential statements made on transcripts.*



keeping guard up to protect something valuable important means high alert + careful to guard something. Something others might want to access but have to pose + get to that point to get closer to the thing he wants to protect from others. implys its valuable.

not related alert

careful unafraid anxious vulneable safe alert

harm yourself when you vulnerable when your guard down he can be less vigilant

person is going to do to you when your guard is down. And.... Just having someone there that's got your best interests at heart. positive + it is someone who they've made a choice to support + care

it on your side less chance of trouble or danger as you exposed consequences difficult to tolerate

A solution to a problem to fix it or to recover from an illness - abuse? injury / damage

stages + phases

people can appear polite but it might not look as it can flip quickly

unpredictable changable suddenly

not knowing is the problem + time is the one to fix the problem

- 3 -

## *Appendix H: Clustering of Personal Experiential Statements with quotes.*



***Appendix I: Example of organising Personal Experiential Themes (PETs).***



***Appendix J: Organisation of Group Experiential Themes (GETs).***



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

**A. Life stresses**

Influences of substances on participants

*"I believe I was spiked because I was round some workmates house, and they gave me some speed and the next day I started hearing voices."*

*"I was doing my final exams for a three-year apprenticeship, but I had been doing that for a while and it didn't seem to be any problem.... Like I said, I believe I was spiked. Because these guys said like, they'll give me speed. When I took it two of them gave each other a look. They looked at each other in a strange way when I took it. And then a week later, after I've been hearing voices for like, a week. I mentioned that I'm hearing people slagging me off next door. And they gave each other that same look again, the same two"*

Stresses with caring for his son and self-medicating with weed to manage the stress

*"So, looking after my son my son, he came to live with me when he was like about 5-6 years old and then from there. About two years later his mum decided that she wanted to take him back, but I didn't want to give him back, I didn't think she was a fit mum at the time. It was stressful going to court and I was smoking weed on top of it, because of the stress I think I was self-medicating really and things got on top of me really".*

Same cycle of smoking weed daily affecting mental health

*"Back then, just living for the day, just living for the day. Like I'd wake up, call the boys, like boom what's the motive. The motive was always weed, but we asked what the motive was. Yeah, link up, sit there for like 7-8 hours smoking, weed come back, do what I can in terms of like, whatever commitments I had to my clients, go to bed, wake up, do that again. And yeah, I'm sure that's all fine and good when like you don't have psychosis. But once those symptoms started happening for me. And I wasn't slowing down, I was speeding up with the smoking. Yes, it was inevitable. To be honest. That's how I was living in my life. Like whatever symptoms I was having, didn't matter. And I was gonna just be a weed head for the rest of my life."*

Life stresses caused by a betrayal

*"My childhood was… I had a very, very tough upbringing, basically a very, very tough upbringing. You know, back in [names a county in Africa], where I come from, I can see the person I did trust was my grandmother, she was the only person that looked after me, you know, from day one to day Z. And sadly, when I was about one year old, my mum actually passed on, she died, sadly. I put trust on my dad, my father, who actually let me down. He let me down to an extent where he brought me to this country telling me my step mum is my mum. All a pack of lies. The way she treated me was very very horrible. I was quite confused. I was so confused. "*

*"Understanding everybody's got problems in life... somebody told me that everybody has a mental health...everybody's got issues in life. Everybody's got problems"*

Acknowledging the ability to manage daily stresses has been affected by substance use and reliance

*"It was more so that, because **my mindset was so unreliable from the weed** and that, that it was a thing of a normal stress for most people that you can just get on with became a massive, **massive stress**, like just inter interacting with my mum, sometimes. Rather than just us sitting down and having a discussion. I'd end up pissing her off, or she'd end up what pissing me off, and it would become a whole thing. So yeah, no, it was more just... **the way I was living my life amplified regular stresses too much."***

He didn't have a lot of money at the time and things will not go in as expected.

*"I mean, in terms of stress, like...**honestly, I just had the same stress as everyone else does.** What am I gonna do my future? How can I make today better? How can I make myself a better person? On top of that, there's all the other stuff on your plate. I suppose the first admission was a stress cos before I got... put into like the adolescent ward. I'd been doing like graphic design stuff for like three or four years, and I was quite up in the game with that stuff. So, when I started, when I first started becoming unwell, and like my ability to hit deadlines and stuff was lacking. **That was stressful, because then I was making less money**. And... that bothered me a lot."*

Life stresses caused by financial difficulties

*"Back then like **things were tight with money**"[….]"Not everything was going the way I really wanted it to go" […] "**Money was part of it.** Even though, like I feel like if I was to go back to having the same amount of money that I had back then I would deal with it better now"*

Relationship breakdowns

*"I was in a relationship with my son's mother and then she ended up cheating. And then I cheated and then basically I told her because I couldn't keep it in. Then from there it was good, we were in a relationship and stuff like that. Then a few months later, I was kicked out. Then I started having dreams and stuff. I had a dream; I told my aunt then she called the ambulance then from there it all went down."*

*"Remember I had a trust in her because I thought she was my mum. I was 10 years of age; I was still young, I thought she was my mum and at one point. One day, she came to me telling me 'don't call me Mum I'm not your mum' that's what she told me. She had an argument with my dad and came straight to me, telling me 'don't call me Mum, I'm not your mum' and then that's when I started having, you know this track record"*

A sense of safety related to trust

*"Because if she's capable of saying that she can be capable of taking your life. Of course, she can. So sometimes words are very, very important. The way you treat someone is very important. And that's what trust is about. You trust someone who will believe treat you really well.* ***But trust can be killing****. See a lot of people who say trust, trust, trust but at the end of the day they betray you."*

*"Safety is massively important. I mean, I grew up in [part of London], [Part of London] it's nice now but it was the hood init. Yeah, man. trusting the wrong person saying the wrong thing to the wrong person... can get you killed.* ***You could be killed.*** *It's happened to people I know; it's happened to people I love."*

*"****Before I ended up in hospital it was betrayal after betrayal...*** *sneaky sly stuff....and… Yeah."*

*"No, that's when I was framed init because I thought the voices were my mum's next-door neighbours Yeah."*

**B. Self-sufficient and self-reliant I need to do things myself and not I don't need to access services as I can handle it myself**

They can manage difficulties independently

*"No, I depend on myself"*

*"You don't get looked after or cared for. You have to look after yourself."*

*"I think I would have felt shit about myself cos **I should be able to handle whatever comes my way** […] Like I said I'm strong, I should be able to handle it…I've always been that way…since I was born".*

Help seeking may be considered weak.

*"I think…it doesn't mean that you're weak, I think you're acting weak if you're seeking help. You wana portray that you're weak."*

*"The news of my mother passing on had an impact on me. It had a very, very big impact on me. But for me, I'm grown up now**. I'm a man now**. So, what it is, I can handle it now. I **don't really need any help from anybody.** So that's why I don't even trust anybody. You know, so yeah, so we actually, yeah"*

Expectation to manage difficulties independently

*"I'm growing up as well. So, I know how to handle any situation in my life."*

*"Honestly, I'm not very good at that. I'm not very good at seeking help. Even when I need it to this day. Like if I was becoming unwell 1) I wouldn't notice. That's just how my condition works for me, I wouldn't be able to tell. I'd still think everything was cool. And... in any other aspect where I would need help in my life... I rarely ever, like really ever delegate that responsibility to anyone, to others. **If I can't solve it myself then I consider it unsolvable** more time, which is not healthy, and I know that... but... it's definitely who I am."*

*"Very rarely, very rarely. But **now and again I'll ask for advice from people. But that doesn't really colour my decision. That's just more information**, that's it. But yeah, **I'm not very good at asking for help from people.***

Try and manage difficulties independently rather than seek support

*"So, I would say if you feel like that, **maybe try and do your own research.** Like, I don't know, cover up holes if there's holes on your wall. I don't know. Cover up stuff or something**, just to make yourself feel better, and see if there's any difference** if you don't feel any better. Maybe it's time to look for some help, like if they find that there's nothing in your room, and you still feel not too good. Maybe it's time to start taking some medication."*

*"A positive experience? I don't agree with mental health services. I don't agree with them, cause* ***I think people can work out their problems by themselves."***

*"I used to kind of look after myself when I was younger, but I've had to more because mental health services are trying to mess me up.* ***If I'm not careful I could end up locked up in hospital again on a medication what's gonna kill me"***

Acknowledged that he may have not been able to seek support himself

*"I think it would have to kind of be an* ***outside help, rather than source****, rather than family. I would say I'm more open to it now definitely"*

*"I just learned, like,* ***you have to be careful what you say to people*** *as well. Like, if you're feeling a type of way,* ***try and handle it****. Like don't, leave it until you're in dire, like, or it's an emergency or anything like that.* ***But you got to realise that everything you say to these people it's all noted down.*** *And nine times out of 10 they're not really gonna believe anything you tell them (laughs) and that's just how it is like, like, it's difficult ones still."*

*"Nah I told people I know...but still it's hard to trust people."*

**C. Misunderstanding/mismatch/ other people have noticed and think need support and asked for support on their behalf.**

Experiences were real and contrasted with what other people observed/believed

*"I didn't know it was voices, I didn't know what it was so... **I was confused** you know what I mean. I remember the first time I started hearing voices, the first night I kept going out my back doors looking for where the voices were coming from."*

*"I didn't feel like I needed anything**. I thought I was normal".***

*"**I thought I was fine.** But when I look back on it now, it's just like the behaviour was erratic, immature."*

*"Cos they've **just diagnosed me as paranoid schizophrenia** but **at the time,** I wouldn't say that, at the time **I would say that I was more depressed and just stressed out**. I don't know, it just developed overtime cos **I started hearing voices** and things like that you know. **But it's not random voices, my family members** and things like that **so I wouldn't say its abnormal if that makes sense?"***

*"They thought that I needed treating."*

*"My mum said I was talking to myself when I was rapping, I was rapping and crossing the street and then she she she shouted out 'I hope you're not starting trouble, shouting out at people and talking to yourself'. I was like what are you talking about? I'm rapping. I even done the rap back to her, she's always trying to get me sectioned [laughed]"*

*"When I was unwell, I always thought there was like people watching me from an unknown place"[….]"So that was one thing that was stressing me a lot, When I look back at it now, it doesn't really make too much sense.[…]I couldn't get over the feeling if you get what I'm saying. **I was stressed out. I was depressed. I was sad.** I would stay in my room for days on end not really go anywhere sometimes."*

*"Trust wasn't even really a factor, because **I was so out of it**, that **I couldn't really normally have normal relationships with people**. Even though we would do normal things together. Like everyone knew that at one point, [his name] could be perfectly fine and the next...he could be completely out of it just wiling out or whatever. So, yeah, I don't think trust was even a factor in the way I lived back then to be honest."*

*"When I was by myself, and I had time to reflect, I had more dreams. it's like the dreams I was having were like visions.... […] I had all these dreams when I was by myself, I was in prison, no TV nothing. Just the bible, Quran, just books and stuff like that. Just read and stuff. Every time I kind of have a dream, it means something. **But only certain people that I talk to can understand that. Not everybody"***

*"Not everyone in my life at that time had the best intentions for me. So, it was difficult for me to differentiate between friends, people I can trust and enemies,* ***because enemies were trying to make themselves look like friends and just mix up my life".***

*"I think it was difficult because at that time.... like****... I was quite unwell****".*

Cultural misunderstanding

*"There's one thing I'll come back to a lot, which is... I wouldn't say, yeah, culturally, as well,* ***socially and culturally****, Black people are much more... I guess the easiest way to describe would be religious, kind of people. So... considering the kind of things that unwell, people are usually fixated on,* ***God, and religion is one of them****. And... I, in my experience, I've found that as a Black person...* ***if I'm talking to a certain person of a different ethnicity, about my current conception of God, or how I'm struggling with God. I find certain groups of people, particularly predominantly white, British people are much, much quicker... to call that like... like I'm suffering delusions*** *at that point. A lot of the time if, if you talk about... having, God being on your mind, they just write that off as you* ***being unwell****. That's like, that's a symptom of psychosis. Whereas...if I was to say that to... to a random Black person,* ***we'll have a discussion about it, because they believe too.*** *So yeah, that's, that's a mad. That's a major hurdle. Because yeah...* ***I still struggle to think right now, because it upsets me that you know, yeah, to think about God is synonymous with being mentally ill. Well, that's sad. That's beyond sad."***

*"If I'm talking to somebody that lives... that's not from the culture. They aint going to understand...like how I'm talking to you now.* ***I can tell you things that was affecting other Black people inside, and you'll take that on board that's good.*** *That's why I said that I'm glad that you've done this because... you're helping a lot of us... have a voice and to speak up."*

Felt betrayed by others for seeking help on their behalf

*"Like even* ***my mum reached out to the*** *services at the time,* ***I didn't like that, so I got angry****"*

*"I just thought she don't want the best for me she just she's trying to get me in trouble.* ***She's trying to get me sent to hospital or prison*** *or whatever. But now when I look back at it, it's like I see Yeah, everyone that was like close to me, had some of the best intentions for me but I couldn't take it in properly at that time."*

*"I think* ***my mum wanted to spite me****... my mum knows that she can't threaten police with me, so* ***the next best option is to dose me up init."***

*"I've never had a close relationship with her [aunt]. So, I think that's the first conversation that I've had with her since I was probably... 13. So yes, it was a big like... That's why my trust is yeah...****that's why it's hard for you to trust people****.... because* ***I had one conversation****...* ***just told her one little dream that I had. And the next thing you know...when I've gone home the ambulance was waiting for me."***

*"My mum and family would notice when I'm getting unwell, but **it would always get to the stage where I will just… police would come for me**… or I do something to end up back in hospital"*

*"I had a certain level of trust, what I did was that I hit my key worker, so I know I shouldn't have hit him**. I thought there was trust there** because I spoke to the staff the night before and I explained to him. I said to him can you tell my key worker [name] or tell the staff not to knock on my door the next day, so yeah. There was a certain level of trust that got broken basically because the staff are not meant to do that. I don't know what happened, but they still had a feeling or belief to come up to upstairs my room after I told the staff member, do you know what I mean?"*

Healthcare professionals not holding/containing their distress

*"Dr [Consultant name] came and assessed me and then he even told me [his name] **you're okay. He told me to stay in the prison**, he told me stay there, but I didn't want to continue in prison, you know. And my mum's story started **depressing me**. I just said to him, that I'm having a very, very, very bad time in the prison. So, we decided, you know, to come to court and organise for me to go to the hospital. And that's why I was in hospital."*

*"Even with cameras on laptops, you know **people can hack your laptop... so, ask how I'm feeling**. See if any of the things that I'm saying are actually even possible, make sure that no one hasn't hacked anything even."*

*"Even though you'd be thinking, why would someone want to watch him or watch her. But the thing is, is like **it's possible**. That's the end of it. So, you never know. Like, they didn't even give me advice to say, oh, yeah, the camera on your laptop, put a sticker over it or something like that."*

*"There's actions that they should be taking, they should be saying, well, if you have this camera on your laptop, maybe cover it up or maybe like, get some antivirus software for your laptops so no one can hack you, instead of just saying no, that doesn't exist. '**We think you're unwell'**, we think your this, we think your that."*

*"I didn't know because I was too young, I didn't know that I would develop this kind of erm illness. I didn't know that. That's what mental health is about, you just don't know."*

Restriction of freedom and compulsory treatment

*"I got stabbed init…. I got stabbed in the neck. My mum took me hospital and then and then I got sectioned because I didn't want to speak to the psychiatrist".*

*"**Everyone treated me like I was guilty.** No one would listen when I said I didn't do nothing. **Everyone treated me like I was guilty**. I was **locked up in prison**. **Locked up in hospital**, **drugged up** and told to plead guilty"*

*"They were probably thinking that **we can't have him on the streets, it's a bit dangerous** or whatever."*

*"First time actually I felt sick yeah, actually I had a, I had like it I had one sickness encephalitis it's called. Then they gave me a lumber puncture and everything, I was in a coma for a bit and then I got better and **then they said like that I was mentally unstable**, so they put me on a psychiatric ward like a low secure ward that was the first. So, I'm 35 now, so I was 23 so that's about 12 years ago."*

*"They came to my house; they asked me a few questions and then they said that I need to be sectioned."*

*"I'm getting proper angry. So, it's one of them ones where I'm just thinking that no one has the best interest for me. No one don't want to do this. No one don't want to do that".*

*"**Punish me** and have me **locked up** and stuff like that".*

*"Well communication wasn't there I don't think…yeah…communication wasn't there I don't think between staff and the patient yeah"*

*"I didn't really wana be on the medication to start with and **they kinda put me in a corner**. **I did have trust issues with them***

Experience of fear/threat and the need to protect themselves

*"Five men came in and said, they said they're taking me, and I was like you're not taking me shit cuz and I charged at them, and I punched one of them. They grabbed me, yeah"*

*I vaguely remember like being in hospital and waking up and there were two like nurses beside me. They weren't normal normal nurses; **I didn't know at the time they were mental health nurses**. Apparently, I got up, I woke up and got one of the nurses in a headlock and I was shouting at them and stuff like that**, so they were worried.***

*"Either I committed a crime, or I smashed up my room… and they must have just came around and they were like, Yeah, 'we think you're unwell, we're gonna have to section you, blah, blah, blah'. And then **I went into hospital, just like that."***

*"And then that's when I know ambulance just pulled up outside. **I had a few minutes to get my things and that was it**".*

**D. Trying to understand/make sense of the admission**

It didn't make sense to them

*"No, I still don't know why I was detained"*

*"No, I never, it never made sense...I think I was just having a bad week or just a bad time in life. But I'm in hospital... But then it can blow over... and then... get back to normal. When you're in hospital...you have to do your best to get out."*

Decision was drastic

*"Going to hospital was too drastic" [deep sigh]*

Lack of understanding about mental health illnesses

*"Back then I didn't really know about mental health at all. Like no one talked about it. No one knew anyone that was unwell like that. So, when, back then like mental health was like... you see it movies, isn't it? Like 'One Flew Over the Cuckoo's Nest' and stuff like that. It's just it's not, no one has, until you've been there and seen it with your own eyes. You probably think is like an asylum. So yeah, no one really knew, and I didn't know, so yeah, I couldn't tell you to be honest [laughs]."*

*Well, I think it's like a trap, it could be like a trap prison, like you could feel trapped in there."*

*"It didn't make sense. Because while I was in prison, I was fine. It didn't make sense to put me in hospital. Hospital nearly broke me. I was really depressed I spent all the time sleeping... not even sleeping, just curled up on the sofa in a room by myself."*

*"I think it was right, I think they could have treated me better. They could have given me a prison sentence or something"*

*"But I think why I was* ***kept in there was because of the crime I committed****."*

Are healthcare providers prejudice or discriminating?

***"It's just it's just a dustbin for Black people.*** *Same way,* ***the prison and the hospital are dustbins for Black people.*** *They just mash you up and throw you in there, lock you up for a long time. And some Black people, they don't fight for their rights. Because if they lock you up,* ***if you don't try and get out through a tribunal or something, they're not going to let you out. They'll keep you in there, experimenting on you with their poisons."***

***"That's everywhere, everyone's got some degree of unconscious bias****...so there's that to begin with.* ***But in hospitals as well as that, you kind of get stereotyped by certain stuff, don't you?*** *You know, like,* ***'Ah I see that's another weed smoking or crack head smoking, or whatever'.*** *They're never gonna, it's a bit like the teacher problem that some kids have, where the teacher tells them that they're not going to be anything. So, they never amount to anything*

*because they don't think they can? Yeah, that kind of thing happens a lot on the wards. That happens a lot.... But obviously, there are consultants, and there are psychologists, and there are nurses and so on who don't really have that problem.* ***They can, they help everybody****. So yeah,* ***I would say it's there but it's not****, It's not particularly bad. I don't think, I don't think it will hold you back altogether."*

Perceived racism

*"I think that Dr [Consultant]… I think he's racist. I think he wants to characterize every Black person as* ***paranoid schizophrenia. That's what I've observed****."*

*"If you look into the* ***amount of time Black people spend in hospital*** *compared to white people or other colours. If you look into the medications, they're on.* ***How comes they get put on medications with the most dangerous side effects?*** *If you look at frequency of being locked up, how often they get locked up.... If you just look into it, you'll see for yourself that its racist."*

*"It's that Black people don't engage with mental health services, because* ***mental health services are racist."***

Black patients treated differently and is there an acceptance of that?

*"Well, on the forensic… I've actually realised is a lot of Black people, Black patients get treated anyhow. That is life, isn't it? Some of them, get treatment that's not good, when they are in the hospital, you know. It's...it's just way it is"*

*"When I was in hospital that one time.... there's loads of Black people basically. Yeah.... Loads of Black people about one or two white people. Asians, it will be the same that one or two. Black men... Black men, it's a high percentage in there. And they will be treated a bit different than the others when we're in hospital."*

*"I see white people come into the hospital with the same symptoms as I had, hearing voices.* ***They get called bipolar or drug induced psychosis*** *or something else. Yeah. Every Black person coming in, all different symptoms, and they all get called schizophrenic,* ***paranoid schizophrenic****.* ***I don't see how me hearing voices makes me a paranoid schizophrenic. It's just auditory hallucinations. How's that schizophrenia?*** *Yet, still someone can believe that they're God and they get called schizophrenic as well"*

*"It's sad there's no variety, a lot of Black people are put in this, you know, forensic hospitals, and* ***some of them are not really mad,*** *some of them are not really, you know,* ***some of them are very, very, they look really well.*** *They're not really really, you know, there's nothing really wrong with them. "*

*"Because the crime I committed;* ***I would have expected to stay there for a while****. So,* ***I can't really say it's to do with my skin colour****.* ***But there has been different times when I haven't gone in for a crime. But I've been there for quite long****.[…] It's not like the white man just went*

*home quick. And then the Black man was there.* ***The white man and the Black man were there like nearly the same amount of time.*** *So, it's a sticky one."*

*"Yeah, I would rather than****… it's better than prison I suppose, that's what they say****- , cos I'm so used…I'm so used to going to these places. I don't really see it as a race thing.* ***I know, I know there's more Black, there's lots of Black people in like, these places like, prisons and hospitals and stuff like that"***

*"At the time I didn't see it as Black being Black, I saw it as an open service like a service for the people and helping people. I didn't think there was colour involved I'm not too sure"*

*"Nah I think it's difficult for all races."*

*"****What they usually put in mental health hospitals is smart adults.*** *So that means there's something wrong somewhere,* ***we've gotta fix it, fix it."***

### E. Not cared for/Needs are unimportant/exacerbating lack of trust

Feeling dismissed

*Erm…not really.* ***They always go down the route of medication, rather than just talking through my problems and actually getting help and dealing with it if that makes sense. It's always just medication*** *I suppose medication does stabilise my mood and you know, I don't know. I've been on a depot for… since 2017 on and off "*

*"Like consultants, doctors, key workers, support workers and stuff like that. I just believe that as* ***soon as it sounds like it's anything to do with mental health, they will shut you down****. Like, bear in mind, they don't know what you're going through".*

*"When Dr [Consultant name] came to see me,* ***I was the one convincing him that I wanted to be in hospital,*** *because I know that if I served my sentence in prison, whereby I come out and probably go back in again for the rest of my life.[…] He told me to stay in prison.* ***He was saying there's nothing wrong me to be in hospital****. But because I told him about my step mum's story and everything that wherever happens, even if it's not mental health, it might have impacted me in the future, so* ***I need some support. For that reason, he sent me to*** *[forensic hospital]."*

***"Once you're labelled as you've got a mental health problem, then you're treated as guilty. No matter what happens.*** *You get into a fight, you're the offender. Anything that happens, you're the one in the wrong straight away.* ***No one listens to you****. They're gonna say no, you got mental health history.* ***You must be the guilty one.*** *People can say you done anything, and they'll believe it."*

*"Nobody asks and I'm not somebody to just...to just go out just start talking. I'm very laid back and reserved."*

*"I told them straight away what I was going through...I didn't hide it from anyone. I told them, I told people at work. I told friends, I told everyone."*

Lack of a collaborative approach

*"They detained me, and I didn't find out until years later that they were saying I was a violent person when I was unwell.* ***So, I needed medication because I'm a danger to others. That's what they were saying because of the lies they told about me."***

*"I don't think they always get it* ***correct*** *when they're saying* ***we want to treat you****, or* ***we want to help you****".*

*"They could consult you on your medication things like that and tell you why you're being held as well".*

***To hear the patient more if they don't want to take mediation all the time,*** *they can try other options".*

*"like I said **they don't believe anything you tell them**, and **they don't really want to take it on board**. So, it's just that... it's kind of **pointless.***

*"Invisible and frustrated"*

Experience of being heard/listened to/cared for

*"One thing about Dr [Consultant name] why I praised him a lot is when he came to see me, he listened to me he also wrote down the reason why I was actually in that condition. He actually took it to court and then explained that [his name] has had a very hard time with family and this and that so he did really listen to me. And that's someone to trust because he gave me a lot of support, He supported me, you know."*

*"But what I've experienced with psychiatrists and psychologists. It wouldn't have helped.... **They don't help at all**. **They didn't even sit down and ask me what I went through.... They weren't interested.... They just said, 'put him on this medication and lock him up'."***

*"Just try to get to know me more as a person rather than like a problem"*

"*One thing that can help is just listening and understand. […] Just...listen and understand... Listen... listen and not understand **but try to understand.**"*

*"Definitely to sit down one to one with someone and then **ask me like from the beginning like what's actually wrong, how are you actually feeling** and then once I do explain that to them, **for them to be like what can we do**?[…] **they could have asked me like how can we make you feel any better**? Is there anything you want to do? Do you want to talk with anyone"?*

***"Seriously ask me what's going on?** Like**, if I said, I think there's a camera watching me, maybe to go more into depth**? **Like, where do you think it is?** You know, **even if they were saying stuff like why they would be watching you or that can kind of put you at ease** a bit or something like that, or, **you know, just anything more than they did, because they hardly did anything... "***

*"What might have helped is like the conversation you know, why do you do it? Again, that's, that's, that requires something that I find **not a lot of professionals are willing to give which is like their personal energy to it** because you'd actually have to, you'd have to have a conversation with me on a level for that to happen **You can't dictate the conversation, it would have to be just exploratory, open-ended conversation and that's hard to find**."*

*"**Options to move on rather than just always just talk about mental health** just **actually help to deal with the problem** whether its drug use. Or if you do have actual mental health, **just get help to deal with the problem."***

Mistrust in services/people who are supposed to help betrayed you

*"Like **it was hard for me to trust** at that that time because you just think if I tell them anything, they're gonna put me in hospital or something like that".*

*"I felt like... **anything that I was telling them or whatever was going on, was getting me closer to hospitalisation,** but I feel like it should be the other way around if you're actually speaking about your problems, they're not devouring you they're not they're taking over your life like you're not scared to discuss them so I would have thought that it would mean it's getting closer to recovery if you want to talk about it…"*

*"You're expecting to get some treatment and help from the staff...**but it's like you can't trust them** basically. But I can't say all the time because there were good ones as well. They weren't all bad you know. There're ones that saw what was happening and then they try to do something. If the person in charge wasn't having it, then... nothing happened."*

*"**They're not to be trusted**...Don't think that 'I've got a problem; I better go hospital'. **They're not to be trusted. They'll put you on a poisonous medication. And they'll lock you up for as long as possible**. They're not interested in treating you. **They don't treat you**. They think giving you medication is treatment.... **They don't treat you**.... **You don't ever talk about what problems you might have bad what stresses you might have been going through**... nothing!"*

*"But **I just didn't really trust them** because **they didn't hear, they didn't really wana hear what I wanted to say** init".*

*"So that's why this world is strange, especially **mental institutions is strange**, because the person **that's meant to be helping you were the ones turning against**... will be turning against you."*

*"It's a dice roll every single time. It's a dice roll because... you never know when...How can I put it...You don't know who you're dealing with. Even when you first meet them, they'll introduce themselves whatever, whatever. But you don't know what their personal triggers are, like **you don't know what it takes for them to switch up on you and start being a negative force in your life. Despite the fact that they're supposed to be there supporting you, working with you."***

**F. Consequences of the experience, why would you request support from services when your trust has been broken? Perpetuates the sense of solving problems yourself.**

Consequences/ impact of the hospital admission

*"Yeah, cause now I've got shakes in my hand…. it stopped my life init… Nearly 2 years"*

*"They put me on some nasty medication. So, like it had some nasty side effects I ended up going to [names a general hospital] they had to call the ambulance. Yeah. So, when it comes to like, if they was to ever say to me like change medication, you're on [chuckles] or do anything strange like that, I wouldn't be having that at all."*

*"Course, they got worse and worse and worse. And not only did things changed, I changed cos I've been beaten down, locked up, drugged up just treated like crap. So, I've changed* ***I have less tolerance for people****. It's my personality because I've just been beaten down."*

*"Mentally, yeah, yeah. The stigma.... Basically, the stigma... don't affect me really. […] I lost work because every time I call for a job and I mention prison hospital, then yeah, it's like come back in two years and stuff like that. And then when I apply it's the same thing. Friends I think I distance myself away from friends myself because I couldn't really trust anybody. Friends...I keep them at a distance."*

*Consequence? I mean, yeah, there's consequences for everything. But none that mattered particularly to me. I mean, I suppose if I was more of an academic person, like formally academic, like I went to university and stuff, then yeah, I would have missed out on a lot of years for that. For my clients, like a person who tends to be self-employed, then climbing the career ladder and stuff like that, I would have missed out on that."*

Consequences/ impact on relationships

*"And then there's the things that you can't buy back, like just just... the not bridges you've burnt.... but friends you've lost along the way, because obviously I've had to go my own way, and they've had to go there's, and yeah, that is what it is, really. But so yeah, there's, there's consequences, but none of them are...so bad that I lay awake thinking about them I have no regret at all."*

*"A little bit yeah cos I was segregated, I was pulled out from the rest as it were stuff like that"*

*"I was pulled out from the community"*

*"I definitely lost contact with a lot of friends. Some are still about but definitely lost contact with a lot of friends.* ***They don't want to know anymore****."*

Lack of transparency/barrier to building trust/broken trust/power imbalance

*"There's a big, big range of people who are in mental health services, and* ***not all of them are particularly good at their own position.*** *So, you have no idea... who to trust, how much to trust them. And what they're going to do, depending on what you do, it's really nuts actually.* ***It's probably the most chaotic relationship you could have because they have control over your life.*** *Like... when you're unwell already, you don't want that. So yeah, it's *impossible* to say. There's certain staff members, you can say anything to, they'll be cool with it, you'll buss joke, you'll be alright. Next staff member, make a joke, they take it the wrong way. Before you know, you go into your ward round, it's being mentioned that you're this way and saying these things you know****. Like I trusted this person and I've been betrayed for something I said,*** *so. Yeah, it's like that really."*

***"That's how I originally got sectioned. It's because I was telling them things like that****, and I was telling them this and I was telling them that and they just didn't want to...* ***you know I'm saying they didn't want to know****".*

*"It just made me feel like it was a bit of like...a set up...****It just didn't feel like they had my best interests at heart****. It was more like they're* ***just doing a job*** *whether or not it's happening or not"…. even though I was wrong at the end of it, like I could have been right [chuckles] it could have been different".*

*"Some of them I've come across some that haven't been too nice, not nice, but I don't know* ***they're just doing their job,*** *init.* ***But then there's others that go just that little bit further and really try to help you".***

*"There's people like yourself... that actually care about what you're doing...****there's people that want to get paid****. That's the easiest and simplest way I can put it."*

*"There's always people that you could go to, it's the belief that's the factor.[…] It's the belief in the fact that whether they'll do their job properly or not.[…] If they did their job properly then you would have a feel-good feeling."*

*"I've been locked up loads of times when there's nothing wrong with me. I've proved it by taking them to tribunal and getting out.* ***They have to stop locking up Black people for no reason****.* ***They have to stop giving them poison and they have to stop holding them inside hospitals for years and years. If you aint cured someone in a few weeks, why are you holding them for years, what's that gonna do?"***

Involvement in decisions could help build trust

*"****If they're getting the right help then I suppose that would build trust more****, but depends on the person, the doctor as well, the environment, it all depends. I know that's not a definitive answer but yeah… It just depends on the person, their character, the doctor and how they deal with stuff, it's a difficult one"*

*"To trust, yeah, if they, I think if the doctors****. If the patient had more say in their care process that would, I think that would help."***

*"I look at people a bit more differently than I did before, yeah. […] I don't open myself up to people as much anymore"*

*"And that comes back to the whole thing about trust. After that, I found it really hard to trust anybody, because they can say anything, they can say anything. And what they say and what they do, oftentimes doesn't match up."*

What could be done to build trust?

*"If they explained what the illness was. If they talked to me about available medications, telling you their side effects and all that as well.... **Being more informed about medication, and options available, and maybe even alternative medicine as well, rather than just medication."***

*So, it's just that I think they should look more deep into things before they **just judge people** and say**, no, that's mental health** or **he's unwell** or he's this or he's that **because there's too many things in this world.***

*"They could be more helpful more open. […] "Just to be looked after basically, yeah that they see that my needs were met on a day-to-day basis, they ask me if I'm happy or sad stuff like that"*

Early/consistent/reliable support may improve outcomes and less likely to be admitted at crisis point

*"On the mental health side of things, it's a lot better now. Because...because I'm sure you've heard of the concept of the revolving door when you leave hospital and come back all the time. Yeah, now that my team is stable, the people who are working with me, their names don't change every other month. I've come to a point where most of my team are people that I'm comfortable with, and I can trust, so I don't have to worry about it too much. I got lucky. I got lucky to be honest. Because it could have been, I could have a rubbish CPN. If I had a worse care coordinator, I wouldn't even be living where I'm living. And we wouldn't even be having this conversation. So yeah, no, I look at it that way. Right now. It's really good."*

*"If they would have come with let's say different avenues **before** ,all of that wouldn't have happened and I done maybe the psychology sessions in the community and maybe found the right medication while I was in the community like **things would have been a lot different before they got worse."***

*"But when you're just kind of sort of ish, unwell for a while, then yeah, it gets very difficult to get what you want… you have to, **you have to go way too far into the system, before help becomes easy to get."***

They would have appreciated support in the community

*"But like, **it doesn't take like you to be locked up to get better. […]** With the right meds and with the right people around you people that have your best interests, like you should be able to get somewhere **without going inside**".*

*"Yeah, **maybe in the community**, like I said erm vocational, workwise, courses, adult education stuff like that."*

***"But I could have done that all outside as well. […]** But it's not like I couldn't have received the treatment outside."*

*"Just a drop-in centre would do, you know maybe somewhere where we can talk about your medication and talk about your mental health. **Rather than going into what's essentially a prison because all of them medium and high security hospitals are just prisons. But it's worse than prison because you have to take medication, what could kill you."***

*"It's like **you're not free,** it's like you're a **slave**, even when you're out and you've still got to engage with them. **It's really and truly against your free will to engage with them.** You don't really want to engage with them…but…you engage with them, **you're told that if you don't engage with them, that you'll be admitted back to hospital."***

*"Just let people know that mental health is real, it's not a disease. Mental health isn't a disease. It's an illness. One thing you should know, is anyone can influence mental health."*

# Chapter 3:

## Press Release for the Literature Review

### *What section you on?*

A recent study conducted in England aimed to examine the impact of ethnicity and section type on admission to mental health in-patient units in England. They found that while there was no significant difference in section type on admission to mental health in-patient units for civil and forensic sections based on ethnicity, there are differences in emergency police holding powers.

The study searched electronic databases for studies reporting the legal status on admission to psychiatric in-patient units by ethnic groups. Out of 509 studies, nine met the inclusion criteria for the review. The sample size between studies varied from 110 to 3,873 participants.

Based on the study's analysis of detention rates in the UK, it was found that there were no differences in legal status upon admission to mental health in-patient units for civil and forensic sections across different ethnic groups. This means that regardless of ethnic background, individuals admitted to these units had similar legal statuses.

However, the study also revealed significant differences in the use of emergency police holding powers between the Black and Asian populations compared to the white population. Specifically, Black, and Asian individuals were more likely to be detained using emergency police holding powers than their white counterparts. This finding suggests that there may be biases or disparities in the use of emergency police holding powers that disproportionately affect certain ethnic groups in the UK.

This study provides important insights into the impact of ethnicity and legal status on admission to mental health in-patient units in England. The findings of this study can inform clinical practice and policy development to improve mental health care for diverse patient populations.

It is important to note that previous research has found that Black and minority ethnic (BME) groups are at an increased risk of compulsory detention in psychiatric care. Therefore, understanding the impact of ethnicity and legal status on admission to mental health in-patient units can help address this disparity and improve all individuals' access to mental health care.

This study highlights the need for further research into the impact of ethnicity and legal status on mental health care access and outcomes. By understanding the unique challenges faced by diverse patient populations, mental health services can work towards providing culturally responsive care and reduce health disparities.

***References***

Bansal, N. *et al.* (2022). "Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography," *PLOS Medicine*, 19(12). Available at: https://doi.org/10.1371/journal.pmed.1004139.

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., & Ariyo, K. et al. (2019). Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry*, *6*(4), 305-317. https://doi.org/10.1016/s2215-0366(19)30027-6

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. *British Journal Of Psychiatry*, *182*(2), 105-116. https://doi.org/10.1192/bjp.182.2.105

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. (2016). Ethnicity and detention are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007. *Social Psychiatry And Psychiatric Epidemiology*, *51*(5), 703-711. https://doi.org/10.1007/s00127-016-1181-z

# Press Release for the Empirical Research Paper

***"It's just a dustbin for Black people"***

In a recent study conducted by researchers in Birmingham, UK, eight Black men previously detained in forensic hospitals were interviewed to explore their subjective experiences of trust before their detention in forensic mental health services. The study shed light on how trust can be used to understand Black men's help-seeking and experiences of mental health services, such as primary care, crisis services, and the police/criminal justice system.

The study identified six group themes: life stresses, self-reliance, disillusionment, lack of communication and cultural competency, feeling invisible and frustrated in their care, and a perception that mental health professionals do not care.

One significant study finding was the impact of life stresses on trust. Participants cited substance use, money issues, and relationship breakdowns as major stressors that negatively affected their mental health. The study also found that many participants were reluctant to seek help, preferring to handle their problems themselves rather than seek external support.

The study also highlighted a perceived lack of cultural competency among mental health professionals, associated with a mismatch between the interpretations of their own experiences and the intentions of mental health professionals. This lack of understanding further eroded trust in mental health services and made it difficult for Black men to access the care they needed.

The feeling of invisibility and frustration in care was another major theme identified in the study. Participants reported feeling dismissed, ignored, and unsupported in their interactions with mental health professionals, leading to alienation and mistrust.

The study's findings underscore the importance of culturally responsive mental health care that addresses the specific needs of Black men. Mental health services could be enhanced through a greater understanding of the unique challenges faced by Black men and working collaboratively with them to create a care plan that meets their individual needs.

The study provides valuable insights into the experiences of Black men in the mental health system and highlights the importance of trust in delivering effective mental health care. By addressing the issues of cultural competency, communication, and engagement difficulties, mental health professionals can build trust with Black men and improve their access to early treatment of mental health care.

***References***

Bhui, K., Brown, P., Hardie, T., Watson, J., & Parrott, J. (1999). African-Caribbean men remanded to Brixton prison. Psychiatric and forensic characteristics and outcome of final court appearance. *Journal Of Clinical Forensic Medicine*, *6*(1), 57–58. https://doi.org/10.1016/s1353-1131(99)90188-8

Choudhry, F. R., Mani, V., Ming, L., & Khan, T. M. (2016). Beliefs and perception about mental health issues: A meta-synthesis. *Neuropsychiatric Disease and Treatment*, *Volume 12*, 2807–2818. https://doi.org/10.2147/ndt.s111543

Jeraj, S, Shoham, T and IslamBarratt, F, (2015). *Mental health crisis services for Black and minority ethnic people*, Race Equality Foundation, https://raceequalityfoundation.org.uk/healthcare/mentalhealthcrisisservicesforBlackandminorityethnicpeople/

McKenzie, S. K., Oliffe, J. L., Black, A., & Collings, S. (2022). Men's experiences of mental illness stigma across the lifespan: A scoping review. *American Journal of Men's Health*, *16*(1), 155798832210747. https://doi.org/10.1177/15579883221074789